Our Vision
The best care
for every patient

NHS
Norfolk and Norwich
University Hospitals
NHS Foundation Trust

Annual Report and Accounts

2021 - 2022

Norfolk and Norwich University Hospitals NHS Foundation Trust

Annual Report and Accounts 2021-22

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Performance Report

Chairman's Statement

Welcome to our review of 2021-22 which covers one of the most difficult years we have experienced as a Trust. As covid recedes we are facing the challenging task of tackling the backlog of elective care, supporting our hard-pressed staff and picking up the service development and quality agenda again.

In the coming year our organisation will be taking a fresh perspective on many aspects of the care and treatment provided by our hospitals following the Covid-19 pandemic. Our teams will be seizing the opportunity to do things differently, implement new ways of working and make the most of new technology.

This new approach is embodied in our new five-year plan for the Trust – Caring with PRIDE – which is being rolled out from April 2022, giving us new impetus for the coming year.

The plan sets out a series of commitments to patients, staff and partners with detailed plans sitting underneath each element. We have also taken the opportunity to update our vision statement to 'The best care for every patient', after extensive public and staff engagement, with support from our hospital governors.

The strategy reflects the wide programme of patient and staff engagement which we undertook to develop the commitments and it comes as we reach the final stages of the pandemic which has reshaped our world.

Covid-19 has left an indelible imprint which will have long lasting changes to the way in which we work. Thankfully there have been positives, such as remote working and the introduction of new technology like the virtual ward which allows us to monitor patients remotely.

The negative effects include the toll on physical and mental health which has affected staff and patients alike, with long waiting lists and a detrimental effect on staff morale and burnout which is reflected in the 2021 staff survey.

To address the concerns raised by staff we are undertaking large scale recruitment programmes to fill gaps in our workforce and we are embarking on a three-year programme to transform the experiences of staff in our workplace. These initiatives are contained in our commitment to staff, part of five-year plan.

On behalf of the board and the governors, I would like to praise our staff and volunteers for the level of personal and professional commitment everyone has shown in stepping up to support patients, families, and each other.

We recognise the outstanding efforts our teams have made over the last two years and say how grateful we are for their selfless care and commitment to our patients.

This year will also be memorable as it is the 250th anniversary of the Norfolk and Norwich Hospital in 2022 which started seeing its first outpatients in July 1772. Over the generations, our hospital has touched the lives of every local family and this year we want to mark our achievements and our history. We will be celebrating this significant milestone with our local community with a series of events, including heritage and open day events.

There have been significant changes in the structure of the NHS over the last year and we are now part of the Norfolk and Waveney Integrated Care System. The ICS is made-up of a wide range of partner organisations, working together collectively to tackle waiting lists, non-elective demand, financial challenges and future investment opportunities. As an organisation we will need to think more broadly, moving away from individual organisation planning towards system-wide planning. We are also part of the system-wide Elective Recovery Board which is aiming to equalise waiting times, by geography, across Norfolk and Waveney and create a fairer system for patients being treated in the three acute hospitals. The Personalised Outpatient Programme launched this month will also see patients offered more choice about receiving follow up appointments and is expected to free up consultant time to see new patients.

We have one of the oldest populations in the country and this has been reflected in the large numbers of patients, between 130-170, who have no criteria to reside in our hospital and need to move on to the next phase of their recovery. The pandemic has disrupted the care sector with many care homes closing and a reduced workforce struggling to meet demand. The solution to Norfolk's social care shortage lies in better and stronger joint working and risk sharing – making small changes across organisations and finding more, community-based innovative solutions.

As a hospital, we are trying to balance the needs of patients who are recovering from covid and other illness with those needing surgery. Our new orthopaedic centre, due to open in summer 2022, will help to address the long waits for hip and knee replacements as it is separate from the main hospital and not affected by emergency demand in the same way. The coming year will also bring a focus on quality of care with nine new quality priorities, covering patient safety, clinical effectiveness and patient experience. Recognising that our staff have had a challenging time over the past two years, we are including an additional priority focussing on staff experience.

I would also like to thank the executive team and non-executive directors for their leadership during this difficult period and for their on-going support as we move on from the pandemic. Their continued support is crucial as we adapt to a changed world and reconstruct our services.

David White, Chairman

Chief Executive's Statement

Our Trust is one of the busiest in the region, with over 10,000 talented and dedicated staff treating a million patients a year. In addition, we have around 600 committed and enthusiastic volunteers, who work tirelessly to enhance the experience of our patients and their families.

We are made up of the Norfolk and Norwich University Hospital and Jenny Lind Children's Hospital on our main site, and the Cromer and District Hospital in North Norfolk. We also run many services in the community such as the Norfolk and Norwich Kidney Centre, mobile cancer treatments and Midwifery.

We are part of the Norfolk and Waveney Integrated Care System (ICS) which is due to go live in July 2022. ICSs are new partnerships between the organisations that meet health and care needs across an area.

For our hospitals, recovering from the pandemic is proving to be as challenging as dealing with the first appearance of Covid-19, with the NHS experiencing disruption to its services in the same way as other sectors, particularly in terms of staff sickness and the practicalities of all the enhanced Infection Prevention and Control measures.

The last year is also significant, because we have reached the point where we need to make further transformational changes in the way we run services and support our staff. Innovation is the key to tackling these issues and we will see our services working in a very different way in the years to come, with an electronic patient record on the horizon. We have already introduced our Virtual Ward and virtual outpatient appointments, all of which have had very positive feedback from our patients.

We will be pulling out all the stops to enable Team NNUH to thrive and innovate as we move forward and use the learning from the past 12 months to shape our future.

Strategy

Our long-term plans are captured in a new five-year strategy – called Caring with PRIDE – which was published in April 2022. It sets out our commitments to patients, staff, partners, services and resources, following a comprehensive communications and engagement programme in summer 2021 where hundreds of patients, families and carers from our local community and our staff and partners contributed ideas.

The plan describes how we will invest in staff and expand services to treat the many thousands of patients who are on the waiting list.

Overall, the plan aims to:

- Improve the experience and wellbeing of our NNUH Team by delivering the NHS People Promise.
- Reduce waiting times with a particular focus on long waits and cancer.
- Achieve recognition for the quality of our care and services by being rated 'good' and well on the way to 'outstanding'.
- Deliver a new digital patient and care system (known as the Electronic Patient Record).
- Deliver our financial strategy and reduce our carbon impact on the environment.

Covid-19

In the early stages of the pandemic, there was uncertainty but also an optimism born of people pulling together to endure a traumatic change in both their personal and professional lives. Now we are dealing with a resurgence of Covid-19 as we enter April 2022 but also a huge backlog of patients to treat and a tired workforce who have given their all during the last two years.

Whilst the big cities experienced larger waves of covid early in the pandemic, we have seen the infection continue to spread at pace in 2022 as our rural and older population succumbs. Thankfully the vaccination programme has been an outstanding success with very few patients needing critical care compared to a year ago. Nevertheless, we are treating in the region of 90 patients for covid through March/April 2022, as high as the number for January, with a further 100 patients recovering from the illness with little capacity in the social care system to support them in leaving hospital.

Staff experience

The staff survey completed in October 2021 shows low scores across a range of indicators including staff morale, work pressure and wellbeing. There has been a slight improvement in some aspects of team working as well as diversity and equality. Frontline clinical teams have been bearing the brunt of the pandemic and report lower scores than non-clinical staff.

It will take a multi-year plan to transform the way in which we work and bring about the improvements that matter to staff. We have made a commitment to staff to focus on a long-term investment in the strength, depth, skills, experience, and wellbeing of everyone in the NNUH Team and in recruitment. The appraisal system is being completely changed with a constructive and positive approach to help staff develop their careers. Identifying our future leaders is a priority for us and we will be introducing succession planning.

There are areas where we can improve staff experience by introducing technology and the e-rostering system which covers about 90% of our workforce will help with matching staff to service needs. Shared decision making is another development which will see staff get more involved in the decisions that affect them and take us towards a more modern style of management.

Performance

One of our biggest challenges is addressing the needs of thousands of patients who are waiting too long for treatments. We have one of the largest waiting lists in the country – 77,000 patients – and we are on track to eliminate 104 week waits by 1 July 2022 in line with national targets.

Since October 2021, our long patient waits have reduced from 7976 to 2362 in March 2022. This has been achieved with assistance from the independent sector and extra effort from our own staff who have taken on initiatives such as 'Super Saturdays' and seven-day rotas.

Moving forward, we have joined the national Personalised Outpatient Programme (POP) which will help us achieve a reduction of 25% in follow up appointments to help us meet the national targets on long waits by freeing up capacity. This will see us adopting Patient-Initiated Follow-Up (PIFU) appointments across our specialties where safe and appropriate to do so. The POP system offers a safe and effective way to manage outpatient waiting lists, giving patients more control over appointments and releasing time so that our clinicians can take up other clinical work such as new appointments, diagnostics and procedures.

An expansion of our services is also required to meet the demand and we will be significantly expanding our surgical and diagnostic services to create more capacity for treating patients. Later this year we will be opening two purpose-built paediatric theatres and we are developing a standalone orthopaedic centre due to open in 2022. We plan to open a major new diagnostic and assessment centre in 2024 in common with the other two acute hospitals, creating three centres across Norfolk and Waveney. We also continue to establish innovative services such as our Ambulatory Procedures Unit, which specialises in procedures for patients with hand trauma. We have also expanded our robotic assisted surgery programme which is on course to be recognised as a centre of excellence.

Patient flow

Throughout 2021/22, we have seen significant numbers of patients who have not be able to leave hospital in a timely way because of a lack of capacity in social care. This meant we have had six-bedded bays with seven or eight beds for extended periods of time. Our staff are making a huge effort every day to work in a system that is under enormous pressure. As a Trust, we also need to do more within the hospital to embed the Discharge to Assess pathways where patients go home with some immediate carer support and are assessed in their own homes for any longer-term needs. We are also putting in place some specialist posts for complex discharges which need a different approach. The Virtual Ward, where patients are monitored once they return home, and Gunthorpe Home First ward, which helps with deconditioning, have been helpful in supporting patients to return home.

The lack of discharges once patients are medically fit to leave hospital has a double impact. The more urgent and emergency patients we see, the less capacity we have for electives, meaning many patients are waiting too long for treatment. It also creates hold ups in the Emergency Department (ED) when there are too few discharges and no beds available for newly arrived patients. A number of actions have been taken through the year from the Safer, Better, Faster programme and we are also reviewing the footprint of ED to make the best use of space and assist flow through the department.

Digital modernisation

There is a lot of work ahead to reach our ambition of being a digitally advanced hospital. However, we are already building the infrastructure and delivering the systems that will ultimately enable us to achieve this ambition.

We have embraced technology with the virtual ward which has proved to be an outstanding success. The most significant project, which will improve both patient and staff experience, is the Electronic Patient Record. It is being supported at national level with 90% of NHS trusts required to have an EPR in place by the end of December 2023. This will mean clinical staff having information at their fingertips to aid decision making, with improvements in patient safety and efficiency.

Finance

There is a continued focus on the Trust's arrangements for achieving economy, efficiency and effectiveness in its use of resources to achieve value for money. In future we can expect an increased focus on finances across the ICS where providers are allocated the bulk of the funding for the local NHS. As we move towards the financial year end, we are forecasting a £9.1m surplus and a repatriation of £4.8m to the system, compared to the planned breakeven position. Across the year, a combination of over-achieved CIPs (Sustainable Cost Improvement Programmes), reduced activity and a high number of vacancies have been contributing factors in delivering the surplus.

Quality

The last year has seen us focus on care quality issues which are particularly important when patients are remaining with us for extended periods. Work has been undertaken to prevent falls, avoid pressure ulcers and improve patient nutrition and hydration. We have published our five-year Dementia strategy which challenges us to go further for people by anticipating their core needs, from early diagnosis with regular assessment, to planning care with patients, carers and families.

Research

Research is important to us as a University Teaching Trust and we've worked with our partners on the Norwich Research Park to develop a strong and thriving partnership between us, the University of East Anglia (UEA) and the Quadram Institute of Bioscience (QIB). This has already enabled our NNUH Team to deliver world-leading research, such as the Norfolk Diabetes Prevention Study and a key role in Covid-19 vaccine research.

Conclusion

There's no doubt that the last year has been one of the hardest for the NHS as we reset our services and do the right thing for our patients. Once again, our teams have been incredible in dealing with this latest stage of the pandemic.

I would also like to thank our Chairman David White who's current term of office as Chair of the Trust finishes at the end of May 2022. Due to health reasons he will not be seeking a second term. We have all greatly valued David's leadership and support, and the significant role he has played in the Trust's sound progress and achievements on our improvement journey, particularly during the challenging times we've all experienced in the last two years.

We have a busy time ahead and supporting staff will be a priority. Our ability to deliver, safe, high-quality care to a million patients a year depends on the outstanding professionalism and dedication of our teams who have gone above and beyond in meeting the challenges of the pandemic.

Sam Higginson, Chief Executive

Overview of Performance

Welcome to our 2021/22 annual report which describes our achievements during the year, covering our service improvements, finances and performance in key areas.

Purpose of the overview section

This overview section gives a short summary of the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Purpose and Activities

NNUH is one of the largest and busiest University Teaching Trusts in the country. We are made up of the Norfolk and Norwich University Hospital and Jenny Lind Children's Hospital on our main site, and the Cromer and District Hospital in North Norfolk. We also run many services in the community such as the Norfolk and Norwich Kidney Centre, mobile cancer treatments and Midwifery.

We are part of the Norfolk and Waveney Integrated Care System (ICS). ICS's are new partnerships between the organisations that meet health and care needs across an area. ICS's are designed to coordinate and plan services in a way that improves population health and reduce health inequalities between different groups. In addition to continuing to work closely with the other hospitals in Norfolk and Waveney and the East of England, a priority for us is to work more closely with GP, community, and voluntary organisations, to support the development of place-based partnerships of care. People access most of the health and care services they need in the 'place' where they live, including advice and support to stay well and access to joined-up treatment when they need it. We will mainly work with the three places of North Norfolk, Norwich, and South Norfolk to ensure as many people as possible can receive as much care and treatment as close to their homes as possible in the future.

Research is important to us as a University Teaching Trust and we've worked with our partners on the Norwich Research Park to develop a strong and thriving partnership between us, the University of East Anglia (UEA) and the Quadram Institute of Bioscience (QIB). This has already enabled our NNUH Team to deliver world-leading research, such as the Norfolk Diabetes Prevention Study and a key role in Covid-19 vaccine research. The Quadram Institute is a collaboration between the Trust, UEA and the QIB. Our endoscopy unit, the largest in Europe, is sited in the Institute, as is our Clinical Research Facility.

Improving the offer to our NNUH Team to support health and wellbeing, training and career development is crucial. More than ever, it is vital that we create the best place to work for our highly skilled and dedicated NNUH Team who continue to deliver services with compassionate care every day. We also need to attract new staff to help with those areas where we have recruitment challenges. The Feedback that the NNUH Team has given through the annual NHS Staff Surveys and the more recent introduction of online discussion forums and open conversations at the Trust, is fundamental to guide the improvements we need to make for people who work here.

Only with an appropriately trained, empowered and supported Team will we be able to deliver our ambitions for the development and improvement of staff and patient experience, quality, performance and the management of our resources, outlined in this strategy.

Brief History

The Norfolk and Norwich Hospital celebrates its 250th anniversary in 2022 - the hospital saw its first outpatients on 11 July 1772 and first inpatients on 17 November 1772.

The hospital became a teaching Trust when it was rebuilt in 2001 and moved from the St Stephen's site in Norwich to Colney Lane on the outskirts of the city. We were authorised as an NHS Foundation Trust on 1st May 2008 in accordance with the National Health Service Act 2006. The NHS Foundation Trust succeeded the NHS Trust formed in 1994.

Strategy

During 2021, we have developed our strategy for the next five years, called 'Caring with Pride', which is inspired by the experiences, hopes and ideas of our NNUH Team, patients and carers, our community, and our partners. Over a six-month period, we asked 'what matters to you?', holding workshops, events and running wide ranging surveys. More than one thousand people have shared their views with us and we are extremely grateful to everyone who has helped us. You have shaped our plan, from recrafting our hospital vision, 'The Best Care for Every Patient', to the actions we will take to progress from where we are today in 2022, to where we need to be in the next five years.

One of our biggest challenges is to treat the thousands of patients who are waiting too long to be seen due to the pandemic. Our plans to address one of the largest waiting lists in the country include significantly expanding our surgical and diagnostic services to create more capacity for treating patients. We will shortly open two purpose-built paediatric theatres and are developing a standalone orthopaedic centre due to be opening this year (2022). In 2024, we plan to open a major new diagnostic and assessment centre. We continue to establish innovative services such as our Ambulatory Procedures Unit, which specialises in procedures for patients with hand trauma. We have also expanded our robotic-assisted surgery programme which is on course to be recognised as a centre of excellence.

Our teaching hospital is one of the largest employers in the region, supporting a 10,500-strong NNUH Team. The feedback that our Team has given through the annual NHS Staff Survey and the ongoing online discussion forums and open conversations at the Trust is fundamental to the improvements we will make. It is by valuing the NNUH Team and developing our organisation and increasing the opportunities that we offer that, together, we will be the best that we can be.

We have an important education and teaching role. A key part of our plan is continuing to develop this with our partners, increasing training opportunities for staff, students and apprentices. We will continue to grow as a learning-centred organisation, supporting and valuing our teachers, and our many medical, dental, nursing, midwifery, allied health professional, and Skills Academy learners. We are focused on providing the best environment for learning and teaching, because we want the people who learn with us to be our colleagues of the future.

Research is vital to our organisation and the future care of our patients. We have worked with our partners on the Norwich Research Park to develop a thriving partnership between us, the University of East Anglia (UEA) and the Quadram Institute Bioscience (QIB). This has seen our NNUH Team deliver world leading research, such as the Norfolk Diabetes Prevention Study, and play a key role in Covid-19 vaccine research. We are committed to further developing our relationships and increasing our research activities in the coming years.

Many of you will have heard of the changing way in which organisations in the NHS and social care are beginning to work more closely through the creation of Integrated Care Systems. We are excited about the opportunities that working together in the Norfolk and Waveney system presents. Over the course of the next five years, we are going to be working increasingly closely with GPs, community partners, social care and voluntary sector organisations. We will be developing services that meet the needs of a growing and older population. Among other things, these services will address unfair and unexplained differences in health and healthcare between groups of people, known as health inequalities.

We will continue to work closely with our trusted neighbouring hospitals, the James Paget University Hospital in Gorleston and The Queen Elizabeth Hospital in King's Lynn. Together we have already launched the Norfolk and Waveney Urology service between all three hospitals, and the Norfolk and Waveney Ear Nose and Throat (ENT) service between ourselves and the James Paget. We are actively working on and developing other joint projects that will benefit more patients in the future.

The pandemic is having an enormous impact on the focus and development of our plans. We are confident that in the next five years we will be able to show real progress through our five core commitments to our patients, our NNUH Team, our partners, our services and our resources. In particular these plans will:

- Improve the experience and wellbeing of our NNUH Team by delivering the NHS People Promise.
- Reduce waiting times with a particular focus on long waits and cancer.
- Achieve recognition for the quality of our care and services by being rated 'good' and well on the way to 'outstanding'.
- Deliver a new digital patient and care system (known as the Electronic Patient Record).
- Deliver our financial strategy and reduce our carbon impact on the environment.

As part of our engagement with stakeholders, we have refreshed our vision and purpose statements:

1. Our Vision: The best care for every patient

2. Our Purpose: Working together, continuously improving for All

Our new purpose statement underpins our commitment to teamwork, collaboration, inclusivity, and quality.

Defining our objectives through a set of commitments

We have also made a series of commitments in the corporate strategy which each have a series of actions attached to them. See more detail at www.nnuh.nhs.uk

The commitment to Our Patients:

- Together we will develop services so that everyone has the best experience of care and treatment

Both the commitment and supporting plans are focused on how we put people and their experiences of our care and treatment first. They concentrate on how we best engage, listen, and learn to improve all aspects of our hospitals, our NNUH Team, and our processes.

The commitment to Our NNUH Team:

- Together we will support each other to be the best that we can be, to be valued and proud of our hospital for all.

The greatest strength of our hospital is the dedicated people who work and volunteer here. This commitment and supporting plans focus on a long-term investment in the strength, depth, skills, experience, and wellbeing of everyone in the NNUH Team. It's imperative we have the right culture of diversity and inclusion, support, and respect at the heart of everything we do.

The commitment to Our Partners:

- Together, we will join up services to improve the health and wellbeing of our diverse communities.

Collaboration and cooperation are the key principles of this commitment and our supporting plans for the next five years and beyond. As partners in systems of care, in education and training, and in research, we know that we can achieve far more working together than individually.

The commitment to Our Services:

- Together, we will provide nationally recognised, clinically led services that are high quality, safe, and based on evidence and research.

This commitment and the supporting plans seek to ensure that we best meet the essential hospital needs of people who live in Norfolk and Waveney, by making sure that our services are the right size and are delivered in the most effective way.

The commitment to Our Resources:

- Together, we will use public money to maximum effect.

The commitment and supporting plans are about ensuring that we effectively use all our allocated resources to provide high-quality and efficient care for patients. It includes the best use of our finances, estates, and facilities, and how we reduce waste and our impact on the environment.

Key issues and risks

In Norfolk and Waveney we have one of the largest older populations which is growing at a greater rate than in most other parts of the country.

Due to age alone, in the 10 years leading up to 2025 in Norfolk there will be approximately 9,000 more people with diabetes, 12,000 more people with coronary heart disease, and 5,000 more people who suffer a stroke and survive. As part of providing high quality services for this older and more frail population, we have developed services that include our Older People's Emergency Department, the first of its kind in the country, and a ground-breaking dementia support service, which is growing each year.

We have continued to increase our capacity to offer services to a growing population and **in** 2020 we added a new 100-bed ward block; the Norfolk Centre for Interventional Radiology, and a specialised negative pressure isolation unit (NPIU) to treat patients with infectious diseases. Our role in the system sees us offer one of the biggest cancer treatment centres in the country, which has world-class facilities. We are also home to other specialised diagnostic, general and emergency services such as heart attack and hyper-acute stroke centres and a Neonatal Intensive Care Unit.

Our Emergency Department (ED) provides a service to ever-increasing numbers of patients. Originally built 20 years ago for 60,000 patients a year, the department now sees more than double that number each year. The service improvements and exceptional hard work of the ED Team was recognised by the CQC in July 2021 when our emergency care achieved a rating of 'Good'. The team is also making further improvements including reducing waiting times for patients, through our Safer, Better, Faster programme. The Trust is currently rated overall as 'requires improvement' by the CQC.

Along with Cambridge, we continue to be one of the main centres for specialist work in the East of England. Patients can access many tertiary services at our hospitals rather than having to travel further afield thanks to investment in services such as robotic surgery, interventional radiology, critical care and cardiology. The pandemic saw us become a regional surge centre with critical care capacity expanded from 20 beds up to 80 depending on demand. These types of specialist services are delivered alongside caring for people of all ages with a wide range of more general medical and surgical conditions, particularly the significantly older population that is unique to Norfolk, many of whom come to us with one or more long term conditions. For more information, see the strategy section on page 15 and the long term trends section on page 30.

Finance

We are also working together as a system on our finances to address the underlying deficit in the Norfolk and Waveney healthcare system and looking for productivity and efficiency savings in our own hospitals. Lower than anticipated levels of activity and expenditure against a fixed income meant we achieved a surplus at the year-end of £9.5m. We delivered £15.6m of savings against a target of £12.6m. About £11.7m of this amount will be delivered recurrently and will benefit us in future years. Work continues in relation to development of schemes with a target of £20.1m recurrent savings planned for 2022/23.

In spite of the pressures on our hospitals, we have continued to see significant development over the last year, helping us to expand capacity and upgrade our facilities. Here is a summary of our progress:

- The North Norfolk Macmillan Cancer Support Centre at Cromer Hospital opened in September 2021.

- A £2.9m walk-in day procedure unit at NNUH opened in August 2021as part of the trust's building improvement programme. It uses cutting edge equipment housed in three neutral pressure treatment rooms, as well as associated support areas to enhance services for ambulatory patients attending for procedures.

- Building is underway on a £6.5m dedicated children's theatre complex. Due to be completed over two phases, in phase one we will provide a twin paediatric theatre suite, a six-bay recovery unit, as well as associated supporting facilities. Combined with the new facilities this will create a high standard of children's surgical capacity to meet the needs of NNUH younger patients, both now, and well into the future.

- A cutting-edge Data Centre, which houses the majority of Digital Health's IT infrastructure, opened in Sprint 2021. The development has been made possible thanks to a £1m grant from NHSI's Critical Infrastructure fund

- A new two-storey modular training facility also opened in the Spring which is primarily used for our Clinical Skills, Resuscitation, Manual Handling and Healthcare Assistants training.

- The Virtual Ward was launched early in 2021 to enable patients to continue their recovery from Covid-19 at home while being carefully monitored remotely. The Virtual Ward provides a safe and effective monitoring and follow-up service for up to 40 patients and the potential to help other patient groups.

- A major project to increase surgical capacity was announced with plans to create a new £11m standalone orthopaedic elective centre. The new Norfolk and Norwich Orthopaedic Centre will see the creation of two new laminar flow theatres and a 21-bedded ward and will provide our Trust with a much-needed standalone and Covid-secure elective surgical facility. The complex is due to open later in 2022 and will result in the repurposing and relocation of activity in the Aylsham Suite, will carry out around 2,500 orthopaedic cases a year for patients who need ankle, foot, hip, knee or shoulder operations.

Research

We have worked with our partners on the Norwich Research Park to develop a thriving partnership between us, the University of East Anglia (UEA) and the Quadram Institute of Bioscience (QIB). This has seen our NNUH Team deliver world-leading research, such as the Norfolk Diabetes Prevention Study, and play a key role in Covid-19 vaccine research.

We are committed further developing our relationships and increasing our research activities in the coming years. Dedicated research staff support studies and at any one time there can be 300 active studies ranging from small local studies to those that are multi-site across the UK and worldwide.

Our Trust has four key strategic goals for research:

1. Embed a culture of research throughout NNUH creating an inspirational environment that is recognised nationally and internationally, which inspires future leaders of clinical research
2. Consolidate and deepen the special partnership with the University of East Anglia and Quadram Institute Biosciences
3. Develop sustainable strategic partnerships critical to the region and wider NHS
4. Be recognised as a leading NHS Trust in applying research and adopting innovation to deliver the best patient care and to benefit the wider NHS

Emergency Preparedness, Resilience and Response' (EPRR)

We need to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak - such as the Covid-19 pandemic - or a major transport accident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004 and the NHS Act 2006 (as amended).

This work is referred to in the health service as 'Emergency Preparedness, Resilience and Response' (EPRR).

All NHS funded services must have robust and well tested arrangements in place to respond to and recover from these situations. The minimum requirements which commissioners and providers of NHS funded services must meet are set out in the current NHS England Core Standards for EPRR (Core Standards). The Trust is audited annually on these core standards and in 2020 The Trust was fully compliant.

Going Concern

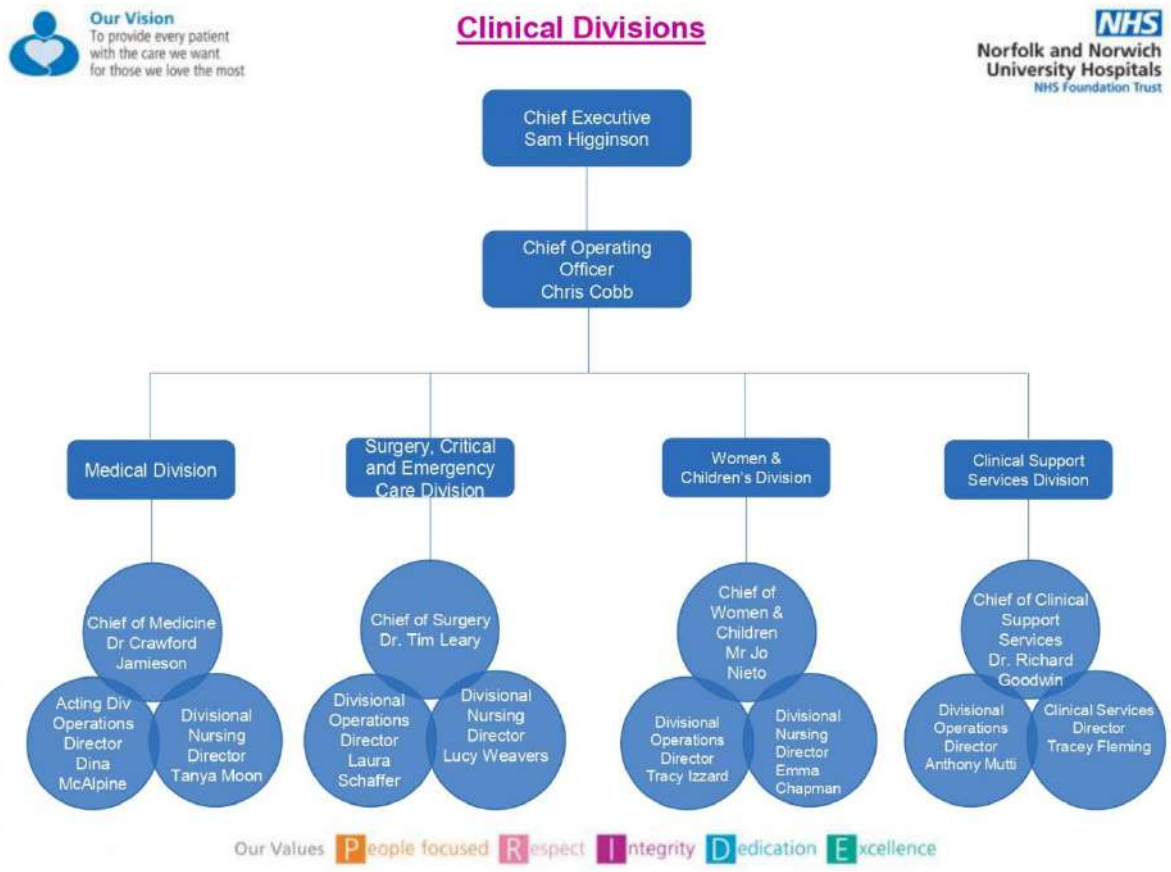
After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following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

Performance Analysis

How we measure performance

Our services are clinical led with four divisions: Medicine, Surgery, Women and Children's Services, and Clinical Support. There is a Chief of Division role in each who is the overall lead for the division, with all roles within the division ultimately reporting to them. The Chief is accountable for the performance of the division. Each division also has a Divisional Operations Director whose primary role is to direct and control operations to deliver the division's business plan including recruitment and training of staff, management of service line budgets and ensuring service quality. There is also a Divisional Nursing/Clinical Services Director whose role is to direct and control divisional clinical staff including maintaining patient safety and ensuring front-line teams are appropriately motivated and trained.

The Chiefs of Division report to the Chief Operating Officer and are part of the Management Board with the Executive Directors. The Management Board is responsible for the operation and performance of the Trust, reporting to the Trust Board. The divisional structures are show below:

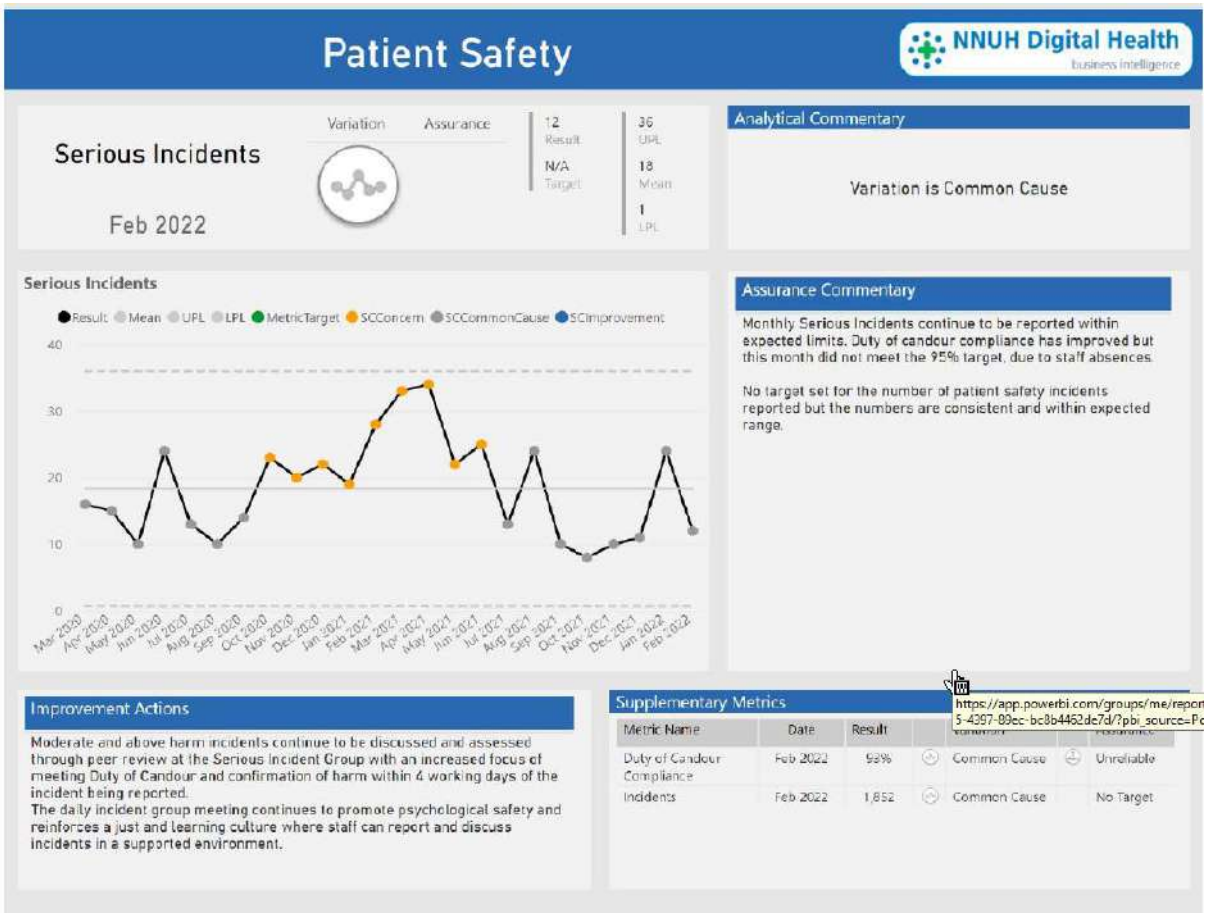


Integrated Performance Analysis

A monthly integrated performance report is produced by the Trust which provides details of how the Trust is performing on key targets such as infection control, cancer waiting time targets, the A&E target, and the 18-week RTT target, plus finance and staffing issues.

It is shared widely with the Trust Board, Management Board, the Council of Governors and with staff. The aim is to keep everyone informed on how the Trust is performing and describe our progress towards meeting targets or introducing new quality initiatives.

Example of a summary slide from the integrated performance report:



During the year, we have been meeting with our regulator NHS England and NHS Improvement to review our performance and have focused on the Trust's improvement plans, financial position and long-term strategy.

KPIs, Risk and Uncertainty

The Trust has a Risk Management Strategy which sets out the accountability and reporting arrangements to the Board of Directors for risk management within the Trust.

Risk is assessed at all levels in the organisation from the Board of Directors to individual wards and departments. This ensures that both strategic and operational risks are identified and addressed and risk assessment information is held in an organisation-wide Risk Register. A risk scoring matrix is used to ensure that a consistent approach is taken to assessing and responding to clinical and non-clinical risks and incidents.

Those risks with a high residual risk rating (following the impact of appropriate mitigating actions) are detailed in a High-Risk Tracker – reported to both the Board of Directors and Management Board through the Integrated Performance Report.

The Hospital Management Board oversees the identification and mitigation of key risks arising from or relevant to the operation of the Trust. Each of the Management Board committees and governance sub-boards have Terms of Reference and they report regularly to the Management Board on areas of risk or issues that require escalation.

There are eight Governance roles across the Divisions. These Leads will play a key role in promoting a safety-first culture and disseminating and best practice learning across all staff groups.

At board level, the Board Assurance Committees will review the adequacy and effectiveness of the structures, processes and responsibilities within the Trust for identifying and managing key risks;

The Board has established the following Committees of the Trust:

- Audit Committee;
- Quality and Safety Committee;
- Finance, Investments and Performance Committee;
- People and Culture Committee
- Nominations and Remuneration Committee;
- Committee in Common (meeting as part of N&W Hospitals Group)
- Charitable Funds Committee.

For more information, see the Annual Governance Statement on page 88.

This section details a number of quality initiatives and programmes that the trust has supported throughout 2021 – 22.

Care assurance

Care assurance was launched in 2021 - 22, which set out three key deliverables:

1) An agreed (small) set of clearly defined key measures/ indicators of high-quality care (Adult Inpatient Metrics (AIMS) or equivalent), which is:

- publicly available and accessible to patients, families, carers, and the public
- can be considered alongside broader factors that underpin high quality healthcare
- are aligned with ‘what matters most’ to patients in terms of their experiences

2) Design of an agreed framework and ‘dashboard / balanced score card’, that enables effective and consistent reporting ‘from Ward to Board’

3) Development and implementation of local care assurance system/processes, building on and sharing learning from what has already been developed / tested

- **Measures/ indicators of high-quality care via Tendable© (previously Perfect Ward)**

A complete review of all quality-based metrics on Tendable has taken place, to ensure measurement is accurate and reliable, the trust has also introduced the action planning module to Tendable which allows real-time actions to be captured when audits are being undertaken.

- **Quality dashboard**

A quality dashboard has been developed and tested to support wards and teams to have data available to them to make informed decisions about quality and safety.

- **Care assurance**

A care assurance tool has been developed and implemented which provides an assurance report to each area visited, to complement other data sets and information to make further improvements.

Clinical documentation

Work has commenced on reviewing clinical documentation, with a focus being placed on patient admission and comprehensive risk assessment, allowing us to enhance patient safety and provide assurance of individualised care plans.

Essential care work

In 2021/22, NNUH has progressed the Essential Care Quality Improvement (QI) Programme: Reducing harm from falls, pressure ulcers and poor nutrition and hydration

This programme focussed on reducing the number of reported incidents and driving demonstrable improvement in the reduction of patient harm as a result of patient falls, poor nutrition and hydration and pressure skin damage and will continue into 2022/23. Although sensitive to the number of available nursing staff, this programme requires a multidisciplinary approach to achieve sustainable change and improvement.

The programme focusses on commonly occurring themes across all three domains, these are:

- Assessing risk
- Care planning
- Monitoring and review
- Self-management
- Education

Adult inpatient Metrics (AIMS) related to the three domains are audited using the Tendable© audit tools in a rolling programme and results are utilised by ward teams to identify areas for improvement. They also serve as an educational tool, with any issues discussed at safety huddles and team meetings. Staff are fully engaged with the process and results are improving with change ideas for improvement coming directly from staff and are tested via a small-scale Plan Do Study Act (PDSA) cycles on the wards.

Falls Improvements: Numerous wards have been running falls improvement projects; improvement huddles meet weekly to review data and agree actions for the coming week. The Falls Steering Group is providing leadership and governance of the QI projects, the implementation of a refreshed Falls Policy and Multifactorial Falls Assessment.

Pressure Ulcer Improvements: The Tissue Viability Team have supported the implementation of PURPOSE T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) which is a pressure ulcer risk assessment framework. It is intended to identify adults at risk of pressure ulcer development and makes a distinction between primary prevention (applicable to those at risk of pressure ulcer development) and secondary prevention (applicable to those who already have a pressure ulcer). There has been a reduction in reportable pressure ulcer incidents during admission by 18% for 2021-22 despite the ongoing covid admission rates, skin integrity risks from covid and additional admission pressures.

Nutrition and Hydration Improvements: The Nutrition Steering Group have oversight of QI projects and other improvement initiatives that are in progress. There has been a focus on completing food charts, improving diet signage around meal choices and dietary needs of patients, including providing a finger food menu. Other QI projects include 'Mouth Care Matters' aiming to improve oral health, and 'Think Drink' to improve hydration status of patients.

CQC

The Trust received an unannounced focused inspection of Urgent and Emergency Care within the Emergency Department at the Norfolk and Norwich University Hospital in May 2021

There were improvements in the Safe and Well Led domains being rated as 'Good' with Responsive remaining at 'Requires Improvement'. The overall rating for Urgent & Emergency Care has also improved too 'Good'.

Work has continued throughout the year across the trust to gather evidence against the CQC domain.

The trust continues gathering evidence and undertaking improvement activity to ensure previous CQC recommendations are actioned.

Quality Improvement (QI) capacity and capability

In 2021 – 22 the trust approved a QI curriculum, which will deliver a blended approach to QI training for all NNUH colleagues. Varying from the full Quality, Service Improvement, and Redesign (QSIR) practitioner programme to a one-day QI fundamentals day, information at induction and supporting the medical deaneries with QI training. The one-day QI training commenced in November 2021.

The Life QI platform continues to be used well for monitoring and displaying team and individual QI projects. QI week took place in November 2021, which allowed the two QI teams, to meet and share information with colleagues.

A QI shared learning bulletin was launched this year, which allow teams and individuals to share their QI work across the organisation.

Norfolk & Waveney Integrated Care System (ICS) Quality Management Approach (QMA) work

Since October 2021, the Quality Improvement Cross-Organisational Team have worked with the Norfolk & Waveney Integrated Care System (ICS), which becomes statutory from July 2022. Quality is a defined requirement as part of the statutory framework for both systems and organisations, and the team have therefore been working to design and develop a Quality Management Approach (QMA) for the ICS to embed a systematic approach to quality when working across organisational boundaries. This includes ensuring quality is considered in strategy and policy development, supporting, and enabling quality improvement at all levels and designing processes to identify and manage risks to drive improvement – all from a system perspective and for the benefit of patients across Norfolk & Waveney.

Cross organisational quality improvement work

Over the last year, the Cross-Organisational Team has worked with the ICS on two specific programmes to look at these clinical pathways from a system perspective. These are heart failure and infection prevention and control (IP&C), both of which have potential to improve patient pathways and maximize patient outcomes. The heart failure programme is aiming to reduce hospital admissions and readmissions, while the IP&C programme is developing a pilot scheme to reduce the level of urinary tract infections through improving hydration. Both programmes have involved a wide range of stakeholders from several ICS partner organisations, demonstrating the benefits of a collective approach to improving quality.

Transformational work

The Transformation & Efficiency Office (TEO) was created in 2021 - 22 and incorporates an independent Programme Management Office (PMO) and a Delivery Team. The TEO was created to provide two distinct functions, 1.) to provide a governance structure to support projects through their entire lifecycle 2.) to deliver Transformational and Strategic priority projects across the Trust. Under the remit of the TEO are the following schemes/initiatives;

- Outpatients Transformation, incorporating:
    - Advice and guidance (A&G)
    - Patient Initiated Follow Ups (PIFU)
    - Virtual Consultations
    - Virtual Reception
- Strategic Initiatives (from Financial Strategy)
    - Assist with the development of schemes from idea to operational plan
    - Provide check and challenge during the development phase (gateways process)
    - Reporting and monitoring of ‘live’ schemes
- Business case development
    - Virtual Ward – an innovative way of providing hospital quality care within the patient’s own home
    - Mechanical Thrombectomy – another new service to the Trust that greatly improves the outcomes for patients who have suffered from a stroke
- Cost Improvement Programme (CIP)
    - Governance and oversight

The TEO exists to provide a sounding board for the wider Trust, to think from alternate perspectives and to provide constructive challenge to aid the development of ideas. The TEO endeavor to be at the forefront of delivery of Transformational change within the Trust and continue to build on the strengths and experience within the team. The structure and remit of the team is due to be reviewed this financial year to ensure the function is aligned to Trust requirements.

Patient experience quality work

The Patient Engagement & Experience team have continued to roll out the Patient Engagement strategy. Over the last year the Patient Panel has grown, and members are embedded across all divisions and on key committees and have taken leading roles in the transformation of PALS and Complaints, shared consent policy development across the acute hospitals in Norfolk and are supporting a number of transformation and improvement initiatives e.g., Quality Management Approach (for the ICS), nutrition improvements and initiatives for carers. In addition to the Patient Panel the team has supported the development of divisional involvement groups, Maternity Voices Partnership and a significant piece of work reaching out to and engaging with seldom heard groups to understand requirements for improvements around inclusion, diversity and equality. For more information, see the Social and Community Report on page 46.

Quality priorities

The Trust agreed 12 quality priorities for 2021- 22. The Trust's performance against the quality priorities is overseen in the trust-wide Quality Programme Board (QPB). During 2021/22, QPB continued to receive a regular performance report, providing up-to-date information on key quality indicators including patient safety, patient experience and clinical effectiveness.

For more information on quality, see the Trust's quality accounts at www.nnuh.nhs.uk

Equality of service delivery

This section shows how we are working on equality of service delivery to different groups with regard to the public sector equality duty.

Complex Health Hub

Our new Complex Health Hub was launched in mid-2021 to ensure that patients with complex needs receive all the support they need through a single pathway while accessing services at NNUH.

We're the first acute hospital in the country to adopt this model, which has been developed by using the experience and knowledge of our specialist staff across the Trust, to really think about how to provide the best possible service for patients.

The Hub brings together the mental health teams from our Trust and the Norfolk and Suffolk Foundation Trust; Mental Capacity Act and Deprivation of Liberty Matron Sara Shorten, the Safeguarding teams, Learning Disability Services, Dementia Services and the Substance Misuse team.

In recent years, we have seen more patients requiring treatment for their physical health who also have underlying needs, which are often quite complex in nature, with the links between mental and physical health well documented.

The Complex Health Hub enables us to treat each person as a 'whole', caring for their mental health, social and cognitive needs on an equal basis to their physical health. By doing this we aim to improve their experience of receiving care at hospitals and lead to better health and wellbeing outcomes for the patient, their carers and our staff.

Trauma informed Practice
The Complex Health Hub will also be leading on a new approach to care known as "Trauma Informed Practice" in conjunction with partners across the Norfolk system.

Trauma Informed Practice will allow us to take a more holistic approach to our patient's care, considering traumatic events a person has experienced and the impact this could have on not only their behaviours and mental health but also the impact trauma has on an individual's physical health.

Feedback from seldom heard communities
The patient experience team has worked on improving engagement with local, seldom heard communities through social media, organising virtual events focusing on listening to our minority groups/communities and carers. Support has also been given to our Women and Children's division to improve engagement with children and young people by increasing feedback opportunities (see more information on page 46)

Training and specialist services
A core element of our services is respect for dignity, protection of vulnerable patients and of human rights. This is reflected in the specialist work of our Learning Difficulties and Safeguarding team, part of the Complex Health Hub. Through a series of Trust policies and protocols, awareness raising, input on the wards and through staff training the dignity and autonomy of patients is enhanced. This is illustrated, for example, in relation to the deprivation of liberty safeguards, reporting of female genital mutilation, protection against domestic abuse and facilitated decision making for patients with dementia. Regular reports on these issues are received and reviewed through the Trust's Caring and Patient Experience Governance Sub-Board.

Case Study

A global first for NNUH using special shield for prostate cancer treatments

Prostate cancer specialists from the Radiotherapy Department at NNUH have become the first in the world to use an innovative technique to help patients receiving treatment for prostate cancer.

Some patients receiving radiotherapy for prostate cancer will have their treatment split into two portions. The first stage of killing the cancerous cells uses a temporary radioactive implant, in a process known as high dose rate (HDR) brachytherapy.

The second part is delivered as a powerful x-ray beam from outside the patient, in a process known as external beam radiotherapy, which is carried out over a number of appointments. During both stages, however, it is possible for healthy tissue to be damaged such as the large bowel which can become chronically inflamed.

By inserting a special "shield" known as a hyaluronic acid rectal spacer, it is possible to protect the neighbouring tissues from the potential damage caused by external beam radiotherapy. The rectal spacer insertion is usually carried out under local anaesthetic, one to two weeks prior to treatment.

However, in June the Brachytherapy Team became the first team globally to insert a hyaluronic acid rectal spacer during HDR brachytherapy treatment.

The composition of other spacing devices has prevented their use during HDR brachytherapy treatment, as they limit the visibility of the ultrasound imaging, which is key for monitoring this type of brachytherapy treatment. The hyaluronic acid spacer does not interfere with the ultrasound signals which means the prostate gland and surrounding organs can be seen fully after the implant has been inserted. This allows the implant to be inserted during the HDR procedure without reducing image quality for the radiotherapist placing the needle.

Long Term Trends

Efficiency

We are working to improve our use of resources, ensuring that our services are efficient and sustainable for the future. We have been reviewing operational and business planning processes to ensure we optimise the use of substantive staff and reduce temporary staffing costs. Making the best use of our elective beds, reducing length of stay and improving discharge processes are key parts of our plan. New models of care such as the Virtual Ward will help us to deliver good outcomes for patients using proven techniques of remote monitoring that allow people to be at home rather than in hospital.

Becoming more efficient will involve harnessing digital technologies to help drive transformation and improve efficiency. For example, the digital transformation of the outpatient experience has been greatly accelerated as a result of the pandemic with many people now being able to access specialist care and opinion without the need to come to the hospital. The EDMS (Electronic Document Management System) is replacing paper records with electronic ones on our first step to becoming a paperless hospital. It means staff will spend more time on patient care and less time on administration with all the information in one place. Work is also progressing on the Electronic Patient Record (EPR) programme. We will be looking at learning from the issues experienced in implementation of EPR systems in other Trusts across the country. We will be aiming to implement a system that will assist communication and system-wide working across Norfolk and Waveney.

Staffing modernisation

There is more work to do on developing our workforce and ensuring our hospitals continue to attract and retain high calibre professionals. We want our hospitals to be a great place to work and develop, to train and have a long and fulfilling career. There is a commitment to invest in the leadership training and development of our managers

We know that staffing levels are a significant issue, and large-scale recruitment plans are under way to help ensure we have the staff numbers we need. As an organisation we are also adopting a more modern management style with shared decision-making councils being set up across the organisation which will give staff a voice in how the organisation is run.

New technology is being adopted that will enable staff to book shifts on smartphones and electronic systems will speed up overtime payments, time to hire and modernise our approach to appraisals.

Put together, all these changes will make a real difference to staff engagement and retention which has been a factor during the pandemic. See more information in the Staff Report on page 101.

Personalised care

Work is progressing on our Personalised Outpatient Programme (POP), which will see us adopting patient-initiated follow-up (PIFU) appointments across our specialties.

Digital platforms are being set up to help deliver this programme and to make booking follow-ups more convenient for patients and our staff.

The new digital systems bring together our current PAS so that patients can request a follow-up appointment, if they need one, via the **DrDoctor** platform by entering their name, date of birth and postcode.

The platforms will enable our teams to send appointment messages via text, email or letter. Training for our teams will be shared soon.

Patients on an active pathway and other exemptions where a follow-up appointment is essential will not be placed on PIFU. Patients who opt out or who are digitally excluded will be able to contact departments in the usual way.

There will be a phased roll-out with three specialties at a time from Spring 2022.

A PIFU enables a patient, or their carer to book their follow-up appointments as and when they need them, rather than at routine intervals - this might be when their symptoms flare up or their circumstances change. This offers a safe and effective way to manage outpatient waiting lists, releasing time so that our clinicians have more time for other clinical work such as new appointments, diagnostics and procedures.

Partnership working

We are part of the Norfolk and Waveney Integrated Care System (ICS). Integrated Care Systems are new partnerships between the organisations that meet health and care needs across an area. ICS's are designed to organise and plan services in a way that improves population health and reduces health inequalities between different groups of people and communities.

The Norfolk and Waveney ICS is made-up of a wide range of partner organisations, working together collectively to tackle waiting lists, non-elective demand, financial challenges and future investment opportunities. As an organisation we will need to think more broadly, moving away from individual organisation planning towards system-wide planning.

Work is underway on development of a clinical strategy for the system that will set out collective clinical objectives and priorities over the next 5-10 years.

The development of the clinical strategy will cover areas such as addressing the backlog and future sustainability of care, mental health support for the population, exploring capital investment to support transformation of care delivery and digital health solutions.:

A priority for us is to work closely with GP, community, and voluntary organisations, to support the development of place-based partnerships of care. People access most of the health and care services they need in the 'place' where they live. This includes advice and support to stay well and access to joined-up treatment when they need it.

Joint working is also taking place between our Trust and the other two acute hospitals in Norfolk and Waveney – the James Paget University Hospital and the Queen Elizabeth Hospital, King's Lynn.

All three acute Trusts are due to have new imaging diagnostic centres to enhance the care we provide across Norfolk and Waveney. All clinicians in the three acute hospitals will be working with the same digital system which will greatly enhance quality and communication.

Existing clinical service collaborations include the Eastern Pathology Alliance, ENT (ear, nose and throat) and Urology acute services. Progress is also being made in provision of procurement and digital services.

Digital modernisation

Being Digitally enabled in the NHS is vital to the development of services and for NNUH, it means transforming the way we deliver care through the use of technology, infrastructure, devices and information. We know that many patients expect technology and information systems to be part of how health and care services are delivered.

There is a great opportunity to make many people's experience and use of services more straightforward, more personalised and more interactive, as they have become used to in other areas of their lives. We also know that, at the moment, people get frustrated when digital systems don't 'talk to each other' and they have to repeat their information multiple times. For us, it is not whether digital technology can play a role in addressing the challenges we face in improving people's health and wellbeing, it is how we make technology transform our services in order to improve patient care.

We know that there's a lot of work ahead to reach our ambition of being a digitally advanced hospital. However, we're already building the infrastructure and delivering the systems that will ultimately enable us to achieve this ambition. These are bringing real benefits to patients and the NNUH Team, while ensuring that we have strong information governance, cyber security and clinical safety.

Performance

Effect of the pandemic

Throughout the year we have seen a steady stream of patients with Covid-19 which has added to the pressures on beds and infection control issues. The acuity of Covid-19 patients in January 2022 is far less with the Omicron variant in circulation, peaking at about 90 patients, compared to the previous January when it was 350. There are fewer patients needing critical care in this wave with increased protection and less severe illness for patients following the vaccination programme.

In January 2022, the health system across the whole of Norfolk and Waveney called a "critical incident" due to sustained and unprecedented pressure on our local services. This was caused by Covid-19 and seasonal winter illnesses like flu and norovirus driving up demand for health and care services. There were also challenges around discharging patients who were well enough to leave our local hospitals – 180 patients at the peak - as well as staff sickness rates.

To address the pressures, staff across the Norfolk and Waveney health and care system working together in January 2022 on a Multi-Agency Discharge Event (MADE) which aimed to support patient flow, unblock delays in discharge, simplify system-wide processes, helping to free up beds and reduce lengths of stay.

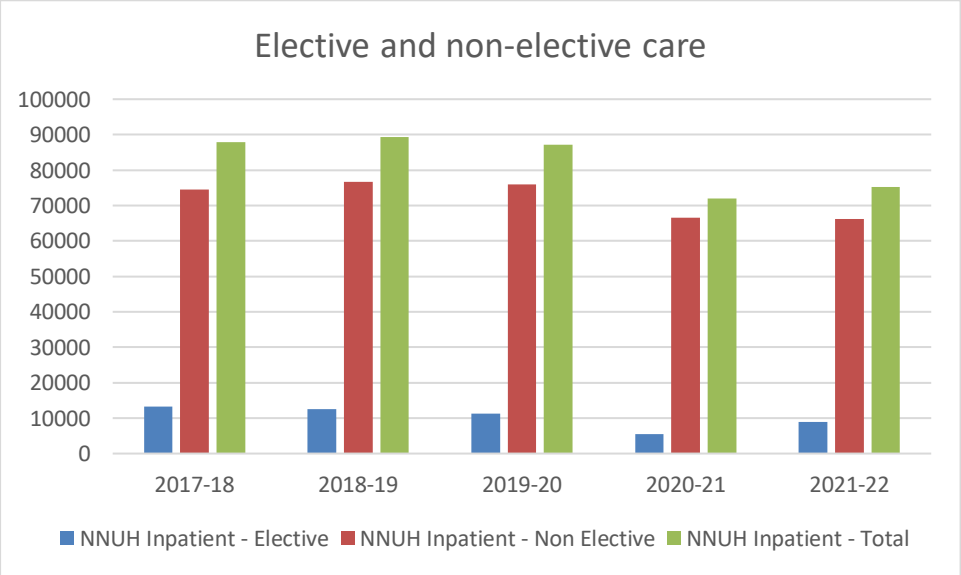
During March 2022, we saw another peak in hospital admissions for Covid-19 with numbers on a similar scale to January and large numbers of staff affected by illness and self-isolation.

On a more positive note, one of the key successes of the Covid-19 vaccination programme is the dramatic fall in the number of patients needing support from critical care services. We have seen small numbers needing this intensive support throughout the year, compared to 80 patients in January 2021, which has enabled us to ring-fence capacity to maintain our elective programme. However, staff sickness and isolation from Covid-19 have hampered our efforts to make as much progress as we would like. More than 70,000 patients remain on the waiting list who need our care and 10,000 of those have been waiting for more than 52 weeks.

Elective care

Our biggest challenge is to address the thousands of patients who are waiting too long for treatment following the pandemic. We saw more patients during 2021-22 than the previous year when the pandemic first began and many services were suspended nationally as the first lockdown got underway. Current plans are to increase the elective activity to 110% in line with national guidance for 2022.

	2020-21	**2021-22**
Elective and non elective	71,915	75,152
Day cases	54,649	84,520
Outpatient appointments (new and follow ups)	584,812	711,847



In 2021-22, we treated 8,913 elective patients, an improvement compared to 5,446 in 2020-21, and 66,239 non-electives (urgent or emergency care), compared to similar numbers of 66,469 in 2020-21.

Our Trust is also one of the busiest in the eastern region for urgent and emergency care and historically this has had an impact on our ability to deliver the elective programme, a situation which has been exacerbated by the pandemic. In addition, the lack of available social and community care has meant that we have around 130-180 patients at any one time who have no criteria to reside and are waiting to move to a community bed or receive social care.

In line with national guidance, we have focussed our resources on treating patients with the most urgent clinical need known as P1 (those needing treatment within hours for conditions such as stroke and heart attacks) and P2 patients (urgent treatment, often for cancer, needed within weeks).

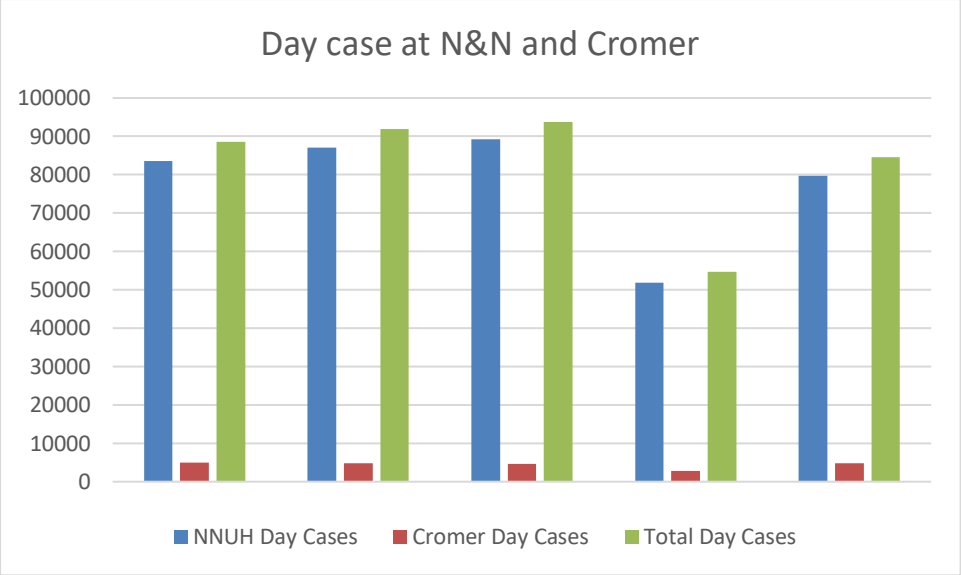
In terms of progress with electives, in October 2021, there were 7,976 patients waiting longer than 104 weeks or that would be waiting longer than 78 weeks on 1 July 2022 if not treated before that date and this had been reduced to 2,362 in March 2022.

To manage the risk for patients waiting for elective procedures, we review our waiting lists in order to prioritise clinical need and prevent harm to those patients who are waiting. Each patient has been contacted by the hospital to discuss their condition and to determine if their symptoms indicate that they should be seen sooner.

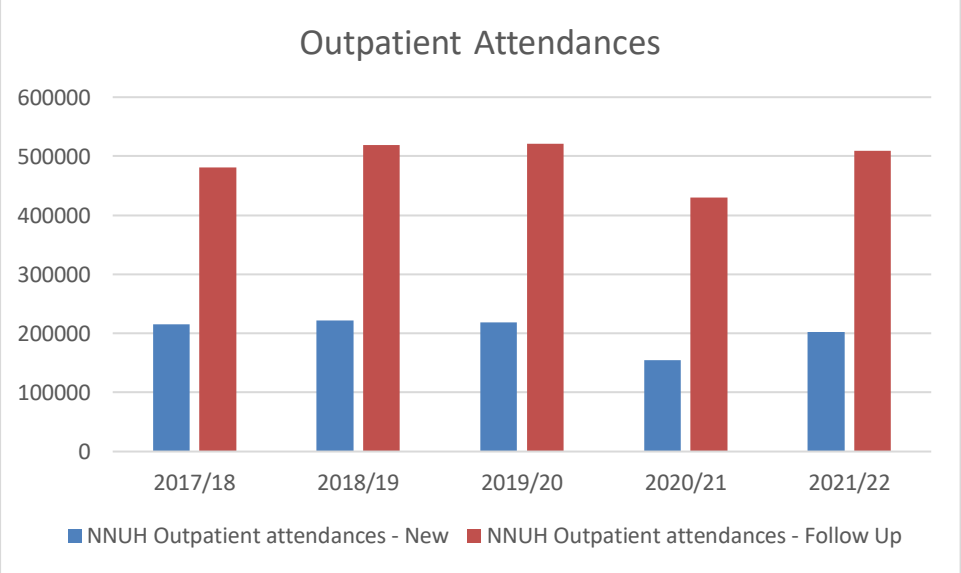
By July 2022, the NHS has been asked to eliminate very long waits of >104 weeks and we are working on this issue in a number of ways with assistance from the independent sector and extra effort from our own staff who have taken on initiatives such as ‘Super Saturdays’ and seven-day rotas. Since October we’ve performed well with 4,800 clock stops anticipated by March 2022. All our services are working very hard to bring down the number of long waits with the aim of having no patients waiting more than 104 weeks by 30 June 2022.

We are also part of the system-wide Elective Recovery Board which is aiming to equalise waiting times, by geography, across Norfolk and Waveney and create a fairer system for patients being treated in the three acute hospitals. The Personalised Outpatient Programme launched this month will also see patients offered more choice about receiving follow up appointments and is expected to free up clinical time to see new patients.

Our longer-term plans to tackle the elective backlog include significantly expanding our surgical and diagnostic services to create more capacity for treating patients. We will shortly be opening two purpose built paediatric theatres and are developing a standalone orthopaedic centre due to open in 2022. We also continue to establish innovative services such as our Ambulatory Procedures Unit, which specialises in procedures for patients with hand trauma. We have expanded our robotic assisted surgery programme which is on course to be recognised as a centre of excellence.



In 2021-22, we treated 79,762 day cases at the N&N Hospital and 4,758 at Cromer Hospital. This is an improvement from 2020-21 where we treated 51,792 and 2857 respectively.



In 2021-22, we saw 202,144 new patients and conducted 509,703 follow up appointments. This compares to 2020-21, where we saw 154,445 new patients and 430,367 patients for follow ups.

Criteria to reside

Criteria to reside is a tool developed nationally to help hospital teams have a discussion about a patient's care and whether they still need to be hospital. It is vital that this information is recorded on a patient's record. Where patients have no criteria to reside, it means they should be going home with support if needed, moving to a care home, or continuing their recovery in a community bed.

Daily discharge rates depend on the application of 'criteria to reside' and bring down length of stay, benefitting patients who are more at risk of hospital acquired infections and falls if they remain in hospital for extended periods.

Norfolk has experienced a significant care challenge throughout 2021-22 we have seen large numbers of patients who have not be able to leave hospital in a timely way because of the lack of community and social care services which remain under pressure. Across the county, nearly 19% of Norfolk patients have no criteria to reside which is one of the highest rates in the country.

The pandemic has shut care homes in Norfolk and led to a fluid situation in terms of the care available to the vast elderly population in our county. Within our hospital, this meant we had six bedded bays with seven or eight beds for a period of time when the Norfolk and Waveney system has been under pressure.

Looking at the big picture, we are caring for patients who should be looked after, for example, in a care home or a dedicated mental health bed which is having a negative effect on both patient and staff experience. There are some things we can control within the hospital, such as using the virtual ward or improving our discharge procedures.

We have used Gunthorpe Ward at the N&N Hospital for pathway one patients, under Discharge to Assess, who are able to return home with support and reablement

Given the scale of the issue, we are also looking to influence external issues such as risk sharing with our partners in the community and social care. This means we are looking for adjustments across the health and social care system to even the pressure and allow us the space we need to tackle the elective backlog as well as our emergency workload. There has been some success with Norfolk and Waveney system initiatives such as the Care Hotel which had 15 beds for people who were ready to leave hospital but need extra care support before they could return home.

Within the hospital we are improving our Discharge to Assess pathways with a new training programme for wards led by new clinical educators based in the Integrated Discharge Team. Discharge co-ordinators work across the wards and we have also put in place some specialist posts for complex discharges which need a different approach.

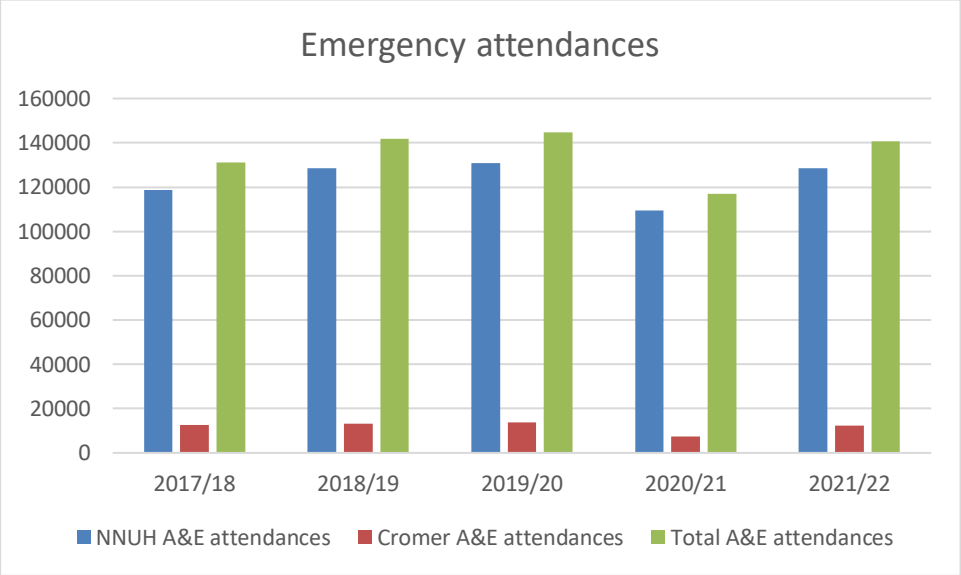
Emergency and Urgent care

Over the last 12 months, our emergency pathway has been severely impacted by infection prevention and control measures and the need to isolate patients with Covid-19.

The pandemic has also changed the nature of ward care from one based on managed patients by speciality to an emergency response with many wards dedicated to patients who have tested positive for Covid-19, or patients who are making a slow recovery from the illness. This has been disruptive to our staff in terms of working practices and team working which is reflected in our low scores for our hospital in the staff survey 2021.

We have continued the work on our Better, Safer, Faster programme to improve patient flow and enable patients to have a smooth journey from the Emergency Department to wards and then home again.

The performance of ED is further affected when mental health patients are waiting for an appropriate mental health placement. Large numbers of patients without criteria to reside make it difficult to maintain flow and make room for the newly admitted coming through the Emergency Department.

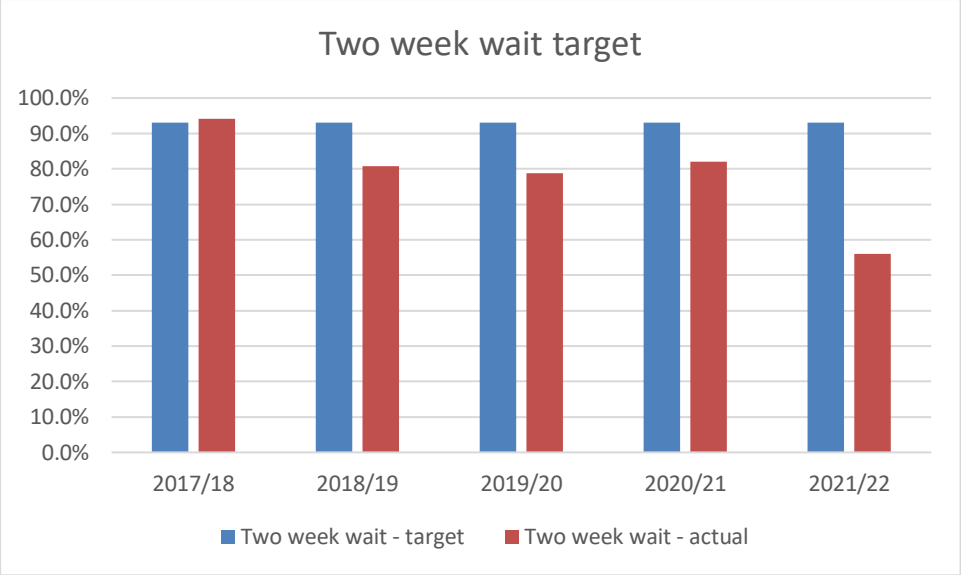


In 2021-22, we saw 128,443 patients at the N&N Hospital's Emergency Department and 12,328 patients at Cromer's Minor Injury Unit. These patient numbers are an increase on 2020-21 where we saw 109,569 and 7,405 respectively.

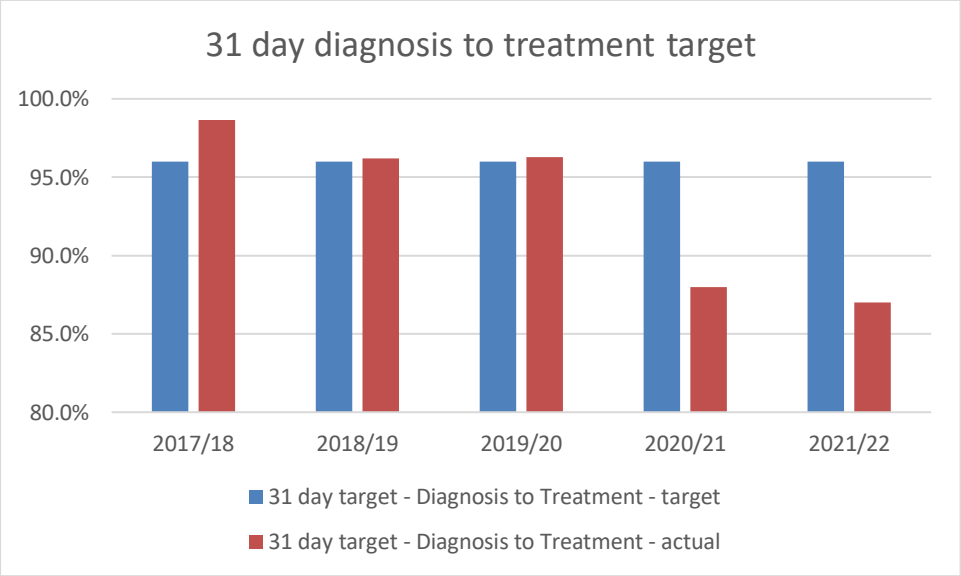
Much of our work for emergency and urgent care has been focussed around the new standards that are being implemented from April 2022 which will require a maximum waiting time in the Emergency Department of 12 hours and all ambulance handovers to be completed in 15 minutes.

Cancer

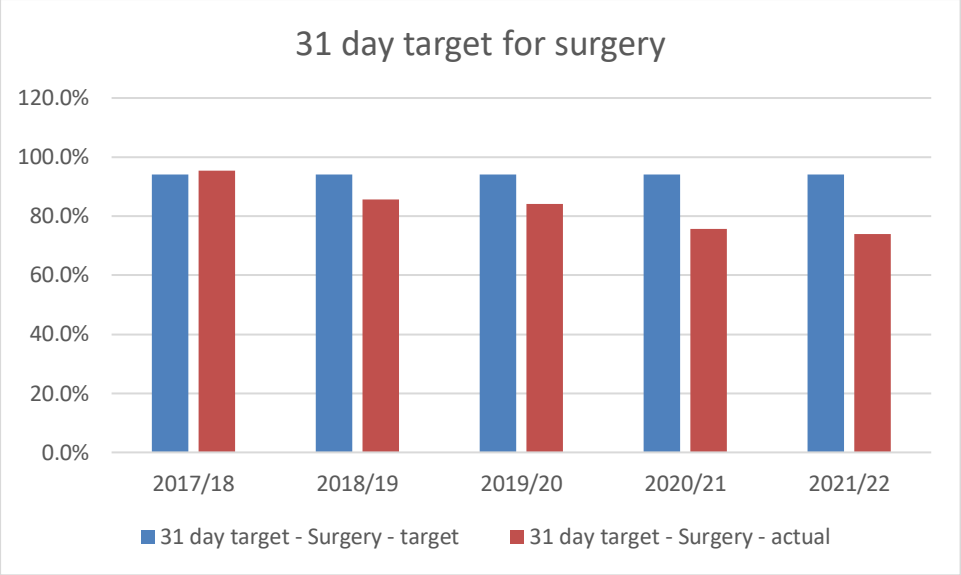
The pandemic had a significant effect on patient behaviour with many people delaying seeking help for cancer symptoms. There was a large rise in two week wait referrals in November 2021 placing huge pressure on services to see large cohorts of patients with greater numbers presenting with more advanced disease.



Just prior to the start of the pandemic in 2019-20, our performance was 78.8% against a target of 93% which rose in the early part of the pandemic to 82% in 2020-21 and then fell to 56% as our services saw more patients coming through for cancer diagnosis in 2021-22.



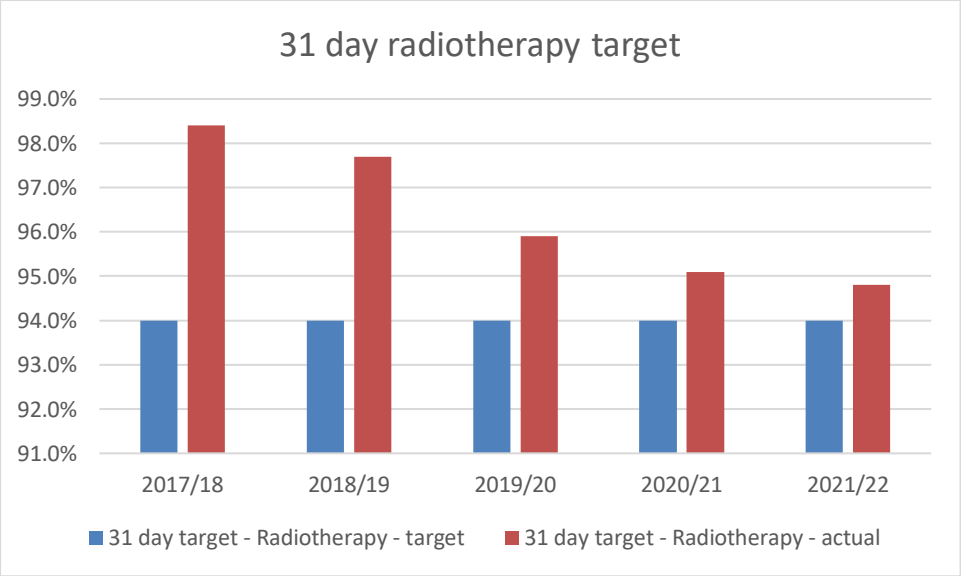
Before the pandemic, our performance on 31 days diagnosis to treatment was 96.3% against the target of 96% which fell to 88% during 2020-21 and then 87% in 2021-22.



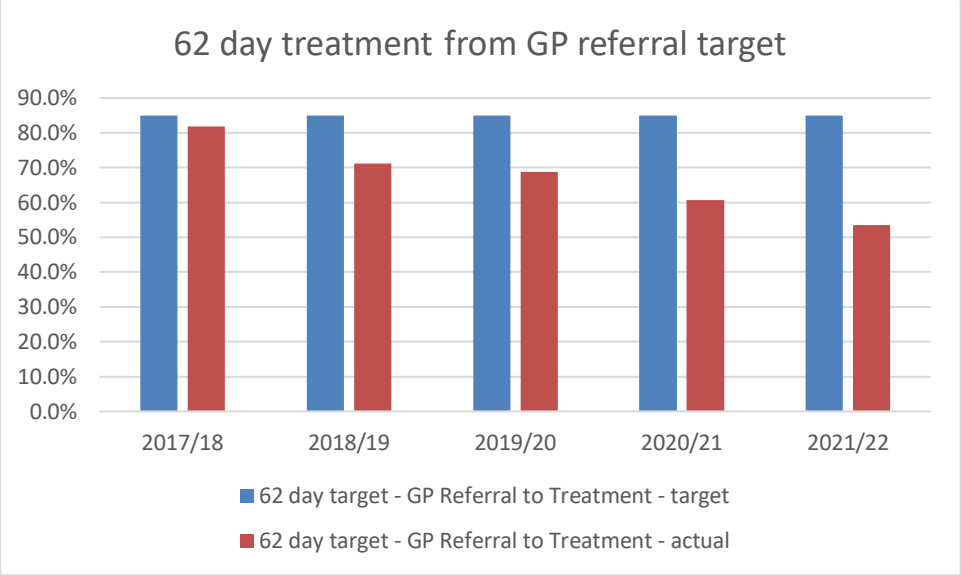
For surgery the target is 94% and our performance in 2019-20 was 84.2%, then 75.6% in 2020-21 and finally 74% in 2021-22.

We have spent the early part of 2022 working through backlogs as our services catch up with demand and we see patients and plan their treatments.

During the year, there was a similar issue for breast cancer two week wait referrals which increased in April 2021, creating capacity issues. The team involved ran extra clinics working tremendously hard to get back on track, with some additional external support one-stop clinics were set up out-of-hours.



The radiotherapy target has been achieved although the pandemic has had an affect on the performance of this service. In 2019-20, performance was 95.9% against a target of 94%, decreasing slightly to 95.1% in 2020-21 and 94.8% in 2021-22.



In 2019-20, performance was 68.7% against a target of 85%, reducing to 60.6% in 2020-21 and 53.5% in 2021-22.

As with the 31-day target, there is a backlog of treatment which we are working through which has affected performance.

Service Development

During 2021/22, a number of developments have taken place to expand our capacity.

Equipment replacement
One of the biggest equipment replacement programmes our hospitals has taken place over the last year. An £8m project has been rolled out, replacing vital imaging equipment including four MRI scanners and a CT scanner.

The new MRI scanners offer ground-breaking technology and improved patient comfort, with the latest techniques, allowing for improved image quality in a shorter scan time.

The replacement scheme has been made possible with 'Aged Assets' government funding that was announced in 2019, as well as benefiting from Adapt and Adopt Covid-19 funding.

Surgical capacity
In August 2021, we opened its new £2.9m Ambulatory Procedure Unit, specialising in procedures for patients with hand trauma. As part of our extensive building improvement programme, the unit has some of the most advanced equipment housed in three neutral pressure treatment rooms, as well as associated support areas.

The new unit will see significant improvements for our patients as its increased capacity will mean a dedicated team will be able to carry out more procedures for patients who need localised anaesthetics, which are currently being carried out by general theatre staff. That will in turn free up the general theatre staff to concentrate on more complex procedures.

Expansion at Cromer & District Hospital
A new cancer care and support centre at Cromer and District Hospital opened in September 2021 in partnership with Macmillan Cancer Support.

The centre – funded by Macmillan and the N&N Hospitals Charity - enables patients, many of whom currently travel to Norwich, to have their treatment and access support services closer to home.

The North Norfolk Macmillan Cancer Support Centre includes:

- Five chemotherapy treatment chairs
- Three new clinic rooms and two new minor procedure rooms, creating an additional 10,000 outpatient appointments annually.
- A Macmillan cancer information and support centre.
- The new unit will also free up space in the main Cromer Hospital building to deliver an extra 600 surgical procedures in dermatology, urology, vascular surgery and pain management.

The number of people living with cancer is growing and predicted to rise from 2.5million today to four million by 2030 in Norfolk, around 6,000 people are diagnosed with cancer each year. There are approximately 35,300 people living with cancer in the county.

Plans for 2022

To support our elective services and expand capacity, we are in the process of building new theatres and looking at ways to transform the way we run our outpatient services.

Norfolk and Norwich Orthopaedic Centre (NaNOC)
Construction is underway on a new £11m Orthopaedic Centre to increase elective surgical capacity. Known as the Norfolk and Norwich Orthopaedic Centre or NaNOC, the new centre will create a stand-alone, and Covid-secure, elective surgical facility containing, two new laminar flow theatres and a 21-bedded ward.

The NaNOC theatres will be a modular construction, meaning the bulk of the construction is carried out ‘off site’. Once built, the modular units are shipped to Norfolk and lifted by crane into position. They are then fitted together as well as connected to services such as water and power. Once fully connected, the units will have internal fixtures and fittings and then clinical equipment installed.

Recruitment is also underway for new clinical, nursing and support staff.

Paediatric theatre complex
A new £6.5m children’s theatres complex in the Jenny Lind Children’s Hospital is being built which will cement our position as a major provider of specialist paediatric care and enable us to meet the needs of our younger patients well into the future.

Due to be completed over two phases and open for patients in 2022, the first phase will provide a twin paediatric theatre suite, a six-bay recovery unit and supporting facilities, with new clinical equipment. Phase two will see the creation of a paediatric ED department along with six day-procedure beds.

The complex will help meet increasing demand on services and deliver an improved experience to patients and carers, including a reduction in waiting times. It will also improve staff experience by enabling us to offer new services in a purpose-built environment.

Case Study

Innovative programme helps train more doctors in robotic-assisted surgery

A new training pilot has been devised by our Sir Thomas Browne Colorectal Unit and Intuitive, the pioneer of robotic-assisted surgery and makers of the da Vinci surgical systems.

This has enabled surgical registrars, on the path to becoming consultants and who have had many years of surgical experience, to complete the training necessary in order to carry out bowel cancer operations on our two da Vinci systems.

From February 2022, several surgical registrars, based here, took part in this robotic surgery training programme, which was championed by Mr Irshad Shaikh, Consultant Colorectal and lead Robotic Surgeon here, and supported by Intuitive.

Mr Shaikh, who teaches robotic surgery nationally and has helped the robotic colorectal programme in ten UK hospitals, said: "I have consistently found that the registrar level trainees are left out in this programme and worked together with Intuitive to devise this training programme. I am very proud of the East of England deanery surgical registrars for successfully completing the first phase of robotic colorectal surgical training and delivering this first national pilot programme at NNUH."

Eleanor Rudge, who took part in the pilot, said: "There are plenty of hospitals within the UK that have access to robotic-assisted surgery, and yet surgical registrars at these hospitals often get very little actual robotic experience. However, we are lucky enough to have someone like Mr Shaikh, who has the vision, the know-how and the enthusiasm, which have all been key to allowing us access to this incredible opportunity. We have also had the support of the entire colorectal unit at NNUH – as a registrar group, we have worked in many hospitals in the region and it is very obvious to all of us that the support of this department is exceptional."

Our Financial Performance

The COVID-19 pandemic continued to require significant change in operational planning processes for the NHS.

The continued pandemic led to a further change to the financial framework with guidance aiming to support the recovery and restoration of services whilst continuing to work in partnership across Integrated Care Systems.

The operational planning guidance identified a set of national priorities, with a focus on supporting our workforce whilst restoring services and making steps to manage the backlog of patients awaiting care.

The Trust created a financial plan for the first half of the year in line with the H1 Operational Planning Guidance, with a break even position for both H1 and H2, on the assumption of a continuation for the second half of the year.

The first plan covered the six months to 30 September 2021, which assumed a breakeven financial position after reflecting the NHS 'block' and COVID-19 funding arrangements for this period. This plan was exceeded with a surplus to 30th September of £7.1m.

The second six months proposed a deficit plan, to give a full year break even plan. This plan was exceeded, with a closing surplus of £9.5m, which was broadly in line with our Forecast Out Turn position.

Thus, the reported financial position for the full year was a surplus of £9.5m compared to a full year plan which was a break-even position.

The overall surplus and improvement on plan was supported by the national response to the pandemic funding arrangements and driven by operational underspends resulting from the impact of the further wave of COVID-19.

Financial Improvement

Throughout the financial year, the Trust has been active in developing efficiency plans responsive to different pandemic/operational scenarios. For the year ended 31 March 2022, £15.6m of efficiency savings were delivered. There has been a focus on capacity planning and productivity improvements alongside the expected activity recovery plans. An enhanced governance and delivery programme with inbuilt quality and safety safeguards underpins this.

Cash Management

As part of the NHS response to the pandemic, the funding flows were structured to be supportive with certain income streams being in advance at year-end. This, along with the accumulated surpluses and the timing of capital cash funding inflows has resulted in closing cash of £95.3m.

Capital Expenditure

We invested £42.5m in new and replacement capital assets during the year (2020/21: £62.8m). The most notable investments were:

- Theatre Refurbishments - £6.4m
- Norfolk and Norwich Orthopaedic Centre - £3.6m
- Clinical Equipment Replacement - £2m
- Diagnostic Assessment Centre – £1.6m
- Other digital investments - £6.8m

Overseas operations
The Trust does not have any overseas operations

Charitable Funding
We are fortunate to be supported by the Norfolk and Norwich Hospitals Charity and The Cromer Community and Hospital Friends Charity. In addition, we are again fortunate to receive support from many external charities and organisations including Macmillan. In 2021/22, we benefitted from £2.0m of charitably donated assets (2020/21: £2.3m).

Operational Future
The Trust continues to be heavily focused on the restoration of services following the impact of the pandemic during the previous two years. The Trust is working closely with system partners to plan and deliver locally against NHS England's priorities for the 2022/23 year ahead, with key areas of focus for us being:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention
- Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
- Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
- Working collaboratively across systems to deliver on these priorities.

Whilst delivering against these priorities, the Trust will continue to make improvements in both the quality of services and effective use of resources for the benefit of patients.

NHS England has set out a financial framework that will apply for the full year 2022/23 that provides clarity over funding arrangements and supports the Trust, along with system partners, to deliver these priorities. The Trust has submitted a deficit plan of £9.0m for 2022/23, which is driven by forecast inflationary pressures exceeding the levels that are funded via NHS contracts. The Trust continues to work with system partners to reduce this planned deficit.

The Trust has a long term financial strategy in place which sees the Trust deliver year-on-year improvement in its underlying financial performance to move towards financial sustainability over a ten-year period.

Financial Accounts 2021/22

The full accounts are attached at the end of this document.

Social and Community

We aim to be at the heart of the local community serving a large population in a rural area. We touch the lives of many people as patients, carers, visitors, members, fundraisers, volunteers and employees. Local people can get involved in a number of ways, principally through our large membership scheme, but also through our patient engagement activities which includes our patient panel or as a volunteer.

Patient and family feedback is vital to help us improve the care we provide and we collect the views of patients and families in several ways outlined on the following pages:

Patient, carer and family feedback

Over the second year of the pandemic we continued to gather feedback from our patients, carers and communities in digital and non-digital ways. Although the options and platforms remained limited to be fully engage with our wider community networks we used this time to strengthen our links and ties with the under-served community groups.

Feedback received through our traditional methods of Patient Advice Liaison Service and complaints continued and our Friends and Family Test feedback saw an improvement. We moved to a new provider, with this saw the rolling out of SMS text messages for the Friends and Family Test for our Emergency Department and several Outpatients areas. We increased and improved ways that people could give us their feedback and with ease. Whilst SMS was rolled out other ways of providing us feedback remained open i.e. online surveys, paper FFT cards returned to some areas of the hospital and volunteers collecting feedback in inpatient areas.

Our work with Healthwatch Norfolk on the feedback received through their website continues. With easing of some restrictions and with guidance and advice from our infection prevention and control colleagues, there were some visits that took place to listen to patients and families. Feedback collected was shared by Healthwatch via their quarterly report and presented to the Patient Engagement and Experience Group sub-board.

Engagement continued through social media and virtual events, we supported the consultation and engagement for our corporate strategy with minority ethnic communities and carers, worked closely with the Maternity Voices Partnership and the Women and Children's Division with their plans to engage and work with children and young people better.

Our work with the divisions and the diverse communities group continued with the equality diversity and inclusion focus on gathering feedback from patients and the public who are from any of the 9 protected characteristics as defined in the Equality Act. A survey was carried out to this effect and the results from this will influence the Equality Delivery System (EDS2 a tool used within the NHS to measure how NHS organisations are performing against key equality priorities.

The aim of EDS2 is to improve services for people who belong to vulnerable and protected groups by assessing health inequalities and provide better working environments, free of discrimination, for people who use and work in the Trust) action plan for the organisation in order for the NNUH to meet the patient focused and workforce focused outcomes. The work carried out in relation to the patient focused outcomes was recognised as good practice regionally within the NHS East of England EDI network, nationally at the Heads of Patient Experience Network and at the annual Patient Experience for Improvement Conference (Mar 2022).

The Carers Forum was re-instated and led the implementation of the Carers policy across the Trust. We have continued our work to maintain our Carers Award Tick-Health Accreditation, Carers Awareness sessions have been provided to staff groups and have seen over 60 staff members who have attended the sessions. A Carers survey was carried out, with 36 responses received findings from this survey have led to an action plan agreed by Carers Forum members to improve on the identification of and recognition of carers and support for when their cared for person is accessing care at the NNUH.

A key aspect of the Patient Engagement strategy was to build strong foundations for engagement, listening, learning from feedback, concerns and formal complaints to triangulate data into action. In 2021 the PHSO (Parliamentary Health Service Ombudsman developed a new Framework for Managing Complaints, which aims to create ‘one front door’ to enable patients and families to give feedback, raise concerns and ensure learning and improvements are systematically addressed. In line with this the complaints function at the NNUH was transferred from Legal Team to Patient Engagement & Experience Team, creating a combined PALS/Complaints Team. The new combined service and team has meant we have one ‘front door’ to support people when they contact the Trust with different levels of complexities and concerns about their training. The team have been training and providing support to divisions to manage their own responses and developing a ‘learning from’ culture.

The Patients’ Panel has grown and is 19 members strong. We are aiming to recruit new panel members to have a panel of 20 members in total. The panel members have adapted and continued to work virtually/via Teams and are embedded across the organisation on committees and supporting Quality Improvement projects for example Transforming Outpatients Committee, Infection Control Committee, Clinical Support Services PPI Forum, Carers Forum and Digital Health work streams. They are engaged with the ward audit programme ‘Care Assurance’ and have formed a sub-group to support the improvements to PALS and Complaints. The panel members are working with us to define our co-production approach and build on the groundwork so far.

Family Liaison Service

Following the success and learning gained from the relative liaison service that was set up over the first year of the pandemic, ward-based Family Liaison Officers temporarily funded by the Norfolk and Waveney CCG were put in place from February 2022 onwards. The main aim of the service remains to improve patient and family experience and wellbeing by maintaining a line of communication during their time in hospital.

Case Study

NNUH Dementia Fayre goes digital during Dementia Action Week

A panel of experts will be answering questions on dementia care and support at the NNUH Dementia Fayrein May 2021.

The annual event, part of Dementia Action Week, will be online on Thursday 20 May to provide information and support to people living with dementia and their families.

A team of experts will be assembled on Thursday 20 May between 2pm and 3.30pm to field any questions you have on dementia care and support. The 'ask the dementia experts' panel will be chaired by Prof Nancy Fontaine, NNUH Chief Nurse, and will include representatives from Alzheimer's Society, Admiral Nurse Service and Norfolk and Suffolk NHS Foundation Trust.

The Trust's new dementia strategy will be launched at the event and NNUH's first Dementia Palliative Care Nurse, Lynsey Hannant, will be talking about her role.

Lynsey said: **"Starting a brand new role at the start of a pandemic was definitely eye opening and the biggest challenge in my career as a nurse so far. The last year has been a complete challenge but also very rewarding at the same time. In such a short time I have gained a vast amount of experience, built great working relationships with many teams within the Trust and am privileged to work within two supportive teams. I have been able to support many patients and their families through some difficult times."**

Complaints handling

We have a long-established process for investigating, managing and learning from formal complaints about the services of the Trust. The Complaints team is integrated alongside the Patient Advice and Liaison Team to provide a seamless service to patients and families who want to raise a concern.

In order to ensure that complaints are used to learn lessons and prompt service improvements for patients, every complaint is reported to the relevant divisional/departmental manager and clinical director so that any necessary actions can be taken. Monthly reports are then reviewed by our Patient Engagement & Experience Governance Sub-Board, with summaries provided to the Management Board and Board of Directors.

Volunteer work to improve the Patients' Experience

We are proud to have a vibrant volunteer community supporting a broad spectrum of areas within the hospital, and who provide an immeasurable contribution to the quality of care received by our patients and their families as well as the working life of our staff. We have over 600 volunteers (across eight sites) providing around 3,000 hours of help throughout the Trust every week and we also benefit from the support of volunteers from many external voluntary, community and social enterprise (VCSE) organisations who are able to provide more specialised help.

People volunteer with us for many different reasons. They may be our recovering patients or retired with time on their hands, some are parents at home with a few spare hours to fit around their children, and some may be wishing to gain the confidence to return to work after a break. Students volunteer to gain valuable experience before embarking on medical studies or other hospital-related careers, and people with learning difficulties or physical and mental health disabilities find volunteering a rewarding way to participate in the workplace while feeling valued for the work they do.

The flexible nature of volunteering enables many volunteers to take on more than one role, this offers them a more varied volunteer experience and maximises their potential to make a positive impact throughout the Trust. Our volunteers are trained to support a huge range of areas.

On wards they can provide assistance at mealtimes, companionship to patients without visitors, stimulation for patients with dementia and activities and music to encourage movement. In addition, a team of volunteers carry out audits and surveys gathering patient experience data from our inpatients on iPads. They also collect card surveys from our outpatient clinics and conduct telephone surveys with patients the day after discharge.

A team of Bleep buddies carry bleeps and can be contacted by staff hospital-wide. They respond to ad-hoc requests for errand running, note collecting, patient escorting and wheelchair pushing duties. Another team of volunteers support our school of medicine assisting them with registering students and providing refreshments on exam days. Fundraising volunteers have been assigned to our fundraising manager and assist her with all kinds of fundraising events and activities and a team of happy welcoming faces provide an extremely knowledgably meet & greet service on our outpatient reception desks.

We also provide volunteer support in some more specialist roles:

End of Life Butterfly Volunteers
We are very proud to work in partnership with the Anne Robson Trust, to bring 'Butterfly Volunteers' to the Norfolk and Norwich University Hospital. The role of the Butterfly volunteer is to provide compassionate care and emotional support at end of life for patients across the hospital. The volunteers provide support to patients and their loved ones who have been recognised as being in the last days and hours of their life and can just sit with a patient, offer gentle hand massage or provide a respite break for the families.

Settle in Service
Our 'Settle-in' volunteers meet patients as they return home and carry out some simple checks around the home. Duties include making a cup of tea, unpacking patient's bags, checking the central heating is working and ensuring there are some basic grocery supplies such as bread and milk in the cupboards. Volunteers carry out simple environment risk assessments around the home, offering advice to patients to prevent falls and signposting to other community services, thus increasing the patients confidence in returning home. The service dovetails into our Volunteer Driver Service which had enabled us to streamline the discharge process and cut down on delays getting patients home.

Volunteer Drivers

A team of volunteer drivers have access to 2 wheelchair accessible vehicles provided by our charity. Our volunteer drivers cover the whole of Norfolk and Waveney and are available Monday to Friday to discharge our patients home in comfort. The service is also able to diversify and has assisted our occupational therapists by delivering enablement equipment, our pharmacy by delivering prescriptions and our cancer services by delivering chemotherapy.

Older Peoples Medicine
In OPM Volunteers provide a wide range of enrichment activities for patients on wards including puzzles, interactive games on smart screens and tablets, memory box activities and reminiscence exercises. OPM volunteers are able to support older patients across all areas of the hospital, not just OPM departments, and will support in the Older People's Emergency Department where they will meet, reassure and accompany patients to further investigations for the duration of their visit. They also offer support to the dementia support team by calling patients' next of kin to discuss and complete 'This is Me' booklets. These booklets can help tell staff and visitors about patients' backgrounds, likes and dislikes and enable a more person-focussed approach to care and support.

Pets As Therapy Dogs
Research provides evidence that dogs can have a positive effect on our patients' wellbeing and assist a speedier recovery. The companionship of a dog and their handler can decrease loneliness, stimulate conversation, encourage movement and social interaction. The hospital is supported by twelve Pets as Therapy volunteers who visit ten different wards.

The visiting PAT team includes Anne and her Mini Dashund Lily, Diane and her German Shepherds Yoda and Juke, Jon and his Poodle Ginger Beer, and Sophie with her Bijon Freise Minty. Feedback from the wards is extremely positive, the PAT dogs lift the mood of some of our long stay patients - they allow our patients with dementia to reminisce about having a dog of their own and staff morale is always greatly improved.

Emergency Department

A successful funding bid to NHSE this year has enabled us to recruit a volunteer coordinator specifically for Emergency Services on a secondment basis. Roles are being developed and volunteers recruited to support patients who may be alone and anxious, patients who are elderly and confused, patients who are homeless or even those at end of life. They will also support staff in a wide range of tasks such as providing refreshments, stocking up clinical areas, taking telephone calls, finding wheelchairs, basic admin tasks and collecting patient feedback.

Investing in Volunteers

Similar to “Investors in People” the voluntary services team have successfully been accredited with the Investing in Volunteers (IiV) award (renewable every three years). The process requires an organisation to produce an initial self-assessment then carry out any service developments identified before they receive a three-day visit from an assessor. The assessor is required to scrutinise evidence-based practice and interview a selection of volunteers and staff. Those interviewed represent a range of specialities, ages and lengths of service, ranging from those who have volunteered for 15 or more years to those recently recruited (within the last six months) and includes a diverse range of volunteers and staff. NNUH are the only hospital in the country to receive the accreditation for a fifth time.

Membership scheme

As a NHS Foundation Trust, we have a membership scheme with over 16,000 public members. Members receive a copy of our magazine The Pulse and they are invited to talks on health topics and events such as our open day and fete. Members also give their views on health priorities and other issues. More information about membership is given in the Council of Governors’ section of the Director’s report on page 85.

250th Anniversary

Throughout 2022, we are celebrating the 250th anniversary of the Norfolk and Norwich Hospital with a series of events for our staff and the local community, organised jointly with the N&N Hospital’s Charity. The events include an Open Day and Fete, Bishop’s House Open Garden event, Cathedral Service, Heritage Open Day Event with The Forum in Norwich, special AGM and various staff events.

Health Overview and Scrutiny Committee

The Health Overview and Scrutiny Committee is part of Norfolk County Council and its role is to scrutinise the local health service, ensuring that patients and the public are properly involved in any changes to services. The committee has examined issues such as ambulance turnaround times at A&E and discharge from hospital, looking at the arrangements in our hospital and others locally.

Healthwatch

Healthwatch England is the national consumer champion in health and care. It has significant statutory powers to ensure the voice of the patient is strengthened and heard by those who commission, deliver and regulate health and social care services. Our patient experience team works closely with Healthwatch to gather patient feedback.

Norfolk & Norwich Hospitals Charity

2021/22 has been another successful year for the Charity. Summary information is given below but full details can be found in the Charity Annual Report and website www.nnhospitalscharity.org.uk

Financial information:

The Charity accounts for 2021/22 are yet to be formally audited but they show total income of £2.5m. Over half our income is received through gifts in wills and we have been notified of 16 new legacy gifts this year. To everyone who remembers us in their Will, and to their families, we are really grateful.

We are actively using our funds to make a real difference for patients and staff and expenditure has increased to £3.4m in the year. We also carry forward commitments of a further £4.3m in approved grants – supporting more projects into the future.

Major Grants:

The Charity provides hundreds of small grants each year – supporting training courses, purchasing additional items of equipment, funding enhancements to the patient environment etc. These collectively serve to make the Trust a better place for our patients. In addition to these relatively small grants, a number of major projects are coming to fruition with support from the Charity:

- the new cancer care and support centre at Cromer & District Hospital has been opened, made possible through a £1.8m donation from the N&N Hospitals Charity in partnership with Macmillan Cancer Support;
- a new Charity Café is under construction at Cromer & District Hospital to provide much enhanced facilities for patients, staff and public. Construction of the café has been funded by the Charity and its operation will generate further funds for the Charity to invest in future developments at the hospital;
- the mobile chemotherapy unit and volunteer drivers scheme have completed their second year of operation, both supported by Charity grants (£571k and £115k respectively);
- a new Staff Training Centre (£100k Charity grant) has been opened, providing additional facilities for developing the skills and expertise of hospital staff.

£2 million Grant agreed for new Orthopaedic Centre

The Charity has agreed a grant of up to £2m to purchase equipment for the new Norfolk and Norwich Orthopaedic Centre (NANOC). We are delighted to support this development, to add additional capacity to treat our local population, building on the long history of orthopaedic surgical expertise in Norwich. Our fundraising appeal for the NANOC has been supported by more than 650 individual donors and to each one, whether their donation is big or small, we are very grateful.

Boudicca Breast Unit

Thanks to overwhelming support from our local community for our Boudicca Appeal, the Charity has been able to fund the development of the new unit, with state of the art equipment and a really lovely waiting area now completed. The final stage of works will be taking place soon, with new counselling rooms and updated clinical space completing the refurbishment.

The Boudicca Appeal will continue – to fund ongoing service development for this group of patients. To donate or fundraise for the Boudicca Appeal visit www.nnhospitalscharity.org.uk

Next Steps and Looking to the Future

The Charity provides support to departments and services across the Trust and all its sites, whether in Norwich, Cromer or elsewhere in the County. We have a number of fundraising appeals either current or to be run during 2022/23, to assist the Trust with further enhancements – in ophthalmology, cardiology, paediatrics and with specialist diagnostic equipment for patients suspected of having cancer.

We are increasingly working with corporate and business partners to achieve great things. We have been particularly grateful for all the support that local partners have offered during the pandemic. If your business might like to work with our Charity, please do contact our Charity Director – John Paul Garside at charity@nnuh.nhs.uk

To find out more about the Charity or to sign-up for our Newsletter please visit www.nnhospitalscharity.org.uk or keep up to date with us on twitter @NNHospCharity

Environment and sustainability

The period of 1 April 2021 to 31 March 2022 has seen a decrease from 10,639tCO2e to 10,449tCO2e from energy for the acute hospital site. During 20/21 the Trust had already moved to a renewable energy contract for this site (which achieved a then reduction of over 3,200tCO2e), this means we had to look elsewhere to achieve the reduction of approx. 1.8% for 21/22.

The majority of the saving is from the reduction in the consumption of gas by the site. By the 31st March 2022 this had reduced from 50,699mWh to 49,792mWh compared to the previous 12 month period.

Every year the hospital produces around 2,500tCO2e of emissions from energy from its combined heat and power plant (CHP). This plant used gas to produce both heat and electricity. Around 6,000mWh of electricity is produced this way in a standard year, saving the trust around £450,000pa on its utility costs (21/22 prices). This CHP is owed by the hospital's PFI partner (Project Co.) and has been in operation for around 21 years. During 21/,22 Project Co. commenced the process of replacing this plant (in partnership with the Trust). The CHP is planned to be replaced in 2025/6 potentially saving the Trust another 2,500tCO2e.

Green Plan

Our new five-year strategic plan – Caring with Pride – includes a commitment on working towards a net zero hospital. In line with service condition 18 of the NHS Standard Contract we have developed a Green Plan. This will serve as a mechanism for the Trust to take a coordinated, strategic, and action-orientated approach towards reducing our environmental impact whilst increasing social value, ensuring our services remain fit for purpose today and for the future.

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

This Green Plan outlines our proposed aims, plans and their targeted outcomes across the "triple bottom line" – social, environment and economic, which are often in tension. It pushes a focus on considering the local and global impacts of these three elements driving change towards the best interests of the public's health.

The plan is broken down into the six key focus areas for ease of responsibility and accountability across our team. It covers aspects such as waste, materials, water, energy use, travel and transport, digitalisation, biodiversity, staff engagement and training and wellbeing. These areas align with the NHS England and NHS Improvement's ambitions and expectations for decarbonisation and create a holistic view around sustainability.

Previously there has been limited profile within the Trust for sustainability and there has been not been a Sustainable Development Management Plan or equivalent produced since 2010. This means NNUH has little baseline data or understanding of its environmental impact. Now that we have a Green Plan in place we will be appointing a Sustainability Lead and the following key actions are being taken to catalyse our progress on decarbonisation and sustainability.

1. Create a good baseline of data to understand our current position on sustainability and carbon footprint.
2. Have our Green Plan signed off by the NNUH Board (signed off in January 2022)
3. Ensure there is a point of focus for sustainability issues on a day-to-day basis and for oversight of the Green Plan and its interface with the Executive and Board.
4. Establish a Sustainability Committee including responsible individuals for all focus areas within the Green Plan. Ensure the PFI, Serco and (when appropriate) Norwich Research Park partners are included as part of this working group.
5. Roll out the Capital Investment Framework to ensure that all new capital investments are sighted on the Green Plan vision, focus areas and is being used to accelerate progress.
6. Investigate lifecycle replacement options with PFI. Establish a strategy through a scoping exercise for major equipment and plant replacement over the next 15 years to support decarbonisation of the Estate.
7. Reduce energy usage through better energy management, including upgrading energy efficiency measures, modifications to CHP operation (as there are perceived faults occurring) and efficiencies of hot water network.
8. Develop a new Travel Plan which addresses emissions from staff, visitor and patient travel, and develop ongoing implementation with stakeholders.
9. Identify the Trust's sustainability benefits through the Clinical and Digital Strategies in response to a changing healthcare landscape including increased use of digital technologies to reduce patient travel, clinical decision making and ensure the Trust continues to work with system partners to ensure how future demands will affect the Trust's physical capacity.
10. Trial initiatives such as "Meat Free Mondays" to reduce the carbon footprint of food purchased and consumed on site.

One example of the work taking place across the organisation is in our sustainability in theatres committee which had a display in the new Greener NHS photography exhibition at COP26 in Glasgow in 2021.

Our surgical and anaesthetic teams were praised for pioneering one of the greenest operating theatres in England by reducing unnecessary emissions while maintaining high quality patient care. We have taken a significant step towards reducing greenhouse gases by removing desflurane – one of the worst polluting agents – from most of our operating theatres.

The NNUH team has also introduced the use of reusable trays for drawing up anaesthetic drugs as well as started waste segregation in theatres, which has led to increased recycling practices. They use reusable surgical drapes and gowns where possible. The move to reusable trays within the main theatre complex is estimated to cut carbon emissions equivalent to at least 6,500 miles driven by the average car.

Anti-bribery legislation

In order to ensure the NHS (including our Trust) provides a transparent view of how taxpayers' money is spent, new guidance has come into force which outlines key areas of potential conflict and guides staff on how to manage them

From 1st June 2017, Managing Conflicts of Interest in the NHS came into effect, introducing consistent principles and rules for managing actual and potential conflicts of interest, providing simple advice to staff and organisations about what to do in common situations and supporting good judgement about how interests should be approached and managed

The guidance is supported by an updated Trust policy: Conflicts of Interest and Business Conduct Policy and area on the staff intranet which was accompanied by a communications campaign with staff.

Arrangements to prevent slavery and human trafficking

We support the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it, and supporting victims. In particular, we are strongly committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses. Steps taken to date include:

Our arrangements:

People

- We confirm the identities of all new employees and their right to work in the United Kingdom, and pay all our employees above the National Living Wage.
- Our Freedom to Speak Up: Raising Concerns Policy, Provides a platform for our employees to raise concerns about poor working practices.
- We undertake awareness training to support our staffing teams to understand and respond to modern slavery and human trafficking. Including how to identify potential victims and the impact that each employee at the NNUH can have on keeping present and potential future victims of modern slavery and human trafficking safe.
- Trust staff will contact and work with the Procurement department when looking to work with suppliers, so that appropriate checks can be undertaken.

Safeguarding:

Our commitment to ensure no modern slavery is reflected in a number of our policies and procedures. These include our Adults and Children Safeguarding Policy and the Procurement Strategy.

Suppliers/tenders:

The Trust complies with the Public Contracts Regulations 2015 and uses mandatory Crown Commercial Services (CCS) Pre-Qualification Questionnaire on procurement, which exceed the prescribed threshold, whereby bidders are required to confirm their compliance with the Modern Slavery Act.

Our procurement team and contracting team are qualified and experienced in managing healthcare contracts and have received the appropriate briefing on the requirements of the Modern Slavery Act 2015, which includes:

- Confirming compliance of their plans and arrangements to prevent slavery in their activities and supply chain.
- Implementing any relevant clauses contained within the Standard NHS Contract.
- We will not award or renew contracts where suppliers do not demonstrate their commitment to ensuring that slavery and human trafficking are not taking place in their own business or supply chains.
- We will adopt best practice advice by The Chartered Institute of Procurement and Supply.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year 2020/21.

Approval of the Performance Report

I confirm my approval of the Performance Report:

Sam Higginson
Chief Executive **Date: 21/06/2022**

Accountability report

Directors' Report

Board of directors

The Board of Directors has overall responsibility for the operational management of the Trust and is charged by statute with ultimate responsibility for the Trust's corporate affairs in both strategic and operational terms. It is responsible for the design and implementation of agreed priorities, objectives and the overall strategy of the Trust.

The composition of the Board of Directors is specified in our Constitution to have a majority of independent Non-Executive Director members and the Board comprises six Executive Directors and up to eight independent Non-Executive Directors (including the Chairman).

In accordance with the Trust's Constitution, the Non-Executive Directors are appointed by the Council of Governors, typically for a three-year term of office and they usually serve two such three-year terms unless otherwise determined by the Council of Governors. One of the Non-Executive Directors is nominated by the University of East Anglia.

The Foundation Trust Code of Governance recommends that NHS Foundation Trusts should identify one of its Non-Executive Directors as Senior Independent Director (SID). The Board has identified Ms Sandra Dinneen as Senior Independent Director.

The Board meets in public every other month and otherwise as required and in accordance with Standing Orders. The Board Agendas are formulated to ensure that time is devoted to strategic, operational and financial matters and there is a strong focus on the quality and safety of clinical services for patients. The Board has approved a Scheme of Delegation of authority and a Schedule of Matters Reserved for decision by the Board. The Trust's Constitution sets out a process for resolution of any conflict between the Board and Council of Governors in the unlikely event that the Chairman cannot achieve such resolution.

Who is on the Board of Directors?

Executive Directors

Chief Executive

Sam Higginson was appointed as Chief Executive of the Trust from October 2019. Sam joined NNUH from Cambridge University Hospitals NHS Foundation Trust where he was Chief Operating Officer. Previously Sam was Director of Strategic Finance for NHS England and Director of Strategic Development at University College London Hospitals NHS Foundation Trust. Sam started his career working with Unicef as a logistics officer co-ordinating the airlift of emergency supplies in Sudan, followed by organising medical teams for a charity in areas of Africa and Afghanistan. He joined NHS London in 2008 after four years on the HM Treasury Health Spending Team. Sam leads the executive team responsible for the overall leadership of our hospitals.

Chief Operating Officer
Chris Cobb was appointed as Chief Operating Officer in January 2019. Prior to becoming COO, Chris was Divisional Operations Director for the Division of Medicine. As COO, Chris is responsible for the operational performance of the Trust and chairs our Divisional Performance Committee. Chris is a member of the Finance, Investments & Performance Committee.

Medical Director
As Medical Director, Professor Erika Denton is responsible for providing professional strategic medical advice to the Board and leadership on clinical quality and safety and clinical research. Erika has been a consultant radiologist at the Trust since 1999. Erika was appointed to the role of Associate Medical Director at NNUH in 2016 and Medical Director in July 2018. Erika chairs our Clinical Safety and Effectiveness Governance Sub-board, Mental Health Board and Research Oversight Board.

Chief Nurse
Professor Nancy Fontaine was appointed as Chief Nurse in August 2018 and is responsible for professional leadership of nurses, midwives, AHPs, Pharmacists and Bio-Scientists across the Trust. As Director for Infection Prevention and Control and Executive lead for Quality, Safety, Patient Experience and Engagement, the Chief Nurse is responsible for providing professional clinical advice to the Board and for leading non-medical research and education. Nancy chairs our Patient Experience and Engagement Governance Sub-board.

Chief Finance Officer
Roy Clarke was appointed to the Board as our Chief Finance Officer in April 2020. Roy has 22 years of healthcare experience in primary, secondary and tertiary services and before coming to our Trust played a key role in the successful construction, commissioning and occupation programme for a new £200m specialist hospital.

Chief People Officer
Paul Jones was appointed as Chief People Officer in August 2019. Previously Paul had most recently served as the Chief Human Resources Officer, helping open a new state of the art teaching hospital for Women and Children in the Middle East. He has more than twenty years' experience as a Human Resources Director, working for hospitals including Oxford University Hospitals NHS Foundation Trust, Kings College Hospital NHS Foundation Trust, Royal Berkshire NHS Foundation Trust and the Cambridge and Peterborough NHS Foundation Trust.

Non-Executive Directors

Chairman
David White was appointed as Chairman in June 2019. David joined NNUH from East Suffolk and North Essex NHS Foundation Trust – where he was Chairman from 2015. David began his career as a social worker in London before becoming a Director of Social Services then moving to East Anglia as Chief Executive of Suffolk Health Authority in 1994. He went on to spend four years as Chief Executive of Thurrock Council before joining Norfolk County Council, where he held the role of Chief Executive from 2006 until his retirement in April 2013. David has lived in Norfolk with his family since 2010.

David is Chairman of both the Board of Directors and of the Council of Governors and of the Board's Nominations and Remuneration Committee and Council's Appointments & Remuneration Committee.

Julian Foster was appointed as Non-Executive Director in June 2019. Julian is a chartered accountant and corporate treasurer. He was Executive Finance Director of Broadland Housing Association and has held senior finance director roles in growing housing association groups in the Eastern region over the last 20 years. After graduating from Trinity College, Oxford, Julian worked in investment banking until moving to the social housing sector. Julian is Chair of the Trust's Audit Committee and is a member of the Finance, Investments & Performance Committee, Charitable Funds Committee and Nominations & Remuneration Committee.

Professor Charles ffrench-Constant was appointed as Non-Executive Director in September 2021. Professor Charles ffrench-Constant is Pro-Vice-Chancellor for Medicine and Health Sciences at UEA. Charles joined UEA from the University of Edinburgh where he established the Multiple Sclerosis Research Centre, progressing over the next 12 years to Directorships of the MRC Centre for Regenerative Medicine, Edinburgh Neuroscience, the Wellcome Trust PhD programme in Translational Neuroscience and then Dean of Research for the College of Medicine. He graduated in Medicine from the University of Cambridge in 1980 and his research has largely focused on finding therapies for Multiple Sclerosis.

Dr Pamela Chrispin was appointed as Non-Executive Director from January 2020. Pam has worked in the NHS for more than 30 years and was previously Medical Director of the East of England Ambulance Service, Medical Director at West Suffolk Hospital and Deputy Medical Director at East Anglian Air Ambulance. Pam is a member of the Trust's Quality & Safety Committee, Finance, Investments & Performance Committee and Nominations & Remuneration Committee.

Sandra Dinneen was appointed as Non-Executive Director in January 2020. Sandra was Chief Executive at South Norfolk Council, Head of Economic Development at Norfolk County Council and is currently a board member for Historic England. Sandra is a member of the Trust's Finance, Investments & Performance Committee, Audit Committee, People & Culture Committee and Nominations & Remuneration Committee. Sandra is the Trust's nominated Senior Independent Director.

Joanna Hannam was appointed as Non-Executive Director from January 2020. Joanna has lived in Norfolk with her family for 30 years, was Head of Customer Services and Communications at Norfolk County Council, Executive Director of the Health Improvement Programme at Norfolk Health Authority and was a lay member at Norwich Clinical Commissioning Group. Joanna is a member of the Trust's Quality & Safety Committee, People & Culture Committee, Nominations & Remuneration Committee and chairs the Charitable Funds Committee.

Tom Spink was appointed as Non-Executive Director in June 2020. Tom is an operations director from the engineering and aerospace industries. He has held various key roles at Aviva including CEO of the General Insurance business in Turkey, and began his current role as Group Procurement Director in 2013. Tom was previously a non-executive director at the East of England Ambulance Service NHS Trust.

Tom is Chair of the Trust's Finance, Investments and Performance Committee and a member of the Nominations & Remuneration Committee and Charitable Funds Committee.

Changes during the Year
In addition to those noted above, there were a number of changes to the membership of the Board during the year:

- Professor David Richardson stepped down as Non-Executive Director in August 2021 and was succeeded by Professor ffrench-Constant;
- Dr Geraldine O'Sullivan stepped down as Non-Executive Director in January 2022.

Division of responsibilities
There is a clear division of responsibilities between the Chairman and Chief Executive. The Chairman is responsible for:

- providing leadership to the Board of Directors and the Trust;
- facilitating the contribution of the Non-Executive Directors to the success of the Trust in the delivery of high-quality healthcare;
- ensuring effective communication with the Council of Governors;
- the annual evaluation of the performance of the Board and its committees and implementing any action required following such evaluation.

The Chief Executive is responsible for:

- working with the Chairman to ensure the development of strategy that is supported by the Board as a whole;
- overseeing operational implementation of the strategic objectives of the Trust;
- creating a framework of values and objectives to ensure the delivery of key targets, and allocating decision-making responsibilities accordingly;
- ensuring effective communication with employees and taking a leading role, with the Chairman, in building relationships with key external partners and stakeholders.

Independence of Non-Executive Directors
The Non-Executive Directors bring wide and varied experience to the Board. They also play a crucial role via the assurance committees of the Board.

There is full disclosure of all Directors' interests in the Register of Directors' Interests. The Register is held by the Board Secretary and is publicly available on our website (www.nnuh.nhs.uk).

Any actual or potential conflicts of interest are dealt with in accordance with procedures set out in the Standing Orders for the Board of Directors. The Chairman has not declared any significant commitments that are considered material to his capacity to carry out his role. The Board considers that the Chairman and the Non-Executive Directors satisfy the independence criteria set out in the Foundation Trust Code of Governance.

As required by the Code of Governance, the Board has considered Professor ffrench-Constant's role on the Board, given that the University of East Anglia has a material business relationship with the Trust. The Board has considered whether this could affect, or appear to affect, Professor ffrench-Constant's independence as a Non-Executive Director.

The Board noted that whilst Professor ffrench-Constant's role as the University Pro-Vice Chancellor for Medicine & Health Sciences involves liaison with the Hospital Executive regarding areas of joint strategic importance, he is sufficiently removed from the day-to-day operational activity of the hospital to enable him to remain independent. When viewed in conjunction with the safeguards against conflicts of interests as set out in the Board's Standing Orders, the Board considers that Professor ffrench-Constant satisfies the criteria for 'independence'.

In accordance with Regulations overseen by the Care Quality Commission, Foundation Trusts are required to ensure that all directors meet the requirements of the 'fit and proper persons test'.

Annual checks are conducted against national registers and through a process of annual declarations. The Board can accordingly confirm that all its director level appointments meet the 'fit and proper persons test'.

The Board's Committees

The Board makes a distinction between management responsibility (led by the Chief Executive) and independent assurance responsibility (led by the Non-Executive Directors).

In accordance with our Organisational Governance Framework, the Board has established a number of committees of the Board responsible for obtaining assurance in defined areas most particularly Audit, Quality & Safety, Finance, Investments & Performance and People & Culture. Terms of Reference allocate specific responsibilities between the committees. The Board has also established a Nominations and Remuneration Committee and a Charitable Funds Committee, which reports to the Board acting for the Trust as Corporate Trustee.

The Board has also established a further committee known as the Committee in Common. This arrangement is mirrored in the two other acute hospital trusts in Norfolk and the three Committees in Common meet together on a regular basis to enhance co-ordination and efficiency in services across the acute hospital sector. The Trust is represented at meetings of these Committees in Common by the Chairman, Chief Executive, Director of Strategy and Joanna Hannam, as a second Non-Executive Director.

Audit Committee:

In accordance with the NHS Foundation Trust Code of Governance, the Audit Committee membership consists only of Non-Executive Directors. The Committee is chaired by Julian Foster with Sandra Dinneen and Charles ffrench-Constant also as members. The external and internal auditors regularly attend Committee meetings and directors and senior managers also attend as required. The Chair of the Audit Committee meets regularly and separately with the External Auditor and the Head of Internal Audit.

The Committee continuously reviews the structure and effectiveness of our internal controls and risk management arrangements. It oversees an agreed programme of external and internal audit and monitors progress to ensure that remedial action is taken by management in any areas of identified weakness.

The Trust's external auditors, KPMG LLP, were appointed by the Council of Governors in 2016 and reappointed in 2021 following a formal tender process and in accordance with

recommendation from the Audit Committee. The fees for the external audit are set out in note 6 of the financial statements.

Auditor Independence and Non-Audit Services

The Audit Committee reviews and monitors the external auditor's independence and objectivity and considerations of avoiding conflicts of interests formed a specific consideration taken into account in appointing the external auditors. The Trust has a policy by which any non-audit services provided by the external auditor are approved. During 2021/22 KPMG LLP have not been commissioned to provide any services to the Trust in addition to undertaking the external audit of the Trust's financial statements.

KPMG LLP is also the external auditor of Norfolk and Norwich Hospitals Charity of which the NNUH Foundation Trust is the Corporate Trustee. The fees in respect of this engagement in 2021/22 are set out in note 6 of the financial statements.

The Chair of the Audit Committee confirms the independence of the external auditors to the Council of Governors at its meeting where the Annual Report and Accounts are presented and also reports any exceptional issues to the Governors during the course of the year should this be necessary.

Statement on disclosure of information to auditors

The Executive and Non-Executive Directors who held office at the date of the approval of the Directors' report confirm that, so far as they are aware, there is no relevant audit information of which KPMG LLP (the Trust's external auditor) is not aware. They also confirm that they each have taken all reasonable steps in order to make themselves aware of any relevant audit information and to establish that KPMG LLP knows about that information.

Code of Governance and associated disclosures

The NHS Foundation Trust Code of Governance is based on the principles of the UK Corporate Governance Code and has been in place in its revised form since 2014. The Code requires certain disclosures to be made by Foundation Trusts and information is included in this section to demonstrate compliance with the Code and its disclosure requirements.

i) Directors:

- A section of the Annual Report above reports specifically on the Board of Directors, its role and composition. It confirms that the Board considers all of the current Non-executive Directors (NEDs), including the Chairman, to be independent. Through a formal process, the composition of the Board was revised during 2019/20 to increase the number of independent Non-Executive Directors, thereby strengthening the independent majority on the Board.
- All appointments to the Board have been the result of open competition. The Directors Report details the experience of members of the Board and includes information about the standing Committees of the Board, the membership of those Committees, and attendance at meetings.

- An NHS foundation trust's board of directors is responsible for all aspects of the operation and performance of the trust, and for its effective governance. This includes setting the corporate strategy and organisational culture. All the powers of the Foundation Trust can be exercised by the Board of Directors and the Board has a formal schedule of matters specifically reserved for its decision. Other matters are delegated to the Executive Directors and other senior management.
- The Board of Directors is collectively responsible for taking actions which legally bind the Trust. All members of the board of directors have collective responsibility as a unitary board for every decision of the board. The Board of Directors meets regularly and held thirteen formal meetings in 2021/22.
- The Chairman of the Trust is Chairman of the Board of Directors and Council of Governors and leads both groups on strategy and monitoring. As detailed above, there is a clear distinction between the roles the Chairman and the Chief Executive.
- Independent professional advice is available as required to the Board or its standing committees and the Trust is a member of the national NHS risk-pooling schemes which provide cover in respect of legal proceedings and other claims against its Directors.
- Meetings of the Board of Directors are routinely open to the public. Governors are encouraged to attend public Board meetings and arrangements are in place for governors to report to the Council of Governors on Board meetings they have attended.
- In line with national guidance on social distancing during the Covid 19 pandemic we have needed to restrict physical access to meetings. To ensure as much openness and transparency as possible however facilities to attend meetings by video/teleconference have been made available and the papers from meetings of the Board are made available via the Trust's website.
- In order to facilitate governor oversight of the role of the Non-Executive Directors, the Board and Council have established a structure whereby designated governor observers attend meetings of Board committees. This practice has been in place since February 2019 and involves systematic reporting to the Council.

ii) ***Governors***:

- The general duties of the Council of Governors are to represent the interests of the Trust's members as a whole and the interests of the public; and to hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors.
- The Council of Governors meets formally four times a year. Details of the composition of the Council of Governors and attendance at meetings are contained within the Council of Governors section of the Annual Report.
- Meetings of the Council of Governors are routinely open to the public. In line with national guidance on social distancing during the Covid 19 pandemic we have needed to restrict physical access to meetings. To ensure as much openness and transparency as possible however facilities to attend meetings by teleconference have been made available and the papers from meetings of the Council are made available via the Trust's website.

iii) Board Independence:

- As detailed above, the Board considers that all the Non-executive Directors who have served during the year are independent according to the principles of the Code. This includes Professor ffrench-Constant who, as Pro-Vice-Chancellor of Medicine & Health Sciences at University of East Anglia, is appointed to the Board to reflect the Trust's status as a University Hospital Trust hosting the Norwich Medical School.
- Independence is kept under review and is based on whether each Director is independent in character, judgement and behaviour. Also considered are factors such as participation and performance on both the Board and Board Committees.
- Non-Executive Directors (NEDS), including the Chairman, are not NHS employees and do not contribute to the NHS pension scheme in their NED role. Non-Executive Directors have confirmed their willingness to provide the necessary time for their duties.
- Appointment of the NEDS is made by the Council of Governors in accordance with standard terms and conditions.
- In addition to the process for maintaining the Register of Interests (detailed below) every meeting of the Board and Board Committees starts with an item for Declaration of Interests relating to any item scheduled for discussion or consideration at the meeting.
- The Chairman holds meetings with the Non-executive Directors without the Executive
- Directors being present. The Senior Independent Director (SID) also meets with the other Non-executive Directors without the Chairman being present.

iv) Policy for Raising Matters of Concern

Arrangements have been put in place by which the Trust's employees may in confidence raise matters of concern. These arrangements are covered in the Trust's Freedom to Speak-Up Policy commonly known as a "Whistle-blowing Policy" and the Trust has appointed a full-time Freedom to Speak-Up Guardian.

v) Board performance

The Board of Directors oversees performance through receipt and scrutiny of a monthly Integrated Performance Report (IPR) and an established reporting schedule. Board reports include standard quality and safety metrics, details of operational performance against relevant national targets and updates on workforce issues and the financial position. The action being taken to reduce identified high level risks or areas of concern is also detailed.

The Board receives regular reports from its assurance committees in the domains of Quality & Safety, Finance, Investments & Performance, People & Culture and Audit. These Committees enable enhanced Board-level scrutiny of key issues across the Trust and assurance in clearly defined areas of responsibility.

The meetings of the Board of Directors are managed to ensure that actions are followed up and the Board's reporting requirements are adhered to.

During the course of the year, the Board reviewed its capacity, and that of the management team, to address the current and future challenges facing the Trust, notably the ongoing work to strengthen financial governance and business planning processes.

During 2021/22 the Board undertook a review of its performance including the effectiveness and reporting of its Assurance Committees. This included a questionnaire process co-ordinated by the Board Secretary. Following this review the Board confirms the following in relation to its roles, structure and capacity:

- the Board is satisfied that its Directors are appropriately qualified to discharge their functions;

- the Board is satisfied as to its own balance, completeness and appropriateness to the requirements of the Foundation Trust;

- the Board's Committee and governance structure is appropriate and its progress and efficacy is regularly reviewed;

- the Board considers that it has an appropriate balance of expertise and experience and it has access to specialist advice, as required;

- the Chair of the Audit Committee is a Non-Executive Director with recent and relevant financial experience;

- the Board maintains its Register of Interests which is publicly available on the Trust's website:
  - Dr Chrispin declared her role as Deputy Medical Director with East Anglian Air Ambulance (until January 2022);
  - Mr Clarke declared position as Trustee of the Royal College of Obstetricians and Gynaecologists;
  - Professor Denton declared her position as Partner in Colney Radiology Group LLP;
  - Ms Dinneen declared her role as Strategic Project Advisor – Priscilla Bacon Hospice Care Ltd;
  - Professor Fontaine declared her position as a Patron of the Anne Robson Trust;
  - Professor ffrench-Constant has declared his role as Pro-Vice-Chancellor Faculty of Medicine & Health Sciences at the University of East Anglia; and
  - Mr White declared his position as Trustee on the RG Carter Pension Committee.

  These Board members have accordingly taken no part in decision of matters that related to the relationship between relevant parties and the Trust. Otherwise the Board can confirm that there are no material conflicts of interest on the Board.

The process for appraisal of Board members is that performance evaluation of the executive directors is undertaken by the Non-Executive Directors and Chief Executive. The appraisal of NEDs is carried out by the Trust Chairman for report to the Appointments and Remuneration Committee of the Council of Governors.

The appraisal of the Chairman is co-ordinated by the Senior Independent Director with input from governors and directors.

NHS Improvement has issued guidance which encourages '*all providers to carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework every three to five years".* External assessment of the Trust against the Well-led Framework was conducted by the CQC (report April 2020) resulting in a rating in the Well-Led Domain of 'requires improvement'. During 2020/21 the Trust commissioned an external review of its Financial Governance from RSM, who also provide Internal Audit services to the Trust. That Financial Governance review reported in October 2020 and implementation of associated recommendations has been overseen by the Audit Committee, Finance, Investments and Performance Committee and Trust Board. A Follow-Up review in August 2021 confirmed 'excellent' progress in implementing the agreed actions, resulting in a Green Assurance rating.

vi) Compliance Statement

The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The Board of Directors considers that it complies with the main and supporting principles of the Code of Governance. During 2021/22 the Audit Committee reviewed the Trust's Organisational Framework for Governance and compliance against the Code of Governance. In relation to the more detailed provisions of the Code of Governance, the Trust is compliant with the provisions, with the following exceptions:

A.5.12 The Trust issues on its website copies of papers for meetings of the Board of Directors, including agendas and minutes. Papers for meetings of the Board that are held in private for reasons of personal confidentiality, commercial confidence or other reason are not circulated.

B.6.2 Evaluation of the Boards of NHS foundations trusts should be externally facilitated at least every three years. The evaluation needs to be carried out against the board leadership and governance framework set out by Monitor.

D.2.3 Since November 2019 national guidance ("*A remuneration structure for NHS provider chairs and non-executive directors")* has been in place and applied by the Council of Governors https://improvement.nhs.uk/resources/remuneration-structure-nhs-provider-chairs-and-non-executive-directors The Council of Governors accordingly does not consult external professional advisers to market test at least once every three years. See the Remuneration Report for more detail.

The following provisions require a supporting explanation, even in the case that the Trust is compliant with the provision. Where the information is already contained within the Annual Report, a reference to its location is provided to avoid additional unnecessary duplication.

Table of supporting explanation for required disclosures:

Code of Governance **reference**	**Summary of requirement**	**Disclosure**
A.1.1	There should be a schedule of matters specifically reserved for its decision. The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	A formal and Board-approved Schedule of Matters Reserved is in place. See Board of Directors and Council of Governors sections for details on respective roles and decisions. Detail of the Council's role and mechanism for resolving any potential conflict between Board and Council is detailed in the Council terms of Reference, Standing Orders and the Trust's Constitution.
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	See Directors' Report.
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	See Council of Governors section.
Additional requirement of FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	See Council of Governors section.

Code of Governance reference	Summary of requirement	Disclosure
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	See Directors Report
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience.	See Board of Directors section.
	Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	See Board of Directors section.
Additional requirement of FT ARM	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated.	See Board of Directors section
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	See section relating to Nominations & Remuneration Committee.
Additional requirement of FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	N/A - open advertisement for Chairman and Non-Executive Directors.
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	See section relating to Independence of Non-Executive Directors
B.5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors.	See Council of Governors and Foundation Trust Membership sections
Additional requirement of FT ARM	If, during the financial year, the Governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties	N/A Governors have not exercised this power.

Code of Governance reference	Summary of requirement	Disclosure
	(and deciding whether to propose a vote on the foundation trust's or directors' performance).	
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	See section on Board Performance.
B.6.2	Where there has been external evaluation of the board, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	N/A See Board Performance section for further detail.
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	See Director's Report and Annual Governance Statement.
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	See Audit Committee section and Annual Governance Statement.
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	See Audit Committee section and Annual Governance Statement
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	N/A Council of Governors appointed new External Auditor from 2020/21 audit as recommended

Code of Governance reference	Summary of requirement	Disclosure
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	See Audit Committee Section
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	N/A No Director was released in 2021/22.
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	See Council of Governors section.
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	See Foundation Trust Membership section.
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	See Foundation Trust Membership section.
Additional requirement of FT ARM	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and	See Foundation Trust Membership section.

Code of Governance reference	Summary of requirement	Disclosure
	• a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	
Additional requirement of FT ARM	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report.'	Registers of Interest declared by Directors and Governors are maintained in accordance with a Standard Operating Procedure approved by the Audit Committee and are publicly available on the Trust's website.

Main Activities of the Audit Committee during the Year Ended 31 March 2022
The Audit Committee met on 4 occasions during the year ended 31 March 2022. The focus of the Committee was on:

- governance, risk management and internal control;
- internal audit;
- external audit;
- other assurance functions;
- financial reporting.

During the course of the year the Audit Committee received audit reports from the internal auditors, RSM, in accordance with an agreed Audit Plan and including regular reports on follow-up of recommendations from previous audits. The Audit Plan for 2021/22 included audits relating to Succession Planning; Patient Safety & Incident Framework; Board Assurance Framework; Consultant Job Planning; Clinical Audit; Deep Dive into Waiting List Initiatives; Divisional Management; Financial Governance Follow-up; General Ledger; Cash Management; Succession Planning Policy Review; and Data Security & Protection Toolkit.

The Committee received regular reports from the Local Counter Fraud Service including reviews with regard to processes in place to identify and manage risks associated with fraud. The Committee has also reviewed plans for strengthening systems for risk management in the Trust.

The Financial Accounts of the Trust for 2020/21 were reviewed by the Auditors and presented to the Committee in May 2021. In accordance with the established annual cycle, financial performance for 2021/22 is subject to external audit review during April and May 2022, for review of the Accounts by the Committee in May 2022.

Nominations and Remuneration Committee:
The Board Nominations and Remuneration Committee has a membership consisting of Non-Executive Directors and the Chief Executive. It is Chaired by David White. The other members of the Committee are Julian Foster, Pam Chrispin, Joanna Hannam, Sandra Dinneen, Tom Spink, Charles ffrench-Constant and Sam Higginson. The Secretary to the Committee is the Board Secretary.

The Committee has duties and responsibilities that are detailed in agreed Terms of Reference, reflecting the provisions of the FT Code of Governance. It meets as required and no less than once a year. During 2021/22 the Committee met on 3 occasions. In accordance with its Terms of Reference, the Committee reviews the size, structure and composition of the Board of Directors and makes recommendations to the Council of Governors with regard to the recruitment of Non-Executive Directors.

In the case of Executive Director vacancies, the Committee is responsible for identifying suitable candidates to fill vacancies as they arise. No such vacancies have arisen during 2021/22.

The Committee considers levels of remuneration for executive directors and other senior posts that come within the Committee's remit, by reference to other organisations and NHS Foundation Trusts in particular. During 2021/22, following consideration of national NHS pay-award guidance, the Committee reviewed and approved revision to remuneration for the executive directors, as reported in the Remuneration Report.

In the case of Non-Executive Director vacancies, the Committee is responsible for advising the Council of Governors on the relevant qualities and attributes required to supplement those already on the Board. The Committee has reviewed the schedule of Non-Executive terms of office and has made appropriate recommendation to the Governors accordingly.

Quality and Safety Committee:
The role of the Quality and Safety Committee of the Board is to provide additional capacity for Non-Executive led scrutiny and assurance to the Board concerning quality and safety matters. The Committee has a membership of 6 Board members, including Chief Executive, Chief Nurse, Medical Director and three Non-Executive Directors/Associate Non-Executive Directors. The Committee met on 10 occasions during 2021/22.

The Committee has an agreed annual cycle of business and a Work Programme of reports to be received at future meetings. Matters considered by the Committee during 2021/22 have included the operation of the Trust's clinical governance systems and processes, including our procedures for learning from incidents and examining mortality rates. The Committee has also received regular updates concerning the Clinical Quality Impact Assessment (QIA) process which is used in the Trust to protect quality and safety whilst making financial savings and productivity improvements.

During 2021/22 the work of the Committee has been influenced by the ongoing impact of the Covid-19 pandemic, and it's reporting schedule has reflected Covid-related risks and priorities. The Committee has focused on quality and safety related issues arising from operational pressure and disruption caused by the pandemic. The Committee has also scrutinised risks identified through our risk management process, notably those relating to prolonged waiting times and the level of demand in our emergency care pathway.

Finance, Investments and Performance Committee:

The role of the Finance, Investments and Performance Committee of the Board is to provide additional capacity for Non-Executive led scrutiny and assurance to the Board concerning the Trust's financial position, capital schemes and delivery of contractual operational standards. The Committee has a membership including four Non-Executive Directors, Chief Executive, Chief Operating Officer, Chief Finance Officer, Chief People Officer, Director of Strategy, Chief Information Officer and Chief Nurse.

This year the Committee has received regular reports on the Trust's operational position and performance, in the context of Covid-related restrictions and very high levels of demand for the services of the Trust. Reports to the Committee have concerned the Trust's response to growing waiting lists of patients whose treatment has been delayed by the pandemic and the trajectories for reducing the associated waiting times for treatment.

The Committee has also sought to support and obtain assurance with regard to other areas of Trust activity and achievement of broader Strategic Objectives, where possible. In addition to matters of operational performance, this has involved focus on Use of Resources, cost improvement plans, financial planning and implementation of actions in response to the Financial Governance Review.

People and Culture Committee

The role of the People and Culture Committee of the Board is to provide additional capacity for Non-Executive led scrutiny and assurance to the Board that the Trust has appropriate and effective strategies and plans in place relating to workforce, education, organisational development and culture. The Membership of the Committee includes three Non–Executive Directors, Chief Executive, Chief People Officer, Chief Operating Officer, Chief Nurse, Medical Director and the Chiefs of Division.

Matters considered by the People and Culture Committee during 2021/22 have included: Freedom to Speak-Up; Staff Survey results and actions; Covid-19 Workforce Restoration; Equality, Diversity and Inclusivity; Corporate Risk Register; Internal Audit Reports and Gender Pay Gap Report. The Committee has noted the very real strain on the NHS workforce through the Covid Pandemic and the reflection of this in the Trust in staff sickness, challenges in recruitment and retention and feedback in the Staff Survey. The Committee is encouraging a strategic approach to addressing these issues and will continue to promote development and implementation of the Trust's People and Culture Strategy.

Attendance at meetings of the Board of Directors

The Board meets in public bi-monthly and otherwise as required and in accordance with Standing Orders.

During this year the Board of Directors met on 13 occasions. Attendance at meetings of the Board and its Committees was as shown below:

	7 April 2021	5 May 2021	26 May 2021	2 June 2021	7 July 2021	4 August 2021	6 September 2021	6 October 2021	3 November 2021	1 December 2021	2 Feb 2022	23 February 2022	2 March 2022
Mr David White	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓
Dr Pamela Chrispin	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	X	✓
Mr Roy Clarke	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Chris Cobb	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prof Erika Denton	✓	✓	✓	✓	✓	✓	X	X	✓	✓	✓	✓	✓
Ms Sandra Dinneen	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓
Prof Nancy Fontaine	X	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Mr Julian Foster	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prof Charles ffrench-Constant[1]							✓	✓	✓	✓	✓	✓	✓
Mrs Joanna Hannam	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Mr Samuel Higginson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Paul Jones	✓	✓	✓	✓	✓	X	X	✓	✓	✓	✓	✓	✓
Dr Geraldine O'Sullivan[2]	✓	✓	✓	✓	✓	✓	✓	✓	✓	X			
Prof David Richardson[3]	✓	✓	X	✓	✓	X							
Mr Tom Spink	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

[1] Professor Charles ffrench-Constant was appointed as Non-Executive Director in September 2021.
[2] Dr O'Sullivan stepped down as Non-Executive Director in January 2022.
[3] Professor David Richardson stepped down as Non-Executive Director in August 2021 and was succeeded as UEA nominated NED by Professor ffrench-Constant.

Attendance at meetings of the Audit Committee

The Audit Committee meets quarterly and met on 4 occasions during the year.

	26 May 2021	29 Sept 2021	24 Nov 2021	30 Mar 2022
Mr Julian Foster (Chair)	✓	✓	✓	✓
Ms Sandra Dinneen	✓	✓	✓	✓
Professor Charles ffrench-Constant[1]				✓
Dr Geraldine O'Sullivan[2]	✓	✓	✓	

[1] Professor Charles ffrench-Constant was appointed as Non-Executive Director in September 2021.
[2] Dr Geraldine O'Sullivan stood down as Non-Executive Director in January 2022.

Nominations & Remuneration Committee
The Nominations and Remuneration Committee meets routinely twice a year and otherwise as required. The Committee met on 3 occasions during 2021/22.

	2 June 2021	3 November 2021	1 December 2021
Mr David White (Chairman and Chair of Committee)	✓	✓	✓
Dr Pamela Chrispin (Non-Executive Director)	✓	X	✓
Ms Sandra Dinneen (Non-Executive Director)	✓	✓	✓
Mr Julian Foster (Non-Executive Director)		✓	✓
Professor Charles ffrench-Constant (Non-Executive Director)[1]		✓	✓
Mrs Joanna Hannam (Non-Executive Director)	✓	X	✓
Mr Samuel Higginson (Chief Executive)	✓	✓	✓
Dr Geraldine O'Sullivan (Non-Executive Director)	✓	✓	X
Professor David Richardson (Non-Executive Director)[2]	✓		
Mr Tom Spink (Non-Executive Director)	✓	✓	X

[1] Professor Charles ffrench-Constant was appointed as Non-Executive Director in September 2021 and replaced Professor Ricgardson.
[2] Dr Geraldine O'Sullivan stood down as Non-Executive Director in January 2022.

Quality and Safety Committee – meeting and attendance
The Quality and Safety Committee met on 10 occasions during 2021/22.

	27 April 2021	25 May 2021	29 June 2021	27 July 2021	28 September 2021	26 October 2021	23 November 2021	25 January 2022	28 February 2022	29 March 2022
Dr Geraldine O'Sullivan (Chair of Committee and Non-Executive Director)[1]	✓	✓	✓	✓	✓	✓	✓			
Dr Pamela Chrispin (Chair of Committee and Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prof Erika Denton (Medical Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ms Clare Fernandez (Associate Non-Executive Director)[2]										✓
Prof Nancy Fontaine (Chief Nurse)	✓	✓	✓	X	✓	X	✓	✓	✓	✓

Mrs Joanna Hannam (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Sam Higginson (Chief Executive)	✓	✓	X	✓	X	X	✓	✓	✓	✓

[1] Dr Geraldine O'Sullivan stood down as Non-Executive Director in January 2022.
[2] Ms Fernandez joined the Committee as Associate Non-Executive Director in March 2022.

Finance, Investments and Performance Committee – meeting and attendance
The Finance, Investments and Performance Committee met on 11 occasions during the year as follows:

	28 April 2021	26 May 2021	30 June 2021	28 July 2021	6 September 2021	29 September 2021	27 October 2021	24 November 2021	26 January 2022	23 February 2022	30 March 2022
Mr Tom Spink (Chair of Committee and Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Pamela Chrispin (Non-Executive Director)	✓	✓	✓	X	✓	✓	✓	✓	✓	X	✓
Mr Roy Clarke (Chief Finance Officer)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Chris Cobb (Chief Operating Officer)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mrs Sandra Dinneen (Non-Executive Director)	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Prof Nancy Fontaine (Chief Nurse)	✓	✓	✓	X	✓	✓	✓	X	✓	✓	X
Mr Julian Foster (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Simon Hackwell (Director of Strategy)	X	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Mr Sam Higginson (Chief Executive)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Paul Jones (Chief People Officer)	✓	✓	✓	X	✓	X	X	✓	✓	✓	X
Mr Anthony Lundrigan (Chief Information Officer)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

People and Culture Committee – meeting and attendance
The People and Culture Committee met 5 times during 2021/22. Attendance was as follows:

	24.05.21	26.07.21	15.12.21	27.01.22	28.03.22
Board members					
Prof David Richardson (Chair and Non-Executive Director)	✓	✓			
Chris Cobb (Chief Operating Officer)	✓	X	X	✓	X
Prof Erika Denton (Medical Director)	✓	✓	X	✓	✓
Sandra Dinneen (Non-Executive Director – Chair from 15.12.21)	✓	✓	✓	✓	✓
Prof Nancy Fontaine (Chief Nurse)	✓	X	X	✓	✓

Prof Charles ffrench-Constant			X	✓	X
Joanna Hannam (Non-Executive Director)	✓	✓	✓	✓	✓
Sam Higginson (Chief Executive)	✓	✓	✓	✓	✓
Paul Jones (Chief People Officer)	✓	✓	✓	✓	✓
Divisional members					
Dr Richard Goodwin (CoD - Clinical Support Services)	X	X	(✓)	✓	X
Dr Tim Gilbert (CoD – Medicine and Emergency Services)	✓	✓	X		
Dr C Jamieson (CoD – Medicine and Emergency Services from January 2022)				X	✓
Dr Tim Leary (CoD - Surgery)	✓	✓	(✓)	✓	X
Jo Nieto (CoD - Women and Children)	X	X	X	X	X

(✓) = attendance by a deputy

Council of Governors

The Council of Governors is chaired by David White who, as Chairman of the Trust, acts as a link between the Council and Board of Directors. Directors regularly attend meetings of the Council of Governors and feedback from the Council is a standing agenda item on meetings of the Board of Directors so that the Board is informed of the views of our Members as represented by the Governors.

The Council of Governors is responsible for representing the interests of Foundation Trust members and partner organisations in the governance of the Trust. The Council receives regular reports from the Chief Executive and other Board members on relevant operational and strategic matters. The Council of Governors has a number of specified statutory responsibilities which it has satisfied during the course of the year. In particular the Council has:

- received the Trust's Annual Report and Accounts;
- expressed views for consideration by the Directors in preparing the Trust's strategic plans;
- confirmed the appointment of Professor ffrench-Constant as Non-Executive Director.

The term of office for Governors is three years and the appointment of both staff and public Governors is by election by the members. Elections are held on an annual basis to fill any vacancies on the Council. These elections are administered on our behalf by an independent organisation (Mi-Voice) and in accordance with the election rules set out in our Constitution. We promote elections through mailings to members, media coverage and through the Trust's social media channels. The Trust receives a good level of interest from the local community and staff in filling these vacancies and they are usually contested. As at March 2022 the Governors were:

Public Governors

- Elaine Bailey — North Norfolk
- Erica Betts — Breckland
- Jane Bevington — Norwich
- Peter Bush — Norwich
- Diane DeBell — Norwich
- Nina Duddleston — Breckland
- Carol Edwards — North Norfolk
- Ines Grote — Great Yarmouth and Waveney
- Jackie Hammond — Broadland
- Peter Harrison — South Norfolk
- Chris Hind — South Norfolk
- Tim How — King's Lynn and West Norfolk
- **Shirley Ricketts — Broadland**
- **Joy Stanley — Breckland**
- **Joanna Tuttle — Broadland**

Staff Governors

- Bibin Baby — Nursing and Midwifery
- Terry Davies — Contractors and Volunteers
- Gemma Lynch — Admin and Clerical
- Leanne Miller — Clinical Support
- Richard Smith — Medical and Dental
- Clare Stubbs — Nursing and Midwifery

Partner Governors

- Alison Thomas — Norfolk County Council
- Tracy Williams — Norwich Clinical Commissioning Group
- Vacancy — University of East Anglia

Changes during the year:

The following Governors left the Council of Governors in 2021/22:

- Katie Cullum — Nursing and Midwifery
- Annie Cook — Admin and Clerical
- Mark Hitchcock — University of East Anglia
- Mary Pandya — Rest of England
- **Matthew Roe — North Norfolk**

A copy of the Register of Interests declared by the Governors can be found on our website at www.nnuh.nhs.uk.

Performance of the Council of Governors and its Committee
During the year, the Council of Governors has been briefed on a wide range of matters affecting the Trust including:

- the management of services in the light of the Covid-19 pandemic;
- development of a refreshed Trust strategy, working with public, governors, and staff;
- joint working with partners organisations in the Norfolk and Waveney Integrated Care System, particularly the other acute hospitals in Norfolk;
- major developments on the hospital sites, such as plans for the new paediatric theatres and orthopaedic surgery centre;
- the Trust's financial position and our performance against national standards;
- the Trust's Maternity services and Elective Recovery Programme;
- Infection Prevention & Control, Freedom to Speak-Up and the Trust's Membership Strategy.

Non-Executive Directors also attend formal Council meetings on a rotational basis, to allow discussion on key areas and on the Board Assurance Committees with which they are associated.

In addition to formal meetings, there is a regular programme of Q&A sessions for governors with the Chairman, Chief Executive and other directors. These meetings provide opportunity for more detailed discussion about the Trust's services and plans than may be possible during formal meetings.

Governors have not been able to come on the hospital site very often during the last year because of the risk posed by Covid-19 and the necessary visiting restrictions. Most meetings have been held online, although we have met in small numbers when the regulations allowed. The following is a summary of the events during the year which have involved members and governors:

- a series of place-based discussion sessions with members in July about the Trust's next five-year Strategy
- four governors helped with judging the staff awards
- a meeting was held with governors about plans for the 250th Anniversary
- a finance briefing with Chief Finance Officer Roy Clarke and his deputy Liz Sanford on 15 September
- a tour of the Norfolk Interventional Radiology Centre on 9 August
- a walking tour of Norwich Research Park on 16 September visiting the Quadram Building, Bob Champion Research and Education Building and the Earlham Institute.
- the AGM on 6 October 2021
- a briefing was arranged with Healthwatch CEO Alex Stewart on 19 November
- an induction event for new governors on 19 January 2022.

Attendance at formal meetings of the Council of Governors

The Council of Governors held four scheduled formal meetings in 2021/22. Attendance at Council meetings was as set out below:

		22 April 2021	22 July 2021	7 October 2021	3 February 2022
1	Mr Bibin Baby[1]				✓
2	Mrs Elaine Bailey[2]				✓
3	Mrs Erica Betts	✓	✓	✓	✓
4	Mrs Jane Bevington	✓	✓	✓	✓
5	Mr Peter Bush	✓	X	✓	✓
6	Ms Annie Cook	✓	✓		
7	Mrs Katie Cullum	✓	X		
8	Mr Terry Davies	✓	X	X	X
9	Prof Diane DeBell	✓	X	X	✓
10	Mrs Nina Duddleston	✓	✓	✓	✓
11	Mrs Carol Edwards	✓	✓	✓	✓
12	Mrs Ines Grote	✓	✓	✓	✓
13	Mrs Jackie Hammond	✓	✓	✓	✓
14	Dr Peter Harrison	✓	✓	✓	X
15	Mr Chris Hind	✓	✓	✓	✓
16	Mr Mark Hitchcock	✓	✓		
17	Mr Tim How[3]				✓
18	Mrs Gemma Lynch[4]				✓
19	Ms Leanne Miller	✓	✓	✓	X
20	Mrs Mary Pandya	✓	✓	✓	X

21	Mrs Shirley Ricketts	✓	X	✓	X
22	Mr Matthew Roe	✓	✓	X	
23	Mr Richard Smith	✓	✓	X	X
24	Mrs Joy Stanley	✓	✓	✓	X
25	Ms Clare Stubbs	✓	✓	✓	X
26	Cllr Alison Thomas	✓	✓	X	✓
27	Mrs Joanna Tuttle	✓	✓	✓	✓
28	Ms Tracy Williams	X	X	X	X

[1] Mr Bibin Baby elected December 2021
[2] Mrs Elaine Bailey elected December 2021
[3] Mr Tim How elected December 2021
[4] Mrs Gemma Lynch elected December 2021

Lead Governor
In accordance with the Foundation Trust Code of Governance, the Council of Governors has nominated one of its members to act as Lead Governor with particular responsibility for providing a channel of communication between the Council and NHSI in appropriate circumstances. Governor Erica Betts was selected by Council members as Lead Governor from April 2021.

Appointments and Remuneration Committee of the Council of Governors
In accordance with Statute, the Council has an Appointments and Remuneration Committee. The work of the Committee is supported by the Board Secretary. As at March 2021, Membership of the Committee is:

- David White - Chairman
- Erica Betts
- Terry Davies
- Carol Edwards
- Ines Grote

The Committee is responsible for making recommendations to the Council of Governors with respect to the appointment or reappointment of Non-Executive Directors. This year the Committee has made a recommendation regarding the appointment of a replacement for Professor David Richardson as the UEA nominated Non-Executive Director on the Trust's Board. At the end of Professor Richardson's term of office, his replacement was approved as Professor Charles ffrench-Constant, the UEA Pro-Vice-Chancellor of the Faculty of Medicine and Health Sciences.

One of the duties of the Appointments & Remuneration Committee is to oversee the annual review of the Chairman and Non-Executive Directors. The process for this year has involved a 360 review in accordance with a national framework and guidance. Feedback through the appraisal reviews will be used for self-development and learning.

Governor development
Two virtual training sessions for Governors were held with NHS Providers. Eleven governors attended a core skills module focusing on the roles and responsibilities of governors. Nine governors attended the session about member and public engagement. An induction event was held for new governors on 19 January 2022.

The role of governors has been highlighted in the Trust's Pulse magazine to raise awareness of the role of governors and how they may be contacted by Members. A new Member Newsletter has been developed to improve communication between governors and individual constituencies.

Governor expenses

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. As meetings have been held virtually on MS Teams during 2021/22, there have been no governor expenses.

Our Membership

We have three membership constituencies: Public, Staff and Partners:

- The Public Constituency - consists of people over the age of 16 and it includes patients and their carers, as well as the general public. Most are resident within the Local Authority areas of Norfolk and Waveney, although our constituency of 'Rest of England' caters for persons living outside this area and reflects the broader catchment area of the Trust's specialist services and the wider range of people with an interest in the Trust;

- The Staff Constituency – includes employees who have worked for the Trust for at least 12 months. This constituency also includes our volunteers and employees of contractors who work with us, as specified in our Constitution;

- Our Partners are represented by Governors drawn from the Clinical Commissioning Groups, local government and our partner University (the University of East Anglia).

The membership has grown since we achieved Foundation Trust status and an annual recruitment campaign maintains the public membership above the 15,000 target minimum set by the Council of Governors.

We have a Membership Strategy. We normally conduct an annual face-to-face recruitment campaign in local libraries and we were unable to carry out this task in 2021 because of the Covid-19 pandemic. This has led to a small dip in our membership numbers which we hope to make up during 2022.

Here is our public membership over the last seven years.

Year	Public members
2014/15	16,937
2016/17	16,499
2017/18	17,567
2018/19	17,143
2019/20	17,225
2020/21	16,476
2021/22	15,934

Our staff membership stands at 8,844, making a total of 25,320 members in total.

Communicating and involving our members

We have a programme of internal communication and engagement with staff members which includes a weekly electronic newsletter, staff intranet, in-house magazine, focus groups, surveys and meetings. More detail is given in the Staff Matters section of this annual report.

Public members receive our quarterly in-house magazine, The Pulse. Prior to the Covid-19 pandemic, this publication was used to publicise events such as lectures, the Annual General Meeting and participation in the Patient Choice Staff Award.

In response to the pandemic restrictions, in 2021/22, we have held virtual events with our AGM and staff awards held online. The AGM consisted of a recorded video event and a live Q&A section where people could ask questions of the senior management team and Chairman. Prior to the AGM, members of the public were encouraged to vote for their choice of topic in an online poll. The selected video talks were about the work of the Maternity Team and Emergency Department, plus a review of the year including the Trust's finances. The AGM also included presentation of the Inspiration Awards from the Norfolk & Norwich Hospitals Charity which recognised the support from the local community. The awards were pre-recorded with clips from the award winners as part of the AGM presentation.

Members can contact the Membership Office by telephone on 01603 287634 or through the website or by e-mail at membership@nnuh.nhs.uk

Case Study

New technology launches to speed up sepsis diagnosis for hospital patients

The combined Microbiology departments at the Eastern Pathology Alliance have launched onsite blood culture machines across Norfolk's three acute hospitals to diagnose sepsis more quickly.

Sepsis is a serious life-threatening condition that can occur in patients in the community or in hospital with vulnerable patients and patients with chronic health conditions most at risk.

The blood culture samples of hospital patients with suspected sepsis across Norfolk used to be sent to the Microbiology lab at Norwich Research Park.

However, new machines – the BioMerieux BACT/ Alert Virtuo – have been installed in the laboratories at the JPUH, NNUH and the Queen Elizabeth Hospital, to provide rapid onsite processing and significantly reducing the time it takes to provide information to help clinical staff treat patients.

If sepsis is suspected, a patient's blood is collected and mixed with a sterile culture media to encourage the bug to grow so it can be identified by scientists Microbiology labs.

The new machines are part of the EPA Microbiology network service at the three hospitals and will process hundreds of blood samples each week that will be reviewed more quickly and patients with positive samples can be treated with more focused antibiotics at an earlier stage. Once a blood culture sample is collected it can be delivered to the onsite lab straight away and fed into the fully automated system immediately day or night.

Statements

Principle for cost allocation

The Trust is compliant with the cost allocation and charging guidance issued by HM Treasury.

Political and charitable donations

No political or charitable donations have been made by the Trust in 2021/22 financial year or previous year.

Income disclosures required by Section 43(2A) of the NHS Act 2006

During 2021/22 income from the provision of goods and services for the purposes of the health service in England was greater than the income from the provision of goods and services for any other purposes. Accordingly, the requirement of the Act has been met. Health service income amounted to £753.4m of the total income of £848.8m (2020/21 £657.5m of the total income of £803.4m).

Significant events since the Statement of Financial Position date

There have been no significant events since the Statement of Financial Position date that require disclosure.

Statement from Directors

The Directors consider the annual report and accounts taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

Accounts and Statement of the responsibility of the Accounting Officer

The accounts for the year ended 31/03/2022 can be found at the back of this annual report. The statement of the responsibility of the accounting officer is on page 130.

Related party transactions

During the year none of the Board members, Governors or members of the key management staff or parties related to them has undertaken any material transactions with the NHS Foundation trust. Further details on related parties can be found in note 29 to the accounts.

Better payment practice Code

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Better Payment Practice Code - measure of compliance

	Year ended 31 March 2022		Year ended 31 March 2021	
	Number	**£'000**	**Number**	**£'000**
Total Non-NHS trade invoices paid in the year	130,598	344,624	119,094	336,310
Total Non-NHS trade invoices paid within target	124,287	310,195	109,603	303,404
Percentage of Non-NHS trade invoices paid within target	95%	90%	92%	90%
Total NHS trade invoices paid in the year	3,350	78,104	3,546	72,271
Total NHS trade invoices paid within target	2,720	70,133	2,523	59,526
Percentage of NHS trade invoices paid within Target	81%	90%	71%	82%

Interest paid under the Late Payment of Commercial Debts (Interest) Act 1998

Disclosures relating to any interest paid can be found in note 11.2 to the accounts.

Remuneration report

Annual Report on remuneration

Major decisions on senior managers' remuneration

Remuneration for the Trust's most senior managers (Executive Directors who are members of the Board of Directors) is determined by the Board of Director's Nominations and Remuneration Committee. The Nominations and Remuneration Committee determined that Trust staff on the VSM pay scale should receive a non-consolidated pay award of 2%. The Medical Director in addition to her managerial duties also maintains a clinical practice and received the Medical & Dental pay award of 3% from 1st April 2021. The Medical Director is also entitled under the consultant contract for a Clinical Excellence Award (CEA) in 2021/22.

The only non-cash element of senior managers' remuneration packages are 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. 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.

Any substantial changes relating to senior managers remuneration made during the year

No substantial changes to senior managers' remuneration were made during 2021/22.
Signed by

Signed by Chair of Remuneration Committee - Chairman – Tom Spink

Date 21 June 2022

Senior Managers' remuneration policy

The table below summarises each of the components of the remuneration package for senior managers which comprise 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 external benchmarks 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
NNUH Pension Contributions Alternative Rewards Policy	Senior Managers who opt in (who are not making pension contributions)	Hospital Management Board	A separate cash payment of up to 10% of an employee's basic salary where they have opted out of the NHS Pension Scheme. This is available to all Clinical staff or Senior Managers who face tax implications as a result of reaching or getting close to the Annual Allowance or the Lifetime Allowance.	Payment is made at 10% of gross basic pay.
Clinical Excellence Award Scheme	Medical Director only	Determined by Local Awards Committee in accordance with medical and dental employment contract; not awarded by Nominations and Remuneration Committee	Awards are determined by the Local Awards Committee in accordance with an agreed scheme that recognises clinical excellence across 5 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 9 award is the maximum that can be awarded locally.

Accompanying notes:

(1) There have been no additions or changes to the components of the remuneration package during 2021/22

(2) 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	Notice Period
Executive Directors:				
S Higginson, Chief Executive	21/10/2019	Ongoing	n/a	6 Months
CM Cobb, Chief Operating Officer	17/04/2019	Ongoing	n/a	6 Months
ERE Denton, Medical Director	01/07/2018	Ongoing	n/a	6 Months
NVC Fontaine, Chief Nurse	01/08/2018	Ongoing	n/a	6 Months
PD Jones, Chief People Officer	10/06/2019	Ongoing	n/a	6 Months
R Clarke, Chief Finance Officer	01/04/2020	Ongoing	n/a	6 Months
Non-Executive Directors:				
DR White, Chairman	10/06/2019	31/05/2022	2 Months	3 Months
JA Foster, Non-Executive Director	01/06/2019	31/05/2022	2 Months	3 Months
P Chrispin, Non-Executive Director	01/01/2020	31/12/2022	9 Months	3 Months
S Dinneen, Non-Executive Director	01/01/2020	31/12/2022	9 Months	3 Months
JM Hannam, Non-Executive Director	01/01/2020	31/12/2022	9 Months	3 Months
TI Spink, Non-Executive Director	01/06/2020	31/05/2023	14 Months	3 Months

Name & Title	Date of Commencement	End Date	Unexpired Term	Notice Period
Non-Executive Directors:				
C ffrench-Constant, Non-Executive Director (Appointed 1 September 2021)	01/09/2021	31/08/2024	29 Months	3 Months
D Richardson, Non-Executive Director (Until 31 August 2021)	01/09/2014	31/08/2021	n/a	3 Months
GH O'Sullivan, Non-Executive Director (Until 15 January 2022)	01/11/2016	15/01/2022	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 3 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 2021/22 the membership comprised the Chairman of the Trust, (Chair of the Committee) and all of the other Non-Executive Directors and the Chief Executive (Sam Higginson).

The Committee meets as required, and at least once a year. In accordance with Monitor's Code of Governance for Foundation 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.

The Committee met three times during 2021/22, on 2 June, 3 November and 1 December 2021. The meetings were quorate.

Where an individual's remuneration is above the level of £150,000 per annum pro rata the 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
There was a total of 6 Executive Directors in office during the year and 10 Non – Executive Directors, including the Chairman. In aggregate the Directors received reimbursement of expenses of £7 with claims from 1 director. In 2020/21, 15 directors had been in office, being 6 executive directors and 9 non-executive directors. In aggregate they received reimbursement of expenses of £6,176 with claims from 3 directors.

No significant awards were made to past Directors during the 12 months ended 31 March 2022.
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 2021/22 there were 25 governors (16 public governors, 6 staff governors, and 3 partner governors) and there were no claims for expenses (in 2020/21 there were 25 governors (16 public governors, 6 staff governors, and 3 partner governors) and no claims for expenses).

Remuneration – Audited

Name and title		12 months ended 31st March 2022					12 months ended 31st March 2021				
		Salary	All Taxable Benefits	Annual & Long-term Performance Related Bonuses	Pension Related Benefits	Total	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)	(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	£'000	£	£'000	£'000	£'000
DR White, Chairman	DR White	50 – 55	0	0	0	55 - 60	50-55	0	0	0	55 – 60
S Higginson, Chief Executive	S Higginson	245 – 250	0	0	0	245 – 250	220 – 225	0	0	305 - 307.5	525 – 530
CM Cobb, Chief Operating Officer	CM Cobb	165 – 170	0	0	7.5 – 10	175 -180	150 – 155	0	0	37.5 – 40	190 – 195
ERE Denton, Medical Director	ERE Denton	210 – 215	0	55 – 60	0	270 – 275	210 – 215	0	55 – 60	7.5 – 10	280 - 285
NVC Fontaine, Chief Nurse	NVC Fontaine	150 – 155	0	0	32.5 – 35	180 – 185	145 – 150	0	0	35 – 37.5	180 – 185
PD Jones, Chief People Officer	PD Jones	150 – 155	0	0	32.5 - 35	180 -185	140 – 145	0	0	32.5 – 35	175 – 180
R Clarke, Chief Finance Officer	R Clarke	180 – 185	0	0	0	180 – 185	160 – 165	0	0	280 - 282.5	445 – 450

Name and title		12 months ended 31st March 2022					12 months ended 31st March 2021				
		Salary	All Taxable Benefits	Annual & Long-term Performance Related Bonuses	Pension Related Benefits	Total	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)	(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	£'000	£	£'000	£'000	£'000
P Chrispin, Non-Executive Director	P Chrispin	10 - 15	0	0	0	10 - 15	10 – 15	0	0	0	10 - 15
S Dinneen, Non-Executive Director	S Dinneen	10 - 15	0	0	0	10 - 15	10 – 15	0	0	0	10 - 15
JA Foster, Non-Executive Director	JA Foster	10 - 15	0	0	0	10 - 15	10 - 15	0	0	0	10 - 15
JM Hannam, Non-Executive Director	JM Hannam	10 - 15	0	0	0	10 - 15	10 – 15	0	0	0	10 - 15
GH O'Sullivan, Non-Executive Director (Until 15 January 2022)	GH O'Sullivan	10 - 15	0	0	0	10 - 15	10 - 15	0	0	0	10 - 15
D Richardson, Non-Executive Director (Until 31 August 2021)	D Richardson	5 - 10	0	0	0	5 - 10	10 - 15	0	0	0	10 – 15
TI Spink, Non-Executive Director	TI Spink	10 - 15	0	0	0	10 - 15	10 – 15	0	0	0	10 - 15

Name and title		12 months ended 31st March 2022					12 months ended 31st March 2021				
		Salary	All Taxable Benefits	Annual & Long-term Performance Related Bonuses	Pension Related Benefits	Total	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)	(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	£'000	£	£'000	£'000	£'000
C ffrench-Constant, Non-Executive Director (Appointed 1 September 2021)	C ffrench-Constant	5 – 10	0	0	0	5 – 10	0	0	0	0	0
T How, Non-Executive Director (Until 31 May 2020)	T How	0	0	0	0	0	0 – 5	0	0	0	0 - 5

Taxable benefits cover the monetary value of benefits in kind, such as car mileage allowances where subject to income tax.

Pension related benefits have been pro-rated / time apportioned for Directors who were appointed or resigned 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. 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.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Fair Pay Disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director in the organisation in the financial year 2021-22 was £270k-£275k (2020-21, £270k-£275k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Pay Ratio Information Table

2021-22	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	22,549	31,534	43,201
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	20,330	28,808	40,057
'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 (£)	12.08	8.64	6.31

2020-21	Median
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	29,564
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	26,970
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff): Mid band of highest paid director (£)	9.22

Percentage change in remuneration of Highest Paid Director

	% Change from previous financial year in Salary and Allowances	**% Change from previous financial year in Performance Pay and Bonuses**
Highest Paid Director - (midpoint of band)	0.00	0.00
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)	0.19	19.62

	2021-22	2020-21
Paid Director's Total Remuneration (£'000)	270 - 275	270 - 275
Midpoint of band	272,500	272,500
25th Percentile (£)	22,549	Not Required
Median Total (£)	31,534	29,564
75th Percentile (£)	43,201	Not Required
Remuneration Ratio	8.64	9.22

In 2021/22, 0 (2020/21: 0) employees received remuneration in excess of the highest paid director. Remuneration ranged from £8k to £312k (2020-21 £8k-£301k). Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

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 0.19%.

The highest paid director's remuneration was 8.64 times (2020/21 – 9.22 times) the median remuneration of the workforce which was £31,534 (2020/21 - £29,564).

Total Pension Entitlement

2021/22 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 2022 (bands of £5,000) £'000	Lump Sum at age 60 related to accrued pensions at 31 March 2022 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2021 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2022 £'000
S Higginson, Chief Executive	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CM Cobb, Chief Operating Officer	0 - 2.5	-2.5 - 0	30 – 35	65 – 70	667	4	680
ERE Denton, Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
NVC Fontaine, Chief Nurse	2.5 - 5	-2.5 - 0	60 - 65	130 - 135	1,218	43	1,289
PD Jones, Chief People Officer	2.5 - 5	0 - 2.5	20 – 25	45 - 50	422	27	472
R Clarke, Chief Finance Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A

N/A – Sam Higginson chose not to be covered by the Pension Arrangements during the reporting year.
N/A – Erika Denton chose not to be covered by the Pension Arrangements during the reporting year.
N/A – Roy Clarke chose not to be covered by the Pension Arrangements during the reporting year.
As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

2021/22 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 2021 (bands of £5,000) £'000	Lump Sum at age 60 related to accrued pensions at 31 March 2021 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2020 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2021 £'000
Higginson, Chief Executive	15 - 17.5	0 - 0	50 -55	0 - 0	424	190	642
CM Cobb, Chief Operating Officer	2.5 - 5	0 - 2.5	30 - 35	65 - 70	599	36	667
ERE Denton, Medical Director	0 - 2.5	2.5 - 5	70 - 75	180 - 185	1,481	47	1,558
NVC Fontaine, Chief Nurse	2.5 - 5	-2.5 - 0	60 – 65	130 - 135	1,133	45	1,218
PD Jones, Chief People Officer	2.5 - 5	-2.5 - 0	20 - 25	45 - 50	370	25	422
R Clarke, Chief Finance Officer	12.5 - 15	27.5 - 30	50 - 55	105 - 110	533	197	739

The Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETV's are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Bonus

The Trust is required by NHSI to disclose any payments that fall within the definition of “Performance Related Bonuses” and it has been determined by the Department of Health that Clinical Excellence Awards (CEA) meet this definition. As such they have been disclosed as a “Bonus”. Clinical Excellence 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 Excellence Awards are administered at a national level by the Advisory Committee on Clinical Excellence Awards. These payments were previously classified within Other Remuneration. There have been no new Clinical Excellence Awards payable to the Directors in 2021/22, however one individual who has held the role of Medical Director during the period 2021/22 was in receipt of clinical excellence award as part of their remuneration packages that were determined in previous years.

Signed on behalf of the Board - Chief Executive – Sam Higginson **Date 21 June 2022**

Staff Report

Introduction

We have over 11,500 staff and volunteers who are at the heart of what we do. The year remains to have been an extraordinary time of change for the NHS and our Trust. The last 2 years have seen us work through one of the most challenging periods in the hospitals history, where we have had to respond to the first global pandemic of the 21st Century. We are grateful for the outstanding efforts our staff. We value the contribution made by each and every staff member and recognise that lots of our staff have had to work very differently in meeting the demands on our services.

It is because of each and every member of our team that we are able to turn our vision into reality, seeking every day to provide 'the best care for every patient'. What ever your role, where ever you work, you are key to the delivery of high quality, compassionate care to
our patients. Making the NNUH the best place to work, where we have a climate where everyone can thrive is central.

Analysis of average staff numbers

The information below shows the average staff numbers within the Trust from April 2021 to March 2022.

Average number of employees (WTE Basis)	2021/22	2021/22	2021/22	2020/21	2020/21	2020/21
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
Medical and dental	1,327	736	591	1,281	707	574
Ambulance staff	0	0	0	-	-	-
Administration and estates	1,399	1,315	84	1,386	1,322	64
Healthcare assistants and other support staff	2,610	2,259	351	2,600	2,262	338
Nursing, midwifery and health visiting staff	2,498	2,278	220	2,493	2,293	200
Nursing, midwifery and health visiting learners	61	61	0	2	2	0

Scientific, therapeutic and technical staff	713	684	29	713	674	39
Healthcare science staff	365	340	25	365	340	25
Social care staff	0	0	0	0	0	0
Other	5	4	1	6	3	3
Total average numbers	**8,979**	**7,677**	**1,301**	**8,846**	**7,603**	**1,243**

Analysis of Staff costs

The tables below set out the cost and number of staff for the last two years separately analysed between those staff members with permanent employment contracts with the Trust and those who do not have a permanent employment contract.

This table shows the gross cost of staff, analysed between those who are employed on permanent contracts and others (criteria as per previous table):

	2021/22			2020/21		
	Total	Permanent Staff	Other	Total	Permanent Staff	Other
	£0	£0	£0	£0	£0	£0
Salaries And Wages	360,902	308,606	52,296	353,257	303,621	49,636
Social Security Costs	35,074	29,992	5,082	32,917	28,292	4,625
Apprenticeship Levy	1,753	1,499	254	1,670	1,435	235
Pension cost - defined contribution plans employer's contributions to NHS Pensions	41,932	35,856	6,076	40,412	34,734	5,678
Pension cost - employer contributions paid by NHSE on provider's behalf	18,390	15,832	2,558	17,653	15,173	2,480
Pension cost – other	86	0	86	73	0	73
Termination Benefits	150	150	0	118	118	0
Temporary Staff - Agency / Contract staff	11,016	0	11,016	10,360	0	10,360
Total Gross Staff Costs	469,303	391,935	77,369	456,460	383,373	73,087

Breakdown of male and female staff as at 31 March 2022

	Male	Female
Executive Director	4	2
Non-Executive Director	4	3
Other staff	1,985	7,158

Gender Pay Gap Reporting

It is a statutory obligation for organisations with 250 or more employees to report annually on their gender pay gap. NHS organisations are covered by the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on 31 March 2017. These regulations underpin the Public Sector Equality Duty and require the relevant organisations to publish their gender pay gap data, with the reporting to include mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile. The requirement is to publish annually.

What is a Gender Pay Gap?

The gender pay gap shows the difference in the average pay between all men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are.

It is important to stress that the Gender Pay Gap is different to Equal Pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The NNUH's commitment

We are committed to being an equal opportunities employer and to building equality, diversity and inclusion into everything that it does to truly embed our ethos of *'Our Hospital for All'.* The NNUH is committed to supporting our diverse workforce and the fair treatment and reward of all staff irrespective of gender.

To find more detail on the gender pay gap for our Trust, go to:

- The Trust's website at: https://www.nnuh.nhs.uk/publication/gender-pay-gap-report/
- or see the Cabinet Office website: https://gender-pay-gap.service.gov.uk/Employer/kMHz7VmG

Sickness Absence

As at 31 December 2021, the 12-month rolling sickness rate was 5.0%. The evidence base supports the view that the vast majority of lost days are attributable to long term absence (durations of 28 or more continuous days). These absences accounted for 57.0% of all days lost to sickness absence.

During the 12 months to 31 December 2021, Covid-19 accounted for 15.6% of all sickness absence, if Covid absence was excluded, the 12 month rolling sickness rate would be 4.2%

Furthermore, further evidence suggests that, statistically, a member of staff who has not resumed within the first 7 days of sickness is, more likely than not, going to be absent for between 1-3 months. Accordingly, we recognise the importance of line managers needing to 'Know Your Staff' our compassionate approach

to people management and intervene positively. This could be to support a return from sickness absence but also, if at all possible, to put in place supportive interventions which prevent the need for sickness absence in the first instance.

Sickness absence data
This information is published by NHS Digital:

http://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff Turnover
For the 12 months to 31st December 2021, the staff turnover rate was 13.3%. To address the increase in turnover, a Retention Steering Board has been commenced and established five pillars of Retention. The pillars include; supporting new starters, employee journey, focus support for multigenerational workforce, gathering intelligence and flexible working. Each pillar has an assigned lead supported by a task and finish group with HR, Practice and Development, Trade Union colleagues and Divisional representation. We have streamlined our recruitment processes to improve the candidate experience and quicken the recruitment timeline. We have undertaken several large-scale recruitment campaigns to help ensure we have the staff numbers we need. This includes the 96 international nurses who are due to join us by the end of May and over 90 newly qualified nurses in the summer months. We are also working with other organisations across Norfolk and Waveney to recruit 800 healthcare assistants, with our Trust taking the largest cohort.

This information is published by NHS Digital:

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

Trade Unions

In accordance with the Trade Union (Facility Time Publication Requirement) Regulation 2017, we are required to publish information regarding 'facility' time on a government website by 31 July following the reporting period.

For the period of 1 April 2020 – 31 March 2021, NNUH reported 13 trade union representatives providing 12.09 FTE.

The following table outlines the percentage of working hours these officials spent on facility time.

Percentage of working hours spent on facility time	No of Representatives
0%	3
1 – 50%	9
51 – 99%	1
100%	0

The total spend on paying employees who were relevant union officials for facility time during the relevant period was £62,221.71which represented 0.014% of NNUH's total pay bill. The total hours on paid TU facility time totalled 2,670.50 which represented 23.89% of total paid facility time.

NHS Staff Survey 2021

The annual National NHS Staff Survey has operated since 2003 and allows us to monitor the experiences of our staff and benchmark ourselves against other similar NHS organisations and the NHS as a whole, on a range of measures of staff attitudes and satisfaction. The results are primarily intended for use by NHS organisations to help them review and improve the experience of staff at work and, who in turn, are then feel supported to provide high quality care for our patients.

Our response rate to the staff survey 2021 was 49% with 4,347 respondents, which is above the national acute trust average. The response rate to the 2020 staff survey was 48% with 4,309 respondents.

The most recent survey covers the feedback from staff from when the survey commenced on 4th October 2021 and closed on 26th November 2021.

In line with the commitment in the National People Plan, the NHS Staff Survey has been redeveloped in line with the People Promise, which sets out what NHS staff can expect from their leaders and from each other. These set out, in the words of NHS people, the things that would most improve their working experiences – like health and wellbeing support, the opportunity to work flexibly, and to feel we all belong, whatever our background or our job.

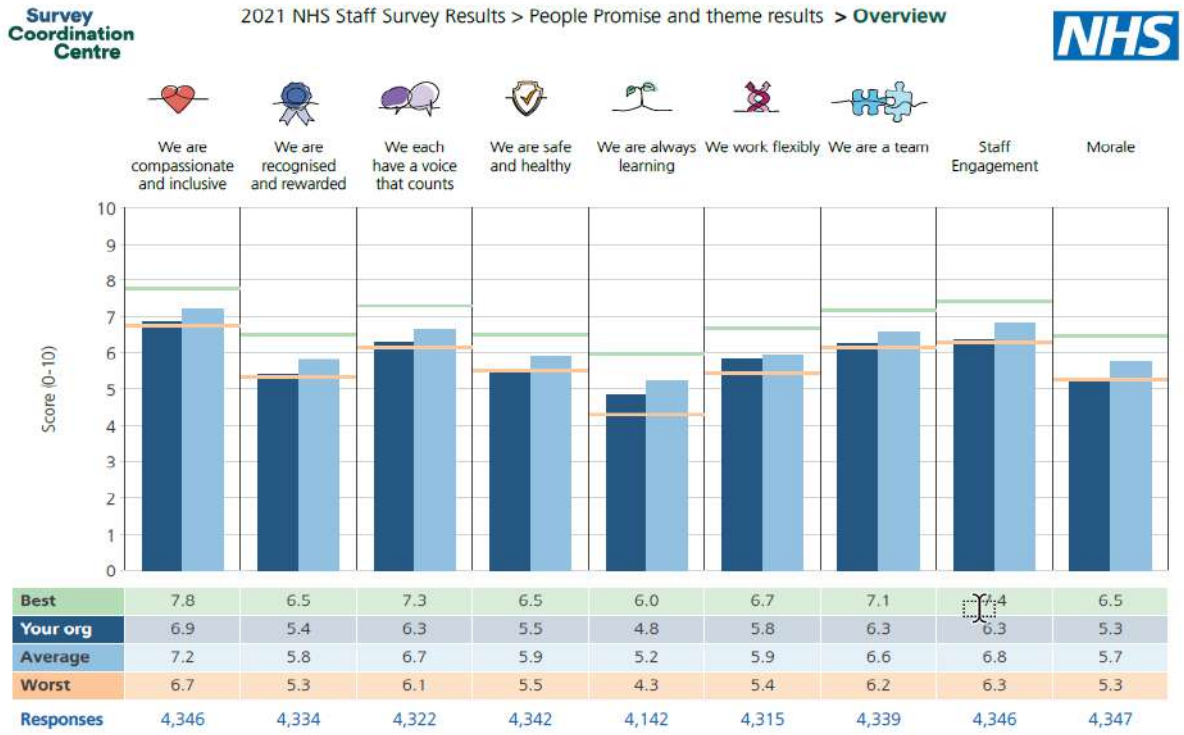
From 2021, the NHS Staff Survey will track progress towards the seven elements of the People Promise:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

In addition to the 7 People Promise themes, there are two additional themes Staff Engagement and Morale.

All themes are scored on a scale that ranges from 0 to 10 (the higher the 'score' the better). Scores for each indicator together with that of the survey benchmarking group (126 acute and acute & community trusts) are presented below.

NNUH 2021 theme scores compared to the benchmark of 126 acute trusts



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	6.9	5.4	6.3	5.5	4.8	5.8	6.3	6.3	5.3
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	4,346	4,334	4,322	4,342	4,142	4,315	4,339	4,346	4,347

When comparing the NNUH 2021 question results to 2020 results, disappointingly only nine improved, five remained the same, forty-nine worsened and thirty-six cannot be compared due to changes to the questions from 2020.

The seven new People Promise theme scores cannot be compared to 2020, due to the changes with the national survey reporting, however all seven scored below the national average acute trust score. The theme scores for Staff Engagement and Morale can be compared to previous years. Both declined from the 2020 survey and are below the national average acute trust score. These two theme scores also declined at a national level when compared to 2020.

The 2021 results represent a difficult period where we are disappointed about their staff experiences of working at NNUH. Data from the 2021 staff survey has provided the Trust with strong evidence that there is significant work to be completed to improve our staff experiences.

We acknowledge the suite of studies over recent years by academics and the Kings Fund, specific to health care settings which clearly evidence that Trusts with higher levels of staff engagement deliver services of higher quality and perform better financially, as rated by the Care Quality Commission. These Trusts have higher patient satisfaction scores and lower staff absenteeism. They have consistently lower patient mortality rates than other trusts. By improving our staff experience we should expect to also find improvements in the experiences and outcomes of our patients.

We are determined to make our hospitals a better place to work and are developing a three-year Improvement Plan to turn around our results. We will work together, both internally and with the wider healthcare system, to make transformational changes to the way in which we work, care for patients and each other.

We understand the huge pressures that our staff are under every day and, as we emerge from the height of the pandemic, we have a programme of work under way to reset the way we work and ensure that our staff receive the support they need. This includes a major investment in improved staff facilities which will make the most difference to our staff.

We want our staff to enjoy working at NNUH, to have fulfilling careers, and to remain with us. We have a significant health and wellbeing programme in place and will build on that to ensure our staff get help quickly when they need it.

Staffing levels are a significant issue, and as mentioned previously, we have several large-scale recruitment campaigns under way to help ensure we have the staff numbers we need.

Other improvements are being taken forward in action plans produced by the divisions to address more specific issues.

The results from Staff Survey 2021 have been shared organisationally and are available for all staff to view on the Staff Survey intranet pages. As well as the national reports from the NHS Staff Survey Co-ordination Centre, there are reports which provide breakdown by staff group/ division and comparison tools.

Information on the staff survey, emerging themes and proposals have been shared with various established boards and forums, including:

- People and Culture Committee
- Joint Staff Consultative Committee
- Hospital Management Board
- Trust Board
- Staff Networks (BAME, LGBT+, Diverse Ability, Woman's Network)

Diversity and Inclusion

Equality, Diversity and Inclusion (EDI) is a critical component to improvements to our organisational culture. The two Equality Standards – Workforce Race Equality Standard (WRES) and Disability Equality Standard (WDES) – along with engaging with our staff networks and Equality and Diversity Group (EDGe) are part of

our efforts for positive change, engagement and inclusivity which support our commitment to make the NNUH "*Our Hospital for All*."

Equality and Diversity Policy and Equality Impact Assessments

Our Equality, Diversity and Inclusion policy describes what is meant by Equality, Diversity and Inclusion. It also defines intersectionality and the types of discrimination. The policy also includes the rights and responsibilities and duties placed upon the Trust, all employees and external stakeholders explaining the processes in place for addressing allegations of discrimination and to ensure that employees do not commit unlawful acts of discrimination**.**

We also ensure that for all new and existing policies they must be monitored and reviewed regularly to assess their equality impact. This can be undertaken using our Equality Impact Assessment Form(s) and guide.

The EIA is a way of investigating whether any of the Trust's policies (this includes project or action plans) and functions/services could impact people unfavourably and how this could be addressed. It will also show areas where the Trust needs to take action to promote equality. It improves the quality of the service that is provided to the public by ensuring that all services are accessible to everyone.

Equality and Diversity Governance

In September 2019, we replaced the HR Equality and Diversity Group (HEDGe) with the Equality and Diversity Group (EDGe) to reflect that patient, service user and customer aspects of EDI is as important a focus as workforce-related matters. The focus for the monthly EDGe meetings alternates between workforce and patient, service user and customer focus, the latter led by the patient engagement and experience team.

The group involves senior management as well as our staff network chairs/ representatives as they work together to identify gaps, improvements and ensures we meet EDI requirements including analysis of data to form responsive actions. It also allows each of the local divisional groups (LEDGe) to contribute and update on their local plans and initiatives.

NHS Equality Standards

Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) is the means of helping the NHS as a whole to improve its performance on workforce race equality. The WRES has nine indicators which highlight differences between the experience and treatment of white staff and Black and Minority Ethnic staff. The data is based on financial years and is required to be published by 31 August each year.

Key indicators taken from the WRES 2021 report are:

- WRES Indicator 1 – 13.2% of our workforce are of a BAME background and 80.3% of our workforce are White.

- WRES Indicator 2 – White candidates are 1.56x more likely to be appointed from shortlisting compared to BAME candidates

- WRES Indicator 3 – BAME staff are 1.64x more likely to enter the misconduct process compared to white staff.

- WRES staff survey indicators - 33% of BAME staff have experienced bullying or abuse from other colleagues.

Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) is a data-based standard that uses a series of measures to help improve the experiences of disabled staff in the NHS. The ten evidence based metrics enable NHS organisations to compare the reported outcomes and experiences of Disabled staff with non-disabled staff. The data is based on financial years and is required to be published by 31 August each year.

Key indicators taken from the WDES 2021 report are:

- WDES Indicator 1 – only 2.3% of our workforce have disclosed they have a disability whereas 23% of respondents to the 2020 staff survey said they had a disability or underlying health condition.

- WDES staff survey indicators – 32.7% of disabled staff have experienced bullying or abuse from other colleagues.

Equality Standard Actions

In 2020 we established an overarching objective for the equality standards to promote NNUH as '*Our Hospital for All'*. This commitment will be closely aligned to the Trust's new Corporate Strategy.

Interventions which looks to address our equality standards and indeed our overarching objective included:

- Implementing a second cohort of our reverse mentoring programme
- Celebrating diverse and cultural difference through a range of events, education and activities.
- Working with the Norfolk and Waveney integrated care system to improve our EDI education training and de-bias our recruitment practices across the system.
- Implementing an accelerated leadership programme for aspiring BAME leaders
- Developing a strengthened zero tolerance policy to protect staff from experiencing bullying, harassment and abuse from patients/ service users.

The Trust has also made a pledge towards the East of England Anti-Racism strategy which guides organisations towards key areas of improvement to support them to focus on addressing. This includes:

- **Education and Commitment:** supporting managers to understand what racism is and their role in accelerating change.
- **Civility, Respect and Safety:** supporting colleagues in feeling safe when speaking up.

- **Representation:** addressing the lack of representation in leadership and decision-making.
  Policies: reviewing policies through an anti-racist lens to ensure they reflect the needs of our people.
- **Experience:** improving staff's experience - ensuring people feel safe, supported and valued.

The Chief Executive published the following statement as the Trust's response:

"We commit to promoting racial equity, celebrating diversity in our workforce and community. We acknowledge that racism still exists and we support our Black, Asian and Ethnic Minority colleagues in standing against prejudice wherever it appears. We pledge our commitment to become a fully inclusive organisation and realise our goal to become Our Hospital for All".

All of the above interventions have been implemented and some of which are ongoing and are included in our EDI Workforce Focused Action Plan as our journey towards embedding NNUH as Our Hospital for All continues.

Case Study

Getting crafty to celebrate NNUH's workforce

A flagship project has been launched to celebrate the heroic efforts of our staff through a new vibrant and colourful art installation.

The Trust is asking the community to put their sewing skills to use and help create this one-of-a-kind display to represent all 92 countries of its workforce.

Each flag needs to be landscape orientation and approximately 18 inches wide and 12 inches high, with ties on the two left corners to enable fixing to the display.

Once made, crafters are being urged to personalise the flag in some way to express what NHS staff mean to them. This could be using embroidery, applique, adding embellishments or simply writing on them with markers. We would encourage you to make the flags from any fabric that is the right colours – this could also be recycled fabric from unwanted clothing or housewares. Please do not go out especially to get materials.

Flags will be allocated to each sewer depending on which countries flags we need flags for, to make sure we have every country represented. Each flag has been graded 'easy, medium, hard or very hard' to make sure you are allocated a flag at a difficulty level you are comfortable with.

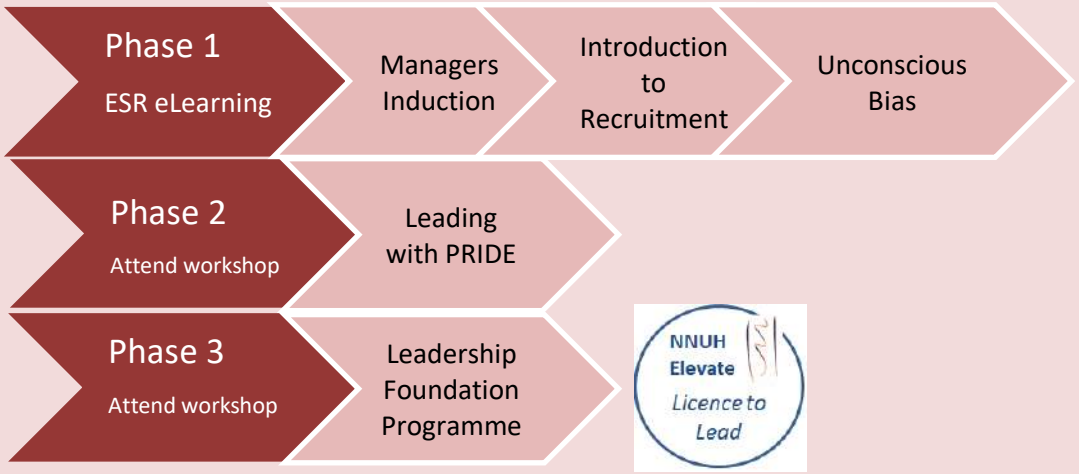
Licence to Lead

We place as much significance on our leadership as we do our clinical skills, so we've professionalised our approach to leadership by making it an essential requirement for any leader to complete a number of foundation learning units to achieve their Licence to Lead.

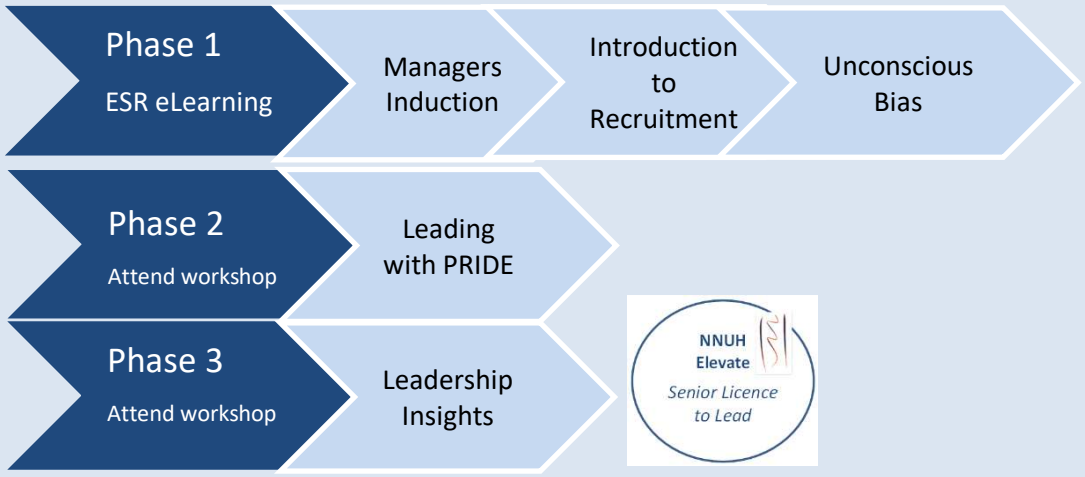
We need to support and encourage our best leaders to take on the most difficult roles and to help them face these challenges in an inclusive and compassionate way, with the right learning and development.

There are two levels:

- Licence to Lead for supervisors and managers who hold line management responsibility
- The Senior Licence to Lead for senior managers and leaders who are managers of managers.

<table>
<tr><th colspan="2">Licence to Lead (Holds line management responsibility)</th></tr>
<tr><td>NEW Line Manager</td><td> 
</td></tr>
<tr><td>Existing</td><td>As above, without the requirement to complete the Managers Induction. However, this can be accessed as a refresher if required.

NB: If any courses have already been completed these will be recorded on your ESR learning record and should not be repeated.</td></tr>
</table>

<table>
<tr><th colspan="2">Senior Licence to Lead (Manager of managers)</th></tr>
<tr><td>NEW Senior Leader</td><td> 
</td></tr>
<tr><td>Existing</td><td>As above, without the requirement to complete the Managers Induction. However, this can be accessed as a refresher if required.

If you have attended the Leadership Foundation Programme then you would not need to attend the ‘Leadership Insights’ workshop.

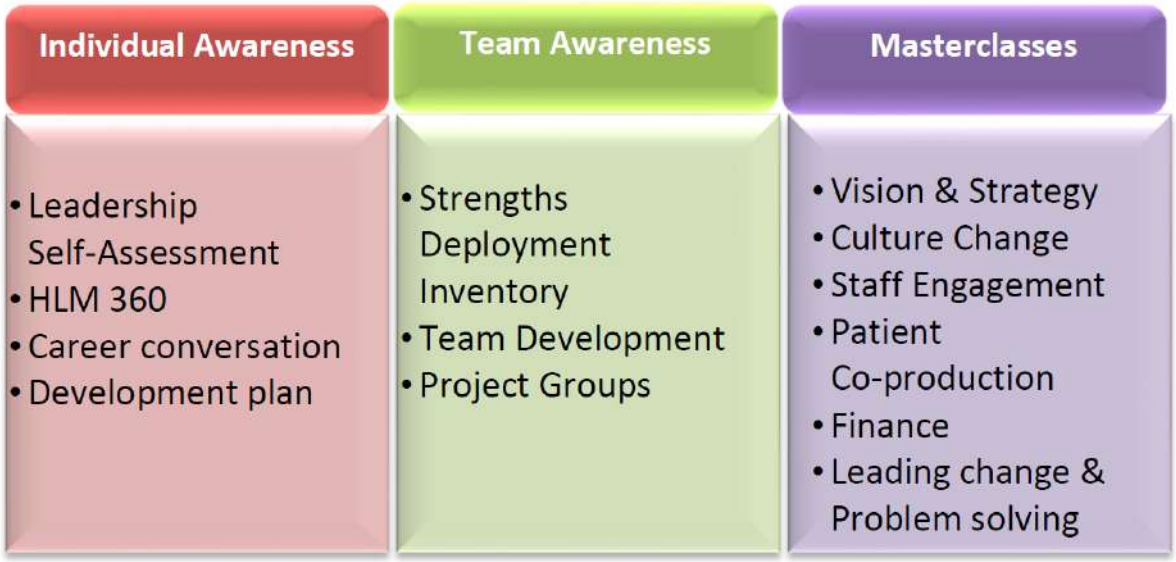
NB: If any courses have already been completed these will be recorded on your ESR learning record and should not be repeated.</td></tr>
</table>

Connected Leaders

The NHS Leadership Long Term Plan recognises that ‘great quality care needs great leadership at all levels’.

This programme is uniquely designed to develop multi-professional leadership teams, together. The value of high performing teams has long been recognised and we want to support our leaders to have the best opportunities to learn and develop specifically to achieve the delivery of the ambitious vision to really meet the needs of patients for the future through sustained leadership cultures necessary for outstanding performance.

Progamme Overview



Accelerated Leaders

The Accelerated Leaders Programme has been designed in collaboration with the NNUH Together Staff Network and aims to bridge the gap between where participants are and where they would like to be. It looks to support black, Asian and minority ethnic colleagues by providing an accelerated leadership pathway within NNUH.

Apprenticeships

During the financial year of 2021/2022, we have seen 210 staff commence on an apprenticeship;136 are existing staff and 74 are new apprentices, of these 37 are 16-18 years old. During the year staff have enrolled on a diverse range of apprenticeships and as a Trust we have utilised the apprenticeship levy to access 28 apprenticeship standards including Mammography Associate, Healthcare Science Practitioner, and Coaching Professionals. We continue to play a leading role within the region for apprenticeships and at the beginning of 2022 we won the Highly Commended award for the 'Large Apprenticeship Employer of the Year at the Apprenticeship Norfolk Awards. Two apprentices from the Trust also received Highly Commended Awards for 'Apprentice of the Year, Higher Degree Level' and 'Achievement in Exceptional Circumstances'.

Since Covid-19 the Career Development team have been running virtual work experience programmes and online events to highlight the variety of careers in the NHS, including year 11 work experience and HCA Apprenticeship webinars. In March 2021 the team returned to face-to-face events and attended the Norfolk Skills and Careers Festival alongside colleagues from across the Trust and ICS. The team continue to deliver 1:1 Career Discussions to support local students and the wider community. These have remained popular throughout 2021/22 and offer individuals with the opportunity to receive tailored support and guidance.

We are working with local training providers on the development of their T-Level programmes commencing in September 2022 to ensure students will be obtaining qualifications and work experience that will enable them to pursue careers within the NHS and social care.

Project Search
Project SEARCH is a work focused Education programme for young people aged 18 to 25 years who have a learning difficulty or learning disability. This project is a joint venture between Norwich City College, Serco and our hospital and has now been running for 13 years. Each year up to ten students will gain experience in three different job roles with the aim for them to gain paid employment, either at the hospital or within the wider community by the end of the programme. Since commencing in 2009, 135 students have accessed the programme.

Following the recruitment for the 2021/2022 programme, eight students started in September 2021 and have been attending various placements across Serco and the main hospital site. These include, grounds maintenance, housekeeping, post room, linen porter service and radiotherapy team in the role of radiotherapy assistant.

Step into Health
Step into Health supports members of the Armed Forces community to gain an understanding of the employment opportunities within health and social care. Our programme has developed to become a partnership offering with other regional organisations including Norfolk Community Health and Care, Serco, Norfolk and Suffolk Care Support, Norfolk and Suffolk Foundation Trust, James Paget University Hospital NHS Foundation Trust, Queen Elizabeth Hospital NHS Foundation Trust, East of England Ambulance Service, and Primary Care.

Due to Covid-19 face to face insight days have been paused, however there have been two virtual events during 2021/22 offering the opportunity for individuals all over the world to join and find out more about NHS Careers.

Prince's Trust
We have worked in partnership with the Prince's Trust for over ten years. However, due to Covid-19 all face-to-face work experience was paused which has impacted on the programmes we have been able to offer during 2021/2022. As an ICS we are working closely with the Prince's Trust to support a pilot Pre-Employment Projects Co-ordinator role which is hosted by the Norfolk and Waveney Health and Care Partnership.

The Pre-Employment Projects Co-ordinator supports those age 16-30 and not currently in education or training with a variety of activities including application and interview support.

Kickstart Programme
The Kickstart Scheme is a government funded initiative which provides funding for employers to create six-month job placements for young people (16-24 years old) who are currently on Universal Credit, and at risk of long-term unemployment due to the Covid-19 pandemic.

We have been hosting placements since June 2020 with the last candidates starting in March 2022 which is when the scheme closed for recruitment. Each applicant receives a salary for a placement of up to 25 hours per week for a period of six months at National Minimum Wage for their age.

We have been successful in applying for 95 placements 29 of which were recruited successfully in to. The candidates are provided with employability skills training during their placement and receive 1:1 mentoring focused on supporting them with future employment, of the 13 that have completed placements at NNUH, 8 have stayed within the organisation.

Destination Outcomes	
Further Education	3
NNUH Employment	2
NNUH Bank	5
NNUH Apprenticeship	1
Other NHS	0
Other Employment	4
Did not complete - Unknown	4

Local Counter Fraud Service (LCFS)

NNUH works closely with our designated local counter fraud specialist as part of the national scheme led by 'NHS Counter Fraud Authority'. This involves proactive and reactive work to ensure that precious NHS resources are not lost to fraud but rather can be spent on patient care and clinical services. This provides a clear route for concerns in relation to fraud to be reported and investigated, and development of an anti-fraud culture.

We take all necessary steps to counter fraud and bribery in accordance with guidance or advice issued by NHS Protect. This process is detailed in the organisation's Anti-Fraud and Bribery Policy.

Consultancy costs

Our expenditure for consultancy for 2021-22 is £831,000 which covers projects where we need additional skills or capacity. The figure for 202-21 was £604,000.

Off payroll engagements

The Trust has a policy that all substantive staff are paid through payroll unless there are exceptional circumstances.

The table below shows the details for 2021/2022:

Off payroll engagements as of 31 March 2022 for more than £245 per day lasting for longer than six months	
No. of existing engagements as of 31 March 2022, of which:	9
No. that have existed for less than one year at the time of reporting.	9
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

The trust may be able to engage contractors on an off-payroll basis, but there is scrutiny for such arrangements.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022, for more than £245 per day and that last for longer than six months	
No. of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022	14
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	14
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	2
Number of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure ***must*** include both off-payroll and on-payroll engagements.	6

Table 1:Exit Packages

	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole Numbers Only	£000	Whole Numbers Only	£000	Whole Numbers Only	£000	Whole Numbers Only	£000
Exit package cost band (including any special payment element)								
<£10,000			31	62	31	62		
£10,000 - £25,000	2	33	2	31	4	64		
£25,001 - £50,000								
£50,001 - £100,000								
£100,001 - £150,000	1	117			1	117		
£150,001 - £200,000								
>£200,000								
Total	**3**	**150**	**33**	**93**	**36**	**243**	**0**	**0**

- Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are the full costs of departures agreed in the year. Where the Norfolk and Norwich University Hospitals NHS Foundation Trust has agreed early retirements, the additional costs are met by the Norfolk and Norwich University Hospitals NHS Foundation Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.
- This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Table 2: Analysis of Other Departures

*Includes any non-contractual severance payment made following judicial mediation and there were no payments made relating to non-contractual payments in lieu of notice.

Type Of Other Departures	Agreements Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs		
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice	33	93
Exit payments following employment tribunals or court orders		
Non-contractual payments requiring HMT approval (special severance payments)*		
Total	**33**	**93**

- As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 6 which will be the number of individuals.
- * any non-contractual payments in lieu of notice are disclosed under “non-contractual payments requiring HMT approval” below.
- **includes any non-contractual severance payment made following judicial mediation, and 0 relating to non-contractual payments in lieu of notice.
- 0 non-contractual payments were made to individuals where the payment value was more than 12 months’ of their annual salary.
- The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report

Formal and informal consultation mechanisms

Staff Engagement
One of our top priorities is to encourage the best from our staff, whilst at the same time maintaining their health, safety and wellbeing at work. Our approach to staff engagement is to involve our colleagues in discussions about key issues and this is reflected in the different ways in which we communicate and consult with staff.

Formal negotiation and consultation with our recognised trade unions is undertaken in a conversational and constructive manner with all those involved invariably wanting a common aim.

The committees where the dialogue takes place include:

- JSCC (Joint Staff Consultation Committee)
- PACS (Pay and Conditions of Service)
- LNC (Local Negotiation Committee)

We have a Women's Network which was an addition to our existing staff networks; BAME, LGBT+ and Diverse Ability Networks which meet frequently to make a positive difference to individuals and our Trust.

Other communication mechanisms
Staff engagement is supported by a comprehensive internal communications programme which includes daily e-newsletters, intranet, magazine, and events. The weekly online Connected sessions, plus other Open Conversation events, are led by the Chief Executive Officer and Executive Directors talking about specific subjects.

These sessions have become more accessible to staff with them being run via Microsoft Teams, with recordings being available to staff after each event. There is also a weekly Chief Executive video, plus feedback reports from the Trust Board meetings and the Team Brief feedback to managers from the Hospital Management Board. Through these mechanisms, staff are kept up-to-date on a range of performance and finance issues affecting our hospitals.

Where there are issues affecting particular staff groups, including service changes, we hold regular meetings with those staff groups and staff side representatives, as appropriate.

Workplace Health & Wellbeing (Occupational Health)

This year has continued to see a significant increase in demand for occupational health services due to the impact of the global COVID-19 pandemic. We have continued to provide services relating to COVID-19 within our own organisation and the other NHS Organisations who contract services from us whilst maintaining core elements of the Occupational Health service.

Response to COVID-19

Risk assessment – Individual and Departmental

In Autumn 2020, we launched a technology solution to provide individual COVID risk assessments which enabled all staff to be risk assessed in minutes with outcomes of the assessment being sent to line managers and the occupational health team. This tool has been updated throughout this year in line with the national changing picture in relation to COVID-19. It has now been linked to the National Q - risk tool and key government information for sustainability purposes.

In addition, the department has reviewed the Workplace risk assessments for clinical areas as national guidance changed so that managers can review, assess and implement covid risk mitigation measures for individuals in their work areas.

Isolation advice and guidance

From the start of this pandemic, the team have kept up to date with the ever-changing advice from the government regarding isolation. This started in the early days with just advising when staff were returning from trips abroad, but over the year this has developed into a full in-house test and trace service for staff.

In peak times, the team have been providing a 7-day service by working additional hours ensuring any positive staff results are contacted and if necessary, ensuring contacts in the workplace are aware of the requirements in line with national guidance. 1500 test/ trace interventions have been undertaken for NNUH staff alone in the last financial year.

During the year, specific guidance was released from NHS England regarding staff isolation and contact requirements. Workplace Health & Wellbeing have reviewed this guidance and developed a robust Isolation Exemption procedure with associated risk assessment tools.

We have worked closely with the Infection Prevention and Control team in ensuring any ward outbreaks include staff contacts and appropriate testing has been undertaken.

Testing

Whilst not directly responsible for the staff testing service, we have worked with our Clinical Support Services team to provide governance advice and support in establishing both the swab and antibody services. We have worked in partnership with the testing team and the WHWB team have been contacting staff if positive results or any other queries in relation to the testing elements. This has been particularly evidence when the introduction of Lamp (Saliva based) testing was introduced for our organisation.

Increased recruitment support

Occupational health services in the NHS are a vital stage of the recruitment process of staff and the need to rapidly ‘on board’ staff was apparent early in this pandemic. The demand for all our NHS customers for this area of work has been significantly increased over the last 12 months. A 19% increase has been seen for our own organisation alone in this area.

Health & Wellbeing during the Pandemic and beyond

The impact of supporting staff at each stage of the Pandemic remains ever present within the organisation and particularly after Winter 2021 which was traumatic for many staff in their experiences. The Health & Wellbeing team devised, with the support of a local retreat business, a dedicated 'Rest and Restore' day for staff. The programme for the day consisted of:

- 2 hour facilitated reflective support, which included sharing experiences and Cognitive-Behaviour Therapy (CBT) strategies for improving wellbeing.
- 2 hour insight and intuition workshop
- 1 hour mindful nature walk / Japanese Water Garden time
- 1 hour Restorative Yoga and relaxation (breath work, affirmation, reading and sound therapy)

Colleagues provided anonymous feedback about the day, venue, benefits and enjoyment. All participants commented that the venue was fantastic, with many going on to say that having a day like this away from the hospital in these grounds added value to the experience.

A few themes emerged from the feedback forms with regard to the most beneficial aspect of the day. First was that of connection with others. There is evidence to support the importance of social connection for wellbeing, and the lack of connection over the pandemic clearly had an impact on staff, particularly noticeable in comments where people stated that they were just so happy to be with others. Interestingly, feedback from the later events also demonstrated the importance of connection and sharing, but the focus shifted from simply being with others to having shared experiences. It is likely that as social support started to return from outside of work, staff felt less isolated.

However, the need to validate one's experience through the expression of shared challenges remained throughout all events. Individual's left the day feeling equipped with new skills to be able to cope with forthcoming challenges.

In addition, we procured Professor Paul McGee to deliver a series of 'Survive to Thrive' wellbeing workshops. Paul is an international keynote speaker who works with many organisations to support the wellbeing and resilience of staff. In addition, we secured some dedicated facilitator training sessions from Paul which will allow members of the team to deliver the material on an ongoing programme within the organisation.

In July, the Wellbeing team was supplemented by a Senior Health & Wellbeing Practitioner. The impact of this role has been truly evident in the few months of employment in providing health & wellbeing representation within workforce developments as well as developing new HWB avenues of work.

Such programmes have included:

- Mindfulness Based Cognitive Therapy course
- Resilience in the workplace workshops
- Line Manager Wellbeing support sessions
- Menopause Support Group
- Long Covid Support Group
- Dedicated support programmes for junior doctors
- Dedicated Critical incident response
- Creation of Wellbeing Advisory Group

Work going forward into the next year is representing Health & Wellbeing in the response to the Staff Survey which will explore the NHS Health & Wellbeing Framework, including Health & Wellbeing as part of the annual performance review for staff and providing managers with the skill set to have Health & Wellbeing conversations with their staff as well as

The service continues to deliver relevant programmes to promote the health and wellbeing of our staff as well as the organisations that contract services from us.

Covid and Influenza Vaccination programmes

The Head of Health & Wellbeing has continued to provide clinical input into the COVID vaccination service being undertaken by the Trust and once again planned and mobilised a team to deliver the annual influenza vaccine.

In Autumn 2021, the team commenced delivering the COVID booster doses and annual influenza vaccine to trust staff. A programme of co-delivery was designed but also allowed staff to have these undertaken separately if that was their preference. An update of 91% of staff received their Covid booster and 80% of staff received a flu vaccination this year.

The team used a dedicated software system to allow online booking and were able to secure a dedicated portacabin via NHS England to create a dedicated vaccine hub.

As a result, the team also supported our local NHS neighbours in providing this service to their organisations inviting them to attend our vaccination centre.

In mid-December 2021, due to the emerging Omicron variant, the government announced a rapid response was required to offer the majority of the adult population in England a covid booster, earlier than originally anticipated. Our vaccine team rose again to this challenge and trained additional staff and managed to deliver within days up to 800 vaccines per day. The centre went on the national booking system and provided this service to all members of the general public.

Our success within this programme, was undoubtedly as a result of increased resource to ensure high accessibility of the vaccines being available to all staff, alongside strong medical and nursing leadership together with the support of a dedicated software programme and prominent communications plan.

Core Occupational Health Services
Core occupational health services for NNUH staff have continued over the course of this year. We have undertaken absence referrals for all our contracts, immunisation services, to provide essential protection to staff who are working in clinical environments, exposed to blood and body fluids. Our blood exposure support line continues and all staff who have such incidents are assessed and supported with any necessary treatment.

Health surveillance process have started to resume. We have continued to adopt the technology solutions put in place during the previous year but are now developing the associated physical screening taking into account COVID risk assessments. For instance, some services are now having spirometry screening being undertaken in an individual's car or outside under a shelter environment where inappropriate room air changes cannot be in place. In addition, having adapted to undertaking DSE assessments via technology – reviewing the workspace and the position of the user using video consultation methods in the pandemic, a hybrid model of assessment is now undertaken – some physically in the workplace and some via technology making efficiencies for both the worker and the team at WHWB.

In other aspects of work, we successfully submitted our annual review of the Faculty of Occupational Medicine SEQOHS (Safe, Effective, Quality OH Service) accreditation programme following the full five-year assessment in July 2017. The team have been working hard in gathering evidence for our next full assessment which takes place in May 2022.

As far as external business is concerned, we have been delighted to continue to our success with our current customers and gaining a significant new contract during this last year. Our team has expanded due to the new business acquired and we have been ensuring that all team members have successful inductions so that all our customers receive a high-quality service. As part of our team expansion, we have also been able to internally promote some members of the nursing team who have developed well into their new roles.

The Head of Workplace Health and Wellbeing, Hilary Winch took on the additional position of Chair of the NHS Health at Work Network in April 2021 which involves representation on National Working groups as well as ensuring we are the forerunners of implementing any changes in guidance, legislation or good practice. Within this role in the last year she has been instrumental in working with NHS Improvement on consistency in standards for screening and immunisation requirements for health care workers as well as contributing to the development of menopause in the workplace material and contributing significantly to NHS England / improvement 'Growing Occupational Health' strategy design.

In addition, she continues to lead MoHaWK (Management of Health at Work Knowledge system) for the Faculty of Occupational Medicine which is the only national OH system to support local audit and benchmarking. As part of this role, she also contributes to the management of the SEQOHS accreditation scheme.

Health and Wellbeing / Staff Experience Working Group
There have been two prominent pieces of work which initially commenced in previous years and have now started to see the impact.

Staff Rest areas
The improvement of rest facilities has now moved forward with the redesign of the East Atrium and the

addition of an additional staff space built within a courtyard area. It is anticipated that continued dedicated staff rest space is developed over the forth coming years

Smoke Free NHS Estate
In line with Public Health England recommendations, NNUH have been working to ensure we implement a completely smoke free estate. A working party was operational prior to the pandemic to consider the steps that need to be taken and consider the impact of those who smoke on our site from staff, patients, visitors and contractors.

A wide range of actions have already taken place which includes:

- A review of the staff policy with staff engagement forums taking place
- Developing new signage for the site
- Liaising with all contractors on site and full communications plan to the general public in Norfolk.
- Patients to be prescribed fast acting nicotine replacement therapy on admission to manage their nicotine addiction
- Availability of fast acting nicotine replacement therapy for visitors, staff and contractors through the retail outlets on site.
- Support for all being provided through referrals to Smokefree Norfolk

Our full launch programme could not take place last year due to the pandemic – but a soft launch was undertaken. During the last year the permanent signage was installed. Continued work is being undertaken to develop the prescribing of fast acting nicotine replacement for patients on admission.

Monthly PRIDE award scheme based on our Trust Values: People-focused, Respect, Integrity, Dedication and Excellence
Each month there are members of staff and teams who receive recognition through this scheme. Members of the staff experience working group review the monthly nominations and make decisions regarding winners. This initiative continues to be really well received.

Health and Safety

The Health and Safety team advises on staff safety in relation to the main risks present in a healthcare environment. The team assists with risk assessment and incident investigation as well as proactively auditing and monitoring standards and compliance across all Trust premises.

During 2021 and continuing through 2022 the Covid-19 pandemic was still in effect within the UK and priorities alternated at a frequent basis to meet the needs and safety of staff working in administrative and clinical operations. The team has also managed to continue elements of business as usual (BAU) during 2021/22.

The main business as usual projects for the year 2021/22 were:

- Trialling of a new Health and Safety Workplace Inspection to further enhance Health and Safety Governance for individual sites and departments. It is envisaged that the inspection template will be provided at the April H&S Committee for approval and subsequent release of an audit plan for 2022/23.
- Continued support to the External Dangerous Goods Safety Advisor which includes the managing and implementation of controls to mitigate any findings observed. The Trust aims to ensure the safety of staff, patients, the public and the local environment by the safe and effective segregation and management of all classes of waste leaving our sites.
- Continued management of the Control of Substances Hazardous to Health (COSHH) electronic system. Including working with clinical teams on the safe storage of chemicals and ensuring the recommended Personal Protective Equipment (PPE) is accessible at point of use.
- Health and Safety Representation for the three Trusts within Norfolk at the ICS CPEG offering advice and guidance from a safety point of view on new items being procured for example ensuring needlesticks have safety devices.
- Offering advice and guidance in conjunction with the Trust Estates team for safety regarding major projects including building works around the sites. The team have been involved in new and existing planning processes to consider the safety of anyone affected by such works and to help ensure that relevant controls are in place for the safety of all users once works are completed. This has also started to encompass advising on future projects which are in the early stages of the planning phase.
- In collaboration with the Security and EPRR Team completing a gap analysis to identify the Trust current compliance with the Violence Prevention and Reduction Standard. This collaborative approach continues to allow for implementation of policy and processes in relation to the prevention of violence to the Trust workforce.
- Continual review of existing health and safety documentation including polices and risk assessments as well as ensuring any new potential hazards are observed and assessed to ensure controls are implemented to mitigate the likelihood of harm occurring.

The main Covid-19 related projects for the year 2021/2022 were:

- Ensuring the Trust is compliant in relation to the Department of Health and Social Care, *FFP3 Resilience in the Acute Setting* correspondence received on June 21. The letter informed of 5 key resilience principles that Trusts are asked to consider and implement:
  - ❖ Item 1: All FFP3 users should be fit tested and using at least two different masks (ideally three):

- ❖ Item 2: FFP3 users should interchangeably wear the masks they are fit tested to.
- ❖ Item 3: Trusts should ensure that a range of FFP3 masks are available to users on the frontline and overall should not exceed 25% usage on any one type of FFP3.
- ❖ Item 4: Frontline stocks will be managed at no more than 7-10 days per SKU.
- ❖ Item 5: Trusts will register FFP3 users and fit test results in ESR and review individual usage every quarter.

- Face Fit Testing Clinics have been managed by the team and utilised a selection of our in-house team of fit testers within the trust to provide competent fit testing to colleagues who would need to wear enhanced Personal Protective Equipment such as FFP3, Respirator. From 28/06/21 the Trust have been able to acquire the use of the Free Fit Testing resource to ensure staff receive a suitable fit test where required on more than one type of mask.
- Continual advice and guidance to the teams in regard to completion of the Generic Workplace Risk Assessment, implementation of controls to work towards a COVID secure workplace.
- Providing support to the PPE Review Panel to ensure the continued development of our PPE/RPE processes to ensure the protection of staff and patients from infection.

Training

The Health and Safety team develops and delivers training packages including the provision of ensuring that there are competent trainers to cover the mandatory training needs of the organisation. The training will cover topics such as health and safety, manual handling, prevention and management of aggression, chemicals and waste.

Unfortunately, due continued threat of the pandemic the provision of the breakaway element of the Prevention and Management of Aggression training was put on hold. This was due to the close proximity that colleagues would need within one another. For new employees requiring this type of training for their role the face-to-face sessions are being scheduled for a return in 22/23 under a Covid controlled environment with controls such as limiting the size of group. A review of the existing eLearning training has also been completed and this has been shared as a mitigation to existing staff who have had the face-to face session previously.

Manual Handling Induction and Refresher training has continued throughout the pandemic in a Covid controlled environment which also included maximising the numbers of attendees to 10 colleagues due to the change of location to a dedicated training facility which allows for more room these sessions have been opened up to no more than 15 attendees.

The pandemic has continued to highlight the importance of the eLearning system as a provision of support for face-to-face training and has been vital in ensuring training can continue. The adoption of new technology by the Trust has also had a positive impact in ensuring an element of training can continue virtually such as Medical Students H&S Induction.

The training process is regularly evaluated and reviewed to ensure it is effective.

Incidents

There are five categories of health and safety related incidents that are reported most frequently for staff. These are slips, trips and falls, needle-stick and sharps injury, patient moving and handling, verbal aggression and physical aggression.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Incidents

During the period April 2021 to March 2022 the Health and Safety Department reported a total of 18 incidents to the Health and Safety Executive as they met the schedule of RIDDOR. 17 of these were related to colleagues; 3 specified injuries related to fractured wrist injuries and the remaining reports fell within absences of over 7 days. There was 1 reported because of a fractured neck of femur to a member of the public.

This is a reduction of 5.26% reporting compared to 2020/21 which had a total of 19 incidents being reported for the period. Most incidents in 2021/22 were reported in Q1, Q2 & Q3 with 5 each, with a further 3 in Q4.

The number of RIDDOR incidents is reflected as an incidence rate against the national average. The Trust's overall incidence rate is 170 per 100,000 employees based on a staffing level of 10000. The national incidence rate for healthcare in 2021/22 was 314.

More detail on health and safety performance is included within the reports that are presented to the scheduled quarterly Trust Health and Safety Committee during the reporting year.

NHS Improvement's Single Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs.

The Single Oversight Framework (SOF) looks at five themes:

• quality of care

• finance and use of resources

• operational performance

• strategic change

• leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

As of 31 March 2022, the Trust has been allocated into segment 3, which is described as 'mandated and targeted support'. The Norfolk & Waveney Integrated Care System (ICS) (of which the Trust is a part) is in segment 4, which is described as requiring 'mandated intensive support'.

For the Trust, support needs have been identified in domains of Quality of care, Finance and use of resources and Operational performance. During 2021/22 the Trust has agreed associated Licence Undertakings with NHSE/I, as detailed in the Annual Governance Statement.

This segmentation information is the Trust's position at 31 March 2022. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website. ***https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/***

Case Study

NNUH In-patient diabetes team win international award

Members of NNUH specialist In-patient Diabetes Services Team from Elsie Bertram Diabetes Centre are celebrating after winning the Royal College of Physicians (RCP) 2021 Excellence in Patient Care Quality Improvement Award.

The announcement was made during the RCP's virtual awards ceremony, held throughout the day on Twitter. NNUH's specialist diabetes in-patient team had been shortlisted for their 18-month programme aimed at helping the thousands of patients with diabetes who are treated at the hospital.

Dr Jason Cheung, NNUH In-patient Diabetologist Consultant and Diabetes UK Clinical Champion, said: **"I am immensely proud of the whole team, who worked so hard on this. We have been able to show that we have really improved the outcomes of our patients, and that these improvements are long term."**

Shelley Walker, senior nurse for NNUH In-patient Diabetes Care Team, said: **"The team has worked very hard through this very dynamic, challenging time in the past few years, especially during the Covid-19 pandemic. Despite all this, we persist with our team effort, and it is very rewarding to see this has visibly made positive improvements for our patients and staff."**

Anna Lartey, senior diabetes nurse educator for the same team, added: **"We hope to take this positive momentum forward, in particular during our current on-going team expansion work, to further expand our support to patients with diabetes, and staff that looks after them"**

Statement of the chief executive's responsibilities as the accounting officer of Norfolk and Norwich Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the Norfolk and Norwich University Hospitals 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 Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Norfolk and Norwich 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 Norfolk and Norwich 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
Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Norfolk and Norwich University Hospitals 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 Norfolk and Norwich University Hospitals NHS 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*.

Signed:

Sam Higginson, Chief Executive

Date: 21 June 2022

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Norfolk and Norwich 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 the Norfolk and Norwich University Hospitals NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Board of Directors has approved a Risk Management Strategy, which sets out the Board's approach to risk management, its Risk Appetite and accountability and reporting arrangements for the management of risk within the Trust.

The Chief Nurse is the Executive Director lead for Risk Management and operational responsibility for implementation of the Strategy and Policy is delegated to other named staff. The Risk Management Strategy has been made available to all Trust staff through our documents management system, called Trust Docs.

In addition to established processes for learning from incidents and patient feedback, the focus of our risk management approach is on proactively identifying and avoiding risks, rather than simply reacting to risks which have materialised. To enhance our capacity and capability in this regard the Trust has a designated Risk Manager and an Associate Director of Quality and Safety, to oversee the system of risk management in the Trust. The Risk Management Team co-ordinates and supports risk activity across the Trust, in close liaison with the divisional and clinical teams.

The Hospital Management Board has an established Risk Oversight Committee which is tasked, through defined Terms of Reference, to enhance our arrangements for the identification and management of risk and development of the Trust's Risk Maturity. Membership of the Risk Oversight Committee includes representation from the Divisional Management Teams and the Committee reports into a regular session of the Hospital Management Board at which the Corporate Risk Register (CRR) and highest-level risks are reviewed and discussed. Reports relating to the Risk Management System and Processes form a regular item for discussion by the Audit Committee as part of its annual reporting cycle. The CRR also informs updating of the Board Assurance Framework (BAF), which documents the principal threats to achievement of the Trust's Strategic Objectives, together with key controls and assurances and any gaps in those controls and assurances.

The Trust's mandatory corporate induction programme includes information concerning both clinical and non-clinical risk, the Trust's approach to managing risk and maximising quality in patient care. In addition, a range of ongoing risk management training is provided to staff and there are policies in place which describe roles and responsibilities concerning the identification, management and control of risk. Such training covers requirements for the safe delivery of services, proper use of equipment and wider aspects of management, health and safety and quality assurance.

The Trust has arrangements in place to ensure that we learn from good practice through a range of mechanisms, including clinical supervision, reflective practice, individual and peer reviews, appraisal and performance management, continuing professional development, clinical audit and application of evidence-based practice. The implementation of guidance from the National Institute of Clinical Excellence (NICE) is overseen by the Clinical Safety and Effectiveness Governance Sub-Board.

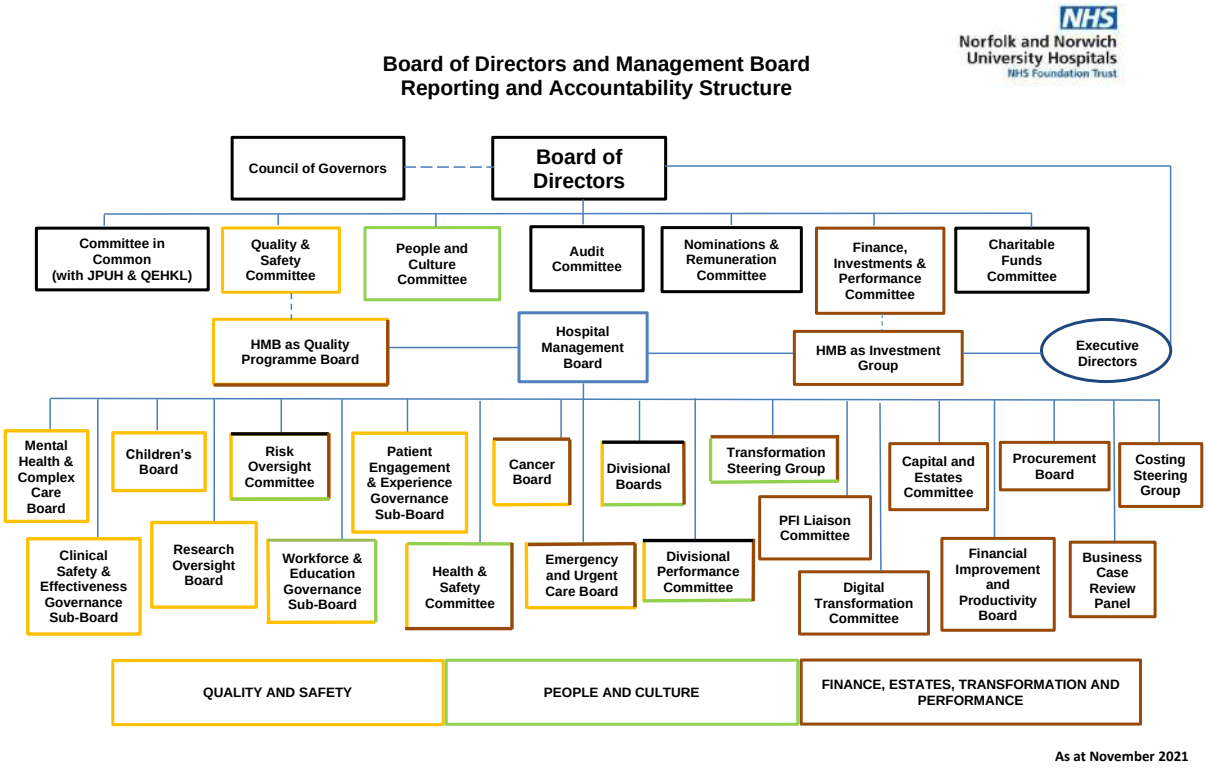
Reduction of risk and maintenance of quality are promoted by constantly reinforcing a culture of openness and transparency and encouraging staff to identify opportunities to learn from patient feedback and to improve the care and services we provide. We have introduced a robust programme of work associated with quality improvement and reduction of risk through our Quality Programme Board supported by an Evidence Group.

The risk and control framework

The Board has approved a Risk Management Strategy which sets out the approach to managing risk within the organisation. The Risk Management Strategy and associated policies define the key roles, responsibilities and reporting lines in relation to the management of risk, as well as the overall governance structure underpinning this at both Board and divisional/directorate level. The Strategy details the Trust's approach to identification, evaluation, control and reporting of risk as well as a statement of the Board's Risk Appetite, which was last agreed by the Board at its meeting April '22.

The Board of Directors is responsible for setting the vision and values and the strategic objectives of the Trust. The Board receives regular reports which detail risk, financial and performance issues and actions being taken to reduce identified high level risks or control issues. This reporting to the Board of Directors is supported through the Trust's governance structure, as detailed in the Trust's Organisational Framework for Governance, which details the roles of the Board assurance committees, together with the Hospital Management Board, its Committees and Governance Sub–Boards.

The Board of Directors has four established assurance Committees, covering areas of Quality & Safety; Finance, Investments & Performance; People & Culture; and Audit. The Board receives regular reports from each of its Committees and the overall governance and assurance structure is as represented below:



The Board's Audit Committee has responsibility to oversee the maintenance of an effective system of integrated governance, risk management and internal control, across the Trust's activities. The Terms of Reference for the Trust's Audit Committee are based on the model contained in the HFMA NHS Audit Committee Handbook 2018, and also reflect the UK Corporate Governance Code (2018) and ICSA Guidance on Terms of Reference for Audit Committees (2020). The Committee is tasked with reviewing the adequacy of the structures, processes and responsibilities within the Trust for identifying and managing key risks.

The Board has established an Organisational Framework for Governance, which sets out the responsibilities for each of the Board assurance committees to review key risks arising within their respective areas of remit. Collectively these committees form a framework for Board assurance.

Each stream within our system of integrated governance is led by a Senior Risk Owner and supported by appropriate teams and management information aiding our corporate and divisional delivery:

- Clinical Governance – led by the Chief Nurse and Medical Director
- Financial Governance – led by the Chief Finance Officer
- Information Governance – led by the Chief Information Officer
- Research Governance – led by the Medical Director
- Workforce and Education Governance – led by the Chief People Officer
- Divisional Governance – led by the Chief Operating Officer

Information and assurance is provided to the Board through:

- scrutiny of key data and metrics reported through a monthly Integrated Performance Report – available to the Board, Governors, staff and public (via our website);
- the work of and reports from the Board's assurance committees;
- 'triangulation' of information from diverse sources including reports and presentations from clinical teams, internal and external audit, external reports and the Board programme of clinical and departmental visits.

Threats to delivery of the Trust's Strategic Objectives (now titled Strategic Commitments) are recorded in the BAF which identifies the controls and assurances available to the Board of Directors in relation to the achievement of those Commitments. Internal Auditors reported in March 2021 "We confirmed the BAF clearly outlines the Trust's strategic objectives and the associated threats to the achievement of these objectives...the Trust's format provides for effective oversight of the key risks to the Trust's strategic objectives." In September 2021, a further Internal Audit review of the processes, controls and content associated with the Board Assurance Framework concluded that the Board could take Substantial Assurance.

Risk is assessed at all levels in the organisation from the Board of Directors to individual wards and departments. This ensures that both strategic and operational risks are identified and addressed and risk assessment information is held in an organisation-wide Risk Register. A risk scoring matrix is used to ensure that a consistent approach is taken to assessing and responding to clinical and non-clinical risks.

Those risks with a high residual risk rating (following the impact of appropriate mitigating actions) are detailed in a Corporate Risk Register – reported to both the Board of Directors and Management Board. High level risks are also reviewed by each of the Board assurance committees as relevant to their individual remits. This structure and process is intended to facilitate a cohesive risk management system operating from ward to Board.

The Hospital Management Board is tasked through its Terms of Reference with assisting me in effectively discharging my duties as Accounting Officer and with overseeing the identification and mitigation of key risks arising from or relevant to the operation of the Trust. It oversees the work of three Governance Sub-Boards, with areas of focus constructed so as to be consistent with the inspection regime of the Care Quality Commission under the following headings:

- Clinical Safety and Effectiveness
- Patient Engagement and Experience

- Workforce & Education

The Management Board has also established a number of other Committees to scrutinise and support areas such as Financial Improvement and Productivity, Research and Capital Planning. Each of the Management Board committees and governance sub-boards have Terms of Reference and they report to the Management Board on areas of risk or issues that require escalation.

A Divisional Performance Committee also oversees the work of our clinically-led Divisions. Our divisional structure forms a key part of our management and governance structure and each of the divisions is represented in the membership of the Management Board. During 2021/22 we have maintained a Performance and Accountability Framework to support oversight of the Divisions and the Finance, Investments & Performance Committee receives regular reports on use of the Framework.

During 2021/22 our divisional governance arrangements were subject to Internal Audit review, resulting in a Partial Assurance Opinion. The associated recommendations have been followed-up with each of the divisions. A new process of annual divisional governance reviews has been initiated and the first cycle was reported to the Audit Committee at its meeting in March 2022.

A schedule of Executive portfolios ('Who Leads on What') is well-established and is available to Management Board and Trust staff on the TrustDocs system. It is reviewed periodically as part of the ongoing Executive Team and Board Development Programme, so that there remains clarity and assurance over capacity and capability with regard to leadership for all aspects of the Trust.

In its most recent assessment of the Trust the CQC found that *"The governance structure was effective in supporting the delivery of the current strategy and of supporting the divisions and staff to deliver high quality care."*

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

The last published report from a full inspection by the Care Quality Commission (CQC) was issued in April 2020. The overall rating for the Trust was that it 'Requires Improvement'. In its report the CQC judged the Trust to be 'Good' for the domains of Caring and Effectiveness, 'Requires Improvement' in the domains of 'Safety, Well-led and Responsiveness'.

The CQC report identified a number of actions that the Trust 'must' and 'should' take in order to improve. Implementation of the associated action plan to implement the necessary changes has been tracked and monitored through the Trust's Quality Programme Board and the Quality & Safety Committee.

In June 2021, the CQC also undertook a focussed inspection of our Urgent and Emergency Services in the Domains of Safe, Responsive and Well-Led. The CQC Team identified a number of improvements from previous inspections, and the overall rating for Urgent and Emergency Services improved from Requires Improvement to Good.

In February 2022, the CQC undertook an unannounced focussed inspection of our Emergency Department at NNUH and the Minor Injuries Unit at Cromer & District Hospital, as part of a wider review of urgent and emergency care pathways across Norfolk & Waveney. The report (May 2022) explains that "*This was to assess how patient risks were being managed across the health and social care services during increased and extreme capacity pressures".* No ratings were given at the conclusion of this inspection however there were no 'Must Do' actions identified by the CQC. 4 'Should Do' actions were specified at the end of the inspection, that the Trust:

- should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system in Norfolk and Waveney;
- should continue to regularly review the nursing staffing levels in order to increase these to meet establishment levels;
- continue to monitor compliance and risk assess the trust policy for boarding patients;
- continue to review the impact of the closure of the discharge lounge and expediate plans for it's relocation to an appropriate setting.

In March 2022, the CQC undertook an announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) of the Trust's radiotherapy service. One area for improvement was identified as: the Trust must ensure that the training of all practitioners and operators are sufficiently documented and must be able produce evidence when required.

We look forward to welcoming the CQC team to the Trust again in due course, so that we can demonstrate our continuing improvement.

Other compliance issues
As part of its internal control framework, the Trust has established Business Continuity processes of Emergency Preparedness Resilience and Responsiveness. These EPRR processes are designed and maintained in accordance with NHSE guidance, with assurance oversight through the Audit Committee.

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. Such measures include staff training, policy frameworks and engagement with relevant staff networks.

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

The Trust recognises the crucial role played by its staff in delivering services to our patients and the Board has a People & Culture Committee, which is an assurance committee and strategic group, with a membership consisting of Board members and divisional leaders. The Hospital Management Board also established a Workforce and Education Governance Sub Board (WESB), chaired by the Chief People Officer and with representation from across the divisions, Human Resources and Education teams.

Through this governance structure the Trust ensures scrutiny of all aspects of people related issues and performance, including safe staffing, safe deployment, learning and development, cultural improvement, sickness, appraisal, mandatory training, retention, recruitment and temporary staffing. Any people related risks that arise from the divisional boards are presented at the WESB for appropriate consideration and intervention.

During 2021/22, a number of areas for improvement have been identified in the People Domain, in particular through:

- the Staff Survey results;
- Internal Audit reviews, including those relating to Succession Planning, Consultant Job Planning, Waiting List Initiative (WLI) processes and Divisional Management;
- our established governance structure and monitoring of metrics including those regarding recruitment, retention and Safe Staffing levels.

The importance of addressing these areas for improvement is recognised and emphasised by the Board and People & Culture Committee.

They are being addressed through development of an overarching People & Culture Strategy, targeted actions in response to staff feedback, implementation of Audit recommendations which are subject to follow-up, re-audit and reporting to the Audit Committee.

Review of economy, efficiency and effectiveness of the use of resources
The Trust's operational Plan for 2021/22 was approved by the Board of Directors following review by the Council of Governors and then submitted to and accepted by NHSEI.

Assurance with regard to delivery of the Operational Plan was sought on behalf of the Board of Directors through the Board assurance committees via reports covering activity, workforce, quality, safety and finance. The process to ensure that resources are used economically, efficiently and effectively across clinical services includes Divisional Performance Reviews meetings, the clinical audit programme and the regular monitoring of clinical indicators covering quality and safety. Progress against cost improvement programmes continues to be monitored through a Programme Management Office process reporting to the Financial Improvement & Productivity Committee and the Management Board.

The Trust's Internal Audit Plan is determined having regard to the Trust Risk Register and audits include objectives ensuring the economical, effective and efficient use of resources and this is applied across all audits. The findings of internal audit reports are reported to the Audit Committee and other Board assurance committees as relevant.

The Trust was subject to a Use of Resources review in December 2019 and the resulting report was published in April 2020. Overall the Trust was rated as 'requires improvement', reflecting the Trust's financial deficit and inability to consistently achieve the constitutional operational standards.

The report identified a number of areas as having scope for improvement, including initiatives to reduce length of stay, improve performance against constitutional operational standards, identify and drive transformational cost improvement programmes and review the workforce model and recruitment strategies to identify and implement innovative ways to address workforce gaps.

A formal response to the Use of Resources assessment was developed and submitted to NHSE&I, outlining the actions the Trust will take as part of our 'journey to outstanding'. The response consisted of strategic enablers running alongside a clear tactical action plan to address the specific recommendations outlined within the report.

As one of the key recommendations, an independent Financial Governance Review (FGR) was commissioned across five Financial Domains and this completed in October 2020. The review identified 53 recommendations, 23 of which were designated as 'Must Do'. This led to the development of a detailed Tactical Action Plan consisting of 65 individual actions for completion.

An initial internal audit review of the Trust's progress against the recommendations was completed in February 2021, with a further review in November 2021. This concluded that overall the trust had made "excellent progress" in implementing the recommendations reviewed. 9 out of 10 'Must Do' actions, and all 9 'Should Do' actions, had been completed. From an initial negative position, all 5 Domains had moved to a Green Opinion, with the biggest improvement seen in relation to the Culture of Financial Stability, supported by development of the Trust's revised Financial Strategy.

Whilst it is recognised that there is clearly more to do, the progress made since the last Use of Resources inspection is evident and externally validated.

The Trust has and will continue to review its position with regard to Getting It Right First Time (GIRFT), agency spend, procurement and efficiencies highlighted by the Lord Carter review, including enhancing its use of Model Hospital. Alongside working closely with local and regional partners to deliver transformational changes that support the delivery of a value for money efficient service as part of the local health economy.

Information Governance

The Trust has in place a Cyber Code of Conduct and Information Governance procedures which set out the Trust's commitment to ensuring that information is efficiently and effectively handled, managed and safeguarded.

This policy framework is supported by an information governance structure including:

- Information Governance Steering Group
- Caldicott Advisory Group
- Digital Transformation Committee

The Chief Information Officer is the Trust's Senior Information Risk Owner (SIRO), reporting to the Board of Directors, and the Medical Director is the Trust's Caldicott Guardian. This structure is supported by a deputy SIRO (the Associate Director for Digital Health) and a deputy Caldicott Guardian (the Chief Clinical Information Officer). Senior managers across the Trust are information asset owners, accountable for a particular group of information assets under the Information Governance policy and management framework.

The Trust continues to raise awareness of Information Governance and the importance of protecting personal information with its staff through a comprehensive training programme available by various means online and face-to-face. To complement this learning, relevant policies, guidance and best practice are made available to staff members via the Trust's intranet.

Personal data related incidents are reported through the Trust Incident Reporting System. The lessons learnt are shared with staff members and they enable the Trust to review and continually improve its information Governance processes for the safekeeping of personal information and to ensure compliance with data protection legislation and Caldicott principles.

During 2021/22, the Trust recorded three Level 2 reportable information governance incidents. These cases have been reported to the Information Commissioner's Office (ICO) and have been concluded with no further action required.

The Data Security and Protection Toolkit (DSPT) is an NHS Digital online self-assessment tool that allows Trusts to measure their performance against the National Data Guardian's 10 data security standards. The Trust completes a DSPT self-assessment every year and the Trust's position was subject to Internal Audit review during 2021/22, which has resulted in a Limited Assurance opinion. A series of improvement actions were identified and a targeted task and finish group has been established to ensure that these actions are completed prior to submission of the annual DSP Toolkit review in June 2022. Assurance on implementation of the necessary improvement recommendations will be obtained through the Audit Committee.

Data quality and governance

There are a number of controls in place across the Trust that provide assurance to the Board with regard to the controls in place concerning Data Quality and Accuracy of Data. The Trust has an experienced Data Quality Manager and Data Quality Team.

To facilitate joint working and exchange of information, this team is closely affiliated to the Commissioning and Income Team.

A review undertaken by the NHSI Elective Care Improvement Support Team (IST) in April 2022 has confirmed that the Trust's Data Quality Team "*provide a service the elective care IST would describe as best practice".*

The Data Quality Team maintain and manage a suite of policy documents for application across the Trust. These include a Data Quality Policy & Strategy; Patient Demographics; Referral to Treatment Access Policy and numerous Standard Operating Procedures. The Team also provide training for Trust staff and audit compliance with data collection and reporting requirements with particular regard to elective waiting time data. The Trust also retains the services of specialised and skilled coding and informatics staff to produce and analyse data and to ensure the accuracy of reporting.

Three key audit programmes are in place with regard to Data Quality:

i) *Referral to Treatment 18 Week Rolling audits*: carried out at a speciality level on a rolling basis, these audits give assurance over the accuracy of data relating to Performance Standards (focussing on RTT Standard) and adherence to policy; as well as compliance to National Rules. The audit results are reviewed through the Trust Assurance Group (TAG);
ii) *Key Systems Audit Programme*: this programme supports reporting of clinical income and provides assurance from standalone systems, to ensure the Trust is able to report correctly attracting the correct level of income from clinical activity and to ensure that information used in Service Line Reporting is accurate, valid, reliable, timely, relevant and complete. Reporting of audit results is taken through the Information Governance Steering Group;
iii) *Clinical Threshold/Individual Funding Requirement:* Weekly and monthly audit work is undertaken to confirm compliance with policy statements agreed with local Clinical Commissioning Groups.

Information to support the quality metrics used in the reporting on quality is held in a number of Trust systems, including Datix (electronic risk management system), PAS (patient administration database) Telepath (electronic pathology system) and ICNet (infection control system). The data is utilised day-to-day in the Trust's operations and, where appropriate, it is submitted to the National Information Centre, which operates national checks to ensure its reliability and accuracy. Further quality data is drawn from the reports that are produced for the Clinical Safety Sub-Board and the Patient Engagement and Experience Sub-Board.

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, Audit Committee, Quality & Safety Committee and Finance, Investments & Performance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors has met regularly throughout the year and has kept arrangements for internal control under review through discussion and approval of policies and practice and monitoring metrics that are agreed as indicative of effective controls. The Board reviews a monthly Integrated Performance Report covering a wide range of performance metrics – these show the key relevant national priority and regulatory indicators, with additional sections devoted to safety, clinical effectiveness and patient experience. This monthly integrated summary is supplemented by more detailed briefings on areas of notable or adverse performance.

The Audit Committee has reviewed the overall framework for internal control and the Trust's Organisational Framework for Governance, and has recommended this statement to the Board of Directors.

The result of the external auditors' work on the annual accounts and annual report are also a key assurance. Further assurance is provided through the CQC intelligent monitoring reports, the outcomes of the clinical audit programme, the results of reviews and inspections by external organisations and our internal audit programme.

Significant and Strategic Risks
During the course of 2021/22 the Board, Management Board, Divisional Boards and the Board Assurance Committees have reviewed the most significant risks facing the Trust, summarised as follows:

i) **Capacity:** high levels of elective demand, and prolonged waiting times in the aftermath of the acute pandemic, have created risks for delivery of the Trust's performance targets for cancer, elective care and diagnostics, leading to extended waiting times, increased clinical risk and use of expensive temporary or outsourced capacity;
ii) **Finance**: if the Trust is to deliver financially sustainable high-quality services to patients, there is a need to enhance financial controls, implement operational transformation and secure support for the structural element of the Trust's financial deficit;
iii) **Emergency demand**: The Trust faces risks associated with high levels of emergency demand, delayed discharges and consequent congestion in our hospital resulting in a need to use escalation areas;
iv) **Quality:** systems, processes and teams that are insufficiently resilient and consistent in practice, or inadequate in capacity, can result in diminished standards of patient experience and quality outcomes;
v) **Digital**: immaturity and vulnerability in the Trust's digital infrastructure creates risk to cyber security, operational resilience, quality and efficiency;
vi) **Staff**: gaps in our workforce resulting from sickness and vacancies impact on our ability to deliver safe and timely care and compound the issues of post-pandemic staff fatigue and diminished satisfaction reflected in the Staff Survey.

The Trust has mitigating actions in place to minimise the potential impact of these risks so far as practicably possible, with the impact of these assessed through reports to the Board and in particular the metrics set out in the monthly Integrated Performance Report. The Board of Directors and Board assurance committees regularly seek assurance on the effectiveness of the controls and progress being made to address gaps in control and assurance to reduce the level of risk.

Threats to delivery of the Trust's Strategic Objectives are recorded in the Board Assurance Framework (BAF), together with the controls in place to counter the identified threats and actions to be taken to provide additional assurance.

In its assessment of the Trust reported April 2020, the CQC found that *"The executive directors, chair and non-executive directors we spoke with all agreed on the most significant risks for the organisation. These included finance, staffing, and capacity. …All could describe the controls in place and their individual responsibilities in addressing these concerns"*.

Licence Undertakings:

NHSI, the independent regulator of Foundation Trusts, has previously investigated the Trust's non-achievement of national operational performance targets and quality challenges as highlighted by the CQC.

The Trust has agreed revised Licence Undertakings with NHSE/I. Key elements of the Undertakings relate to delivery of agreed improvement plans regarding:

- Urgent and Emergency Care, Elective Care and Cancer Care;
- Improved financial performance as part of the STP Financial Envelope, in accordance with the agreed Medium Term Financial Strategy;
- Quality Improvement.

NHSE/I has confirmed its belief that implementation of the actions identified will ensure that relevant Licence breaches do not continue or recur.

Incident Reporting and Raising Concerns

Incident and near-miss reporting is encouraged across all staff groups and specialties across the Trust within an open culture focussed on learning and improvement. The Trust has a single web based incident reporting system which is used by all staff groups to record patient and staff safety incidents, near misses and serious incidents. The number and type of incidents reported and learning from these incidents is disseminated and monitored through the risk and governance structure and a communication route to all staff based on Organisation Wide Learning (OWL) newsletters, Safer Practice Notices and updates through the Clinical Safety and Effectiveness Governance Sub-Board.

The Trust has established a daily multi-professional Serious Incident Group (SIG) which reviews high-rated incidents or near misses, to identify and share learning, ensure any immediate safety actions are taken as well as compliance with the statutory Duty of Candour. The Quality & Safety Committee receives regular reports with regard to the rate of incident reporting in the Trust and the investigation and learning from incidents.

The Trust has a full-time Freedom to Speak-up Guardian (FTSUG) in post to support staff in raising concerns and putting forward suggestions as to how we might make further improvement in the Trust and its services. The FTSUG reports regularly to the Board of Directors, People & Culture Committee and Hospital Management Board, so there is transparency with regard to any issues of concern affecting or raised by staff.

Involvement of Stakeholders in Risk

The Trust liaises with its commissioners throughout the year in relation to risk through regular meetings to review contract/clinical quality matters. The Trust works closely with other local organisations which are part of the formal structure for NHS patient and public involvement, such as the Health Overview and Scrutiny Committee and Healthwatch.

Our Foundation Trust has a membership with approximately 15,000 public members, many of whom are actively involved with the Trust in a number of ways, including a Patient Panel and a regular programme of meetings for members about different aspects of our activities. Inevitably, such activities have been disrupted this year by the pandemic restrictions but we have sought to optimise engagement as possible, through initiatives such as digital communication, remote access to public meetings and a virtual AGM.

The members elect governors who sit on the Trust's Council of Governors and who represent the views of members when contributing to development of the Trust's forward plans and priorities. The Trust's Council of Governors receives regular updates on strategic developments in the Trust and performance against key targets and governance requirements.

The views of patients are sought in a variety of additional ways, including patient electronic surveys, nationally mandated surveys, comment cards and other activities. The Board receives regular reports on feedback from patients through the Patient Engagement and Experience Governance Sub-Board. The Trust has appointed a Lead for Patient Experience and Engagement and established a Patient Panel, to strengthen the Patient Voice in the life of the Trust and in the development of its services. The Board also receives patient feedback through a programme of Patient Stories at the beginning of public Board meetings.

Further information regarding patient and public engagement in the Trust is included in the Annual Report.

Clinical Audit as part of the internal control framework:
The Trust has systems and controls in place to ensure that high quality clinical audits are conducted and their findings acted upon by all directorates and specialties across the Trust. There is a Trust Medical Lead for Clinical Audit and each specialty within a directorate has its own clinical audit lead. The Trust Clinical Audit Lead, the Clinical Effectiveness and Improvement Manager and specialty audit leads are responsible for developing, monitoring and reporting an annual clinical audit programme that reflects local and/or Trust issues around service quality or patient safety. The Clinical Audit Plan is subject to review by the Board's Audit Committee and Quality & Safety Committee.

All clinical audit projects are registered on an electronic system and monitored to completion and subsequent re-audit. The Medical Audit Lead is a member of the Trust's Clinical Safety and Effectiveness Governance Sub-Board which is accountable to, and reports audit activity to, the Hospital Management Board. Clinical Audit is therefore a key element of our governance arrangements for ensuring compliance with key standards and best practice.

During the Covid-19 pandemic, Clinical Audit activity was disrupted by the need to prioritise the Trust's emergency response to the Covid-19 pandemic, in accordance with national guidance. Additional focus on clinical audit activity has been added during 2021/22, with increased reporting to the Audit Committee supplementing that to the Quality & Safety Committee. This forms part of our Board assurance processes to ensure that we are following national guidance, and promoting clinical efficiency and economy in delivering the best possible clinical services to patents.

Internal Audit as part of the internal control framework:
In addition to Clinical Audit, the Internal Audit plan is a risk based programme of reviews based on areas of management concern, emerging risks, and national and historical experience. The Plan is informed by previous internal and external audit work and discussion with the Executive Team.

The Trust's internal audit function is outsourced (to provide enhanced objectivity) and is provided under contract by RSM. The work of internal audit is overseen by the Trust's Audit Committee which agrees the audit plan and it covers risk management, governance and internal control processes across the Trust – including financial management and control, human resources and operational governance.

A report is produced at the conclusion of each audit assignment and, where scope for improvement is found, recommendations are made and appropriate action plans agreed with management. Reports are

issued to and followed up with the responsible Executive Directors, and the results of audit work are reported to the Audit Committee.

During 2021/22, Internal Audit completed 10 assurance assignments resulting in a formal assurance opinion. Of these, 4 confirmed that the Board could take substantial assurance that effective controls are in place (Board Assurance Framework, General Ledger, Cash Management and Succession Planning – Policy Review) and 1 confirmed Reasonable Assurance could be taken (Clinical Audit).

In 4 areas, the result was a partial assurance report (Patient Safety and Incident Framework, Consultant Job Planning, Deep Dive into Waiting List Initiative (WLI) Processes and Divisional Management) and with regard to Succession Planning only Minimal assurance could be taken. In each of these areas, actions to implement recommendations are identified and progress in implementing these actions is followed-up and regularly reported to the Audit Committee. The effectiveness of this approach and the enhanced procedures we have put in place to ensure that recommendations are implemented in a roust and timely fashion is seen in the in-year improvement on Succession Planning from 'minimal' to 'substantial' assurance through taking the Audit Remedial Actions identified.

Consequently, based on the work undertaken in 2021/22 the Head of Internal Audit has concluded: *"the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective'.*

Significant internal control issues
During 2021/22 the Executive, Management Board and the Board of Directors have considered and reflected on the significant risks and challenges facing the Trust, as highlighted by our internal governance framework, Internal Audit and discussion and feedback with regulators.

The Board of Directors has identified the following areas of challenge which pose significant internal control issues for the Trust. As confirmed below, mitigating actions are in place or in development with respect to each of these significant risk areas:

- **Waiting times for planned and elective care:** In common with the position nationally, the number of patients waiting for planned or elective care in the Trust has increased in the aftermath of the Covid-19 pandemic to unprecedented levels. The Trust has put in place measures to mitigate the associated risks but is well-documented nationally that patients are exposed to disease progression and deconditioning during such lengthy waits. This issue has been highlighted both through the Trust's internal clinical governance processes and the annual divisional governance reviews.

- **Demand for unplanned care (physical and mental health) and use of escalation procedures to minimise ambulance off-load waits:**
  i) In the aftermath of the pandemic, an unprecedented increase in patients suffering with mental health difficulties (especially with regard to eating disorders) has been reported. This nationwide phenomenon is exacerbated by local factors and our Trust is now called-on to provide support in the field of mental health to an extent and level of complexity well-beyond that which has traditionally been expected or considered appropriate for an acute hospital. Our staff and systems are facing extreme challenges for which they have not been designed or prepared.

  ii) We have experienced major congestion in our hospital as a consequence of high levels of unplanned demand, in conjunction with huge numbers of patients delayed in hospital whilst they wait for post-discharge health or social care services. Following careful risk-assessment, we have adopted escalation measures in order to enable flow through the ED and reduce the risks associated with delayed ambulance off-loads. Whilst this has been governed by an approved SOP, it cannot be avoided that the need to accommodate 7 or 8 patients in 6-bedded bays has not been a situation that accords with our aspirations on quality, patient experience or staff satisfaction.

- **Workforce Gaps and Staff satisfaction, welfare & resilience:** The process of annual divisional governance review, together with our regular governance systems, has highlighted the challenges that staffing gaps pose to our ability to deliver care in a timely and safe manner. In addition, the feedback from our staff, including that through the national staff survey, reflects the extreme operational challenges facing the Trust, against the background of longer term inadequacies in our infrastructure, systems and processes to support staff resilience, well-being and morale.

- **Succession Planning:** As part of its Internal Audit Plan, the Trust arranged for a review of our Succession Planning process. This confirmed significant weaknesses in the existing planning and processes around future changes in key staff and the associated risks to our continuity of services. These findings were addressed through adoption of a new Policy and Action Plan. A further formal review confirmed that the documentation now in place sets out a clearly defined process to address the identified shortfalls and the operating processes will be subject to a full audit in 2022/23.

- **Financial sustainability:** The Trust has a significant underlying financial deficit. Working in collaboration with system partners and regulators, the Trust has established a Medium Term Financial Strategy and has implemented the recommendations of a Financial Governance Review. There remains an ongoing need for focus on financial efficiencies and control and also on addressing the underlying strategic drivers of the deficit to ensure the long-term financial sustainability of the Trust.

- **Digital immaturity**: assessment against international standard criteria shows that the Norfolk & Waveney STP area is the least digitally developed of any in the NHS in England. The Trust's position in the lowest 5% of secondary care providers (scoring 0.2/5) reveals the size of the challenge and is typified by our reliance on paper-based medical records and a plethora of separate clinical databases and applications with limited functionality and interoperability. Inadequacy of the digital infrastructure in the Trust has continued to impact negatively on the Trust's ability to achieve its potential in terms of operational efficiency, effectiveness and quality improvement.

The Board has taken a number of steps to improve the position, notably through investment in an Electronic Document Management System and an E-Obs system. Ultimately implementation of an Electronic Patient Record (EPR) system will be essential and the business case for a single EPR across the three Norfolk acute hospitals is being pursued as a matter of urgency.

Conclusion

My review confirms that Norfolk and Norwich University Hospitals NHS Foundation Trust has a sound system of internal controls that supports the achievement of its policies, aims and objectives. Significant risks however remain with regard to the Trust's Workforce, its financial sustainability, ability to achieve key performance targets and the timely high quality services to which we all aspire.

I am satisfied that the significant internal control issues that have been identified in this review have appropriate action plans in place or in development to help mitigate the associated risks and are subject to appropriate review, monitoring and escalation both internally and externally.

In his 2021/22 Annual Opinion, the Head of Internal Audit concluded *"the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".* I have taken careful note of that opinion, which accords with my own assessment that whilst much has been done, there is still more to do. The Trust remains resolute in its commitment to continuous improvement and to enhancing the well-being of its staff and its financial and operational sustainability, in order to ensure delivery of the best possible care to our patients.

Signed:

Sam Higginson
Chief Executive **Date: 21 June 2022**

Approval of the Accountability Report

I confirm my approval of the Accountability Report.

Sam Higginson
Chief Executive **Date: 21 June 2022**

FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 MARCH 2022

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Contents

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Norwich University Hospitals NHS Foundation Trust NHS Foundation Trust ("the Trust") for the year ended 31 March 2022 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 state of the Trust's affairs as at 31 March 2022 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2021/22.

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 Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to 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 Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

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

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve control totals delegated to the Trust by NHS Improvement
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Trust's accounting policies.

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

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls and, In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom, we also recognised a fraud risk related to non-pay non-depreciation expenditure recognition, particularly in relation to year-end accruals and the risk that Trust management may be in a position to make inappropriate accounting entries.

We did not identify any additional fraud risks

We have rebutted the fraud risk around revenue recognition. Most of the Trust income (83%) relates to block income where there is an inherently low risk of misstatement. Based on our risk assessment procedures around the other income streams and considering the materiality and nature of the income types, we have assessed that, due to their size, there is a low risk of material misstatement in the current year.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included:
    - Unexpected postings to cash and expenses codes.
    - Journals containing certain words in the description
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.

Assessing the completeness, existence and accuracy of non-pay non-depreciation expenditure recognised with specific emphasis placed on cut-off. This included:

- Inspecting a sample of non pay, non depreciation expenditure in the three months before 31 March 2022, to determine whether expenditure has been recognised in the correct accounting period.
- Sample testing of year end accruals including consideration of year on year movements

Identifying and responding to risks of material misstatement related to non-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 directors and other management (as required by auditing standards), and discussed with the directors 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.

The Trust is subject to laws and regulations that directly affect the financial statements, including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

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 these 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 Directors are responsible for the other information presented in the Annual Report together with the financial statements. 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.
- in our opinion that report has been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2021/22.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 133, 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 dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

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

The Trust is responsible for putting 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 have undertaken 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 the use of 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 issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the relevant NHS regulatory body 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 Trust incurring unlawful expenditure, or is about to take, or has taken, a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

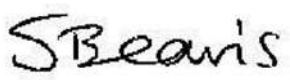
We have nothing to report in this respect.

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 and the terms of our engagement by the Trust. 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 the further matters we are required to state to them in accordance with the terms agreed with the Trust, 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.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Norwich University Hospitals NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.



Stephanie Beavis
for and on behalf of KPMG LLP
Chartered Accountants
Dragonfly House
2 Gilders Way,
Norwich,
NR3 1UB
21 June 2022

Foreword to the Accounts

These accounts, for the year ended 31 March 2022, have been prepared by the Norfolk and Norwich University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed……..

Sam Higginson
Chief Executive Date: 21 June 2022

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2022

STATEMENT OF COMPREHENSIVE INCOME	Note	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Operating income	3	754,520	657,541
Other operating income	4	94,239	145,828
Operating expenses	6	(802,371)	(764,895)
OPERATING SURPLUS / (DEFICIT)		**46,388**	**38,474**
FINANCE INCOME AND EXPENSES			
Finance income	12	61	-
Finance expense - financial liabilities, including unwinding of discount on provisions	14	(33,196)	(31,306)
PDC dividends payable	28	(3,331)	-
NET FINANCE COSTS		**(36,466)**	**(31,306)**
SURPLUS / (DEFICIT) FOR THE YEAR		**9,922**	**7,168**
Other comprehensive income			
Revaluations	15	8,355	2,125
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**18,277**	**9,293**

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2022

STATEMENT OF FINANCIAL POSITION	Note	31 March 2022 £'000	31 March 2021 £'000
Non-current assets			
Property, plant and equipment	15	378,111	349,021
Trade and other receivables	18	51,249	62,463
Total non-current assets		**429,360**	**411,484**
Current assets			
Inventories	17	12,810	13,129
Trade and other receivables	18	28,068	32,260
Cash and cash equivalents	19	95,330	68,945
Total current assets		**136,208**	**114,334**
Current liabilities			
Trade and other payables	20	(106,297)	(114,272)
Other liabilities	22	(27,991)	(16,734)
Borrowings	21	(5,698)	(5,037)
Provisions	25	(2,251)	(468)
Total current liabilities		**(142,237)**	**(136,511)**
Total assets less current liabilities		**423,331**	**389,307**
Non-current liabilities			
Other liabilities	22	(1,654)	(2,128)
Borrowings	21	(176,669)	(182,368)
Provisions	25	(10,009)	(8,087)
Total non-current liabilities		**(188,332)**	**(192,583)**
Total assets employed		**234,999**	**196,724**
Financed by (taxpayers' equity)			
Public dividend capital		310,707	290,709
Revaluation reserve		34,897	27,061
Income and expenditure reserve		(110,605)	(121,046)
Total taxpayers' equity		**234,999**	**196,724**

The financial statements on pages 9 to 47 were approved by the Board on 8 June 2022 and signed on its behalf by:

Signed: ……(Chief Executive) Date: 21 June 2022

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total Taxpayers' Equity
	£'000	£'000	£'000	£'000
Taxpayers' equity at 1 April 2021	**290,709**	**27,061**	**(121,046)**	**196,724**
Surplus for the year	-	-	9,922	**9,922**
Other transfers between reserves	-	(519)	519	**-**
Revaluations	-	8,355	-	**8,355**
Public dividend capital received	19,998	-	-	**19,998**
Taxpayers' equity at 31 March 2022	**310,707**	**34,897**	**(110,605)**	**234,999**

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total Taxpayers' Equity
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2020	**38,436**	**25,328**	**(128,606)**	**(64,842)**
Surplus for the year	-	-	7,168	**7,168**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(181)	181	**-**
Other transfers between reserves	-	(211)	211	**-**
Revaluations	-	2,125	-	**2,125**
Public dividend capital received	252,273	-	-	**252,273**
Taxpayers' equity at 31 March 2021	**290,709**	**27,061**	**(121,046)**	**196,724**

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2022

	Note	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Cash flows from operating activities			
Operating surplus / (deficit)		46,388	38,475
Operating surplus / (deficit)		**46,388**	**38,475**
Non-cash income and expense:			
Depreciation	6	21,591	16,882
Impairments and reversals of impairments		38	7,201
Loss on disposal of non-current assets		(234)	250
Income recognised in respect of capital donations (cash and non-cash)		(2,465)	(8,515)
Decrease / (Increase) in trade and other receivables		5,514	1,272
(Increase) in inventories		318	(1,263)
Increase / (Decrease) in trade and other payables		10,908	41,948
Increase in provisions		3,744	3,560
Net cash from / (used in) operations		**85,802**	**99,810**
Cash flows from investing activities			
Interest received		46	16
Purchase of property, plant, equipment and investment property		(40,145)	(66,126)
Sales of property, plant, equipment and investment property		393	148
Receipt of cash donations to purchase capital assets		1,884	-
Net cash used in investing activities		**(37,822)**	**(65,962)**
Cash flows from financing activities			
Public dividend capital received		19,998	252,273
Movement on loans from the Department of Health		-	(195,131)
Capital element of finance lease rental payments		(66)	(186)
Capital element of PFI, LIFT and other service concession payments		(4,971)	(3,172)
Interest paid on finance lease liabilities		(11)	(3)
Interest paid on PFI, LIFT and other service concession obligations		(33,225)	(31,300)
Other interest paid		-	(814)
PDC dividend paid		(3,321)	-
Net cash from financing activities		**(21,596)**	**21,667**
Increase in cash and cash equivalents	19	26,385	55,513
Cash and Cash equivalents at start of the year	19	68,945	13,432
Cash and Cash equivalents at 31 March	19	**95,330**	**68,945**

NOTES TO THE ACCOUNTS

1. Accounting Policies and Other Information

1.1 Basis of Preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.2 Going Concern

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

NOTES TO THE ACCOUNTS

1.3 Interests in other entities

NHS Charitable Fund

The NHS foundation trust is the corporate trustee to Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund. The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102.

Prior to 2013/14, the FT ARM permitted the NHS foundation trust not to consolidate the charitable fund. Since 2013/14 the Trust has chosen not to consolidate the charitable fund on the basis it is not material.

Interests in Joint Operations

The Trust has a 58% interest in a joint operation for the provision of pathology services in Norfolk known as the Eastern Pathology Alliance (EPA). The arrangement has been effective from 1st November 2013, and has not involved the establishment of a separate entity.

Accordingly, the Trust's share of operating income and expenditure is included in these accounts.

1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This continues into 2021/22. This difference in application relating to the 2021/22 financial year is explained below.

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

NOTES TO THE ACCOUNTS

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.

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.

1.5 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 consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

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

1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

NOTES TO THE ACCOUNTS

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential 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
- the item has a cost of at least £5,000 ; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.
- Items form part of the initial equipping and setting-up cost of a new building, 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 e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

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

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

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

NOTES TO THE ACCOUNTS

A full valuation of the PFI hospital was performed as at 31 March 2020 by the Trust's externally appointed independent valuer, Montagu Evans, Chartered Surveyors.

The revaluation basis for all of the Trusts Land and Buildings was depreciated replacement cost as a Modern Equivalent Asset, with the exception of the Residential Accommodation on the hospital campus and the office accommodation within the main hospital building. These were valued as non specialised assets and were valued on a market value for existing use basis.

The valuation was accounted for in the 2019/2020 accounts. An indexation based valuation was undertaken in 2020/21 for inclusion in those accounts.

For 2021/22, the valuation has been subject to a desktop valuation by Montagu Evans, to assess the valuation movement over the year to 31 March 2022. This movement has been reflected in the 2021/22 accounts, along with capital additions in the financial year.

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23 - Borrowing Costs. Assets are revalued and depreciation commences when the assets are brought into use.

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

NOTES TO THE ACCOUNTS

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

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

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

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

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2021/22 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end. These can be seen in note 15.

Private Finance Initiative (PFI) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

NOTES TO THE ACCOUNTS

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings	5	82
Plant & machinery	3	20
Transport equipment	10	12
Information technology	1	10
Furniture & fittings	5	20

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.9 Inventories

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

In 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.10 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.

NOTES TO THE ACCOUNTS

1.11 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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

Financial assets and financial liabilities are both classified and subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

NOTES TO THE ACCOUNTS

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses for assets relating to Non NHS bodies are determined by reference to an unbiased probability-weighted approach using recent actual recovery experience. A separate assessment is employed for each of the main sources of Non NHS income.

Expected credit losses in relation to NHS bodies are not normally recognised. They are subject to a separate credit note risk assessment.

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

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

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

The lease liability is de-recognised when the liability is discharged, cancelled or expires.

NOTES TO THE ACCOUNTS

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line 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.

1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2022:

		Nominal rate
Short-term	Up to 5 years	0.47%
Medium-term	After 5 years up to 10 years	0.70%
Long-term	Exceeding 10 years	0.95%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2022:

	Inflation rate
Year 1	4.00%
Year 2	2.60%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 25 but is not recognised in the Trust's accounts.

NOTES TO THE ACCOUNTS

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 32 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 32, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.15 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 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.

1.16 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.

1.17 Corporation Tax

The Trust does not fall within the scope of Corporation Tax for the year ended 31 March 2022, neither did it for the year ended 31 March 2021.

1.18 Climate Change Levy

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

1.19 Foreign Exchange

The functional and presentational currency of the Trust is sterling. A transaction denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the dates of the transaction. At the end of the reporting period, monetary assets and liabilities denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's income or expense in the period in which they arise.

NOTES TO THE ACCOUNTS

1.20 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.21 Losses and Special Payments

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

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

1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

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

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	64,435
Additional lease obligations recognised for existing operating leases	(64,435)
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(11,042)
Additional finance costs on lease liabilities	(558)
Lease rentals no longer charged to operating expenditure	11,354
Other impact on income / expenditure	-
Estimated impact on surplus / deficit in 2022/23	**(246)**
Estimated increase in capital additions for new leases commencing in 2022/23	**-**

NOTES TO THE ACCOUNTS

1.25 Critical judgements in applying accounting policies

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

An assessment of the Trusts PFI schemes was made as part of the IFRS transition in the 2009/10 accounts, and it was determined that the PFI scheme in respect of the main Hospital building should be accounted for as an on-Statement of Financial Position asset under IFRIC 12. This required judgements to be made in order to determine the required accounting treatment. The key judgements were to initially value the hospital at the cost of construction, to attribute an asset life of 70 years and to identify the components of the hospital subject to lifecycle maintenance, that should be accounted for separately. The annual contribution to lifecycle maintenance is treated as a non current prepayment until it is capitalised consistent with the operators schedule for replacement.

A full valuation of the PFI hospital was performed as at 31 March 2020 by the Trust's externally appointed independent valuer, Montagu Evans, Chartered Surveyors.

The revaluation basis for all of the Trusts Land and Buildings was depreciated replacement cost as a Modern Equivalent Asset, with the exception of the Residential Accommodation on the hospital campus and the office accommodation within the main hospital building. These were valued as non specialised assets and were valued on a market value for existing use basis.

The valuation was accounted for in the 2019/2020 accounts. An indexation based valuation was undertaken in 2020/21 for inclusion in those accounts.

For 2021/22, the valuation has been subject to a desktop valuation by Montagu Evans, to assess the valuation movement over the year to 31 March 2022. This movement has been reflected in the 2021/22 accounts, along with capital additions in the financial year.

1.26 Sources of estimation uncertainty

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

Estimations as to the recoverability of receivables have been made in determining carrying amounts of those assets. Variation is not expected to be significant.

Judgement has been used to determine the carrying value of provisions, deferral of income and accruals for expenditure.

An estimate has been used to determine total future obligations under PFI contracts as disclosed in note 24.2, in relation to future rates of inflation. This estimate does not affect the carrying value of liabilities in the Statement of Financial Position at 31 March 2022 or 31 March 2021, or the amounts charged through the Statement of Comprehensive Income.

2. Operating segments

IFRS 8 requires income and expenditure to be broken down into the operating segments reported to the chief operating decision maker. In the case of the Trust, this has been determined to be the Executive Directors.

The Executive Directors receive segmental information for expenditure. Segments are defined as the Trust's divisions, as identified in the following table which also describes the service that each provides. The Services division deals with areas such as the commissioning of catering, portering and cleaning, as well as support functions. During the year there was a reshuffle of the Trust's divisions and as a result, the comparatives have been restated.

Income and assets are not reported by division, so are not analysed in the data below. Details of income by source is provided in note 3.1. The Trust's main source of income is from within the UK for the provision of healthcare services.

2021/22:

	Medicine	Clinical Support	Surgery and Emergency	Women, Children and Sexual Health	Services	Pandemic Incident Response	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pay	126,417	75,590	153,977	51,311	41,969	11,144	**460,408**
Non Pay	112,861	36,170	39,582	10,446	79,131	15,622	**293,812**
Total	**239,278**	**111,760**	**193,559**	**61,757**	**121,100**	**26,766**	**754,220**

2020/21 : Restated

	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pay	125,142	74,494	155,242	49,269	35,413	10,124	**449,684**
Non Pay	99,591	31,461	31,546	8,115	73,196 -	23,241	**267,150**
Total	**224,733**	**105,955**	**186,788**	**57,384**	**108,609**	**33,365**	**716,834**

Reconciliation - Pay

	2021/22 £'000	2020/21 £'000
Employee Expenses - Non-executive directors (note 6)	153	147
Employee Expenses - Staff and executive directors (note 6)	460,105	449,419
VSS & Redundancy (note 6)	150	118
Total	**460,408**	**449,684**

Reconciliation - Non Pay

	£'000	£'000
Operating Expenses (note 6)	802,371	764,895
Less: Pay (see above)	(460,408)	(449,684)
Less: Depreciation (note 6)	(21,591)	(16,882)
Less: Consortium payments (note 6)	(19,239)	(17,055)
Less: Loss on disposal (note 6)	234	(250)
Less: Research and development (note 6)	(6,106)	(5,627)
Less: Education & training - notional expenditure funded from apprenticeship fund (note 6)	(1,411)	(1,046)
Less: Impairments (note 6)	(38)	(7,201)
Total	**293,812**	**267,150**

3. Operating income

3.1 Income from activities

	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
NHS Foundation Trusts	1	-
NHS Trusts	-	-
CCGs and NHS England *	751,465	654,377
Non-NHS: Private patients	1,304	1,128
Non-NHS: Overseas patients (non-reciprocal)	308	341
NHS injury cost recovery scheme (formerly RTA)	964	1,239
Non-NHS: Other	478	456
Total income from activities	**754,520**	**657,541**

* The increase in income for activities is partly as a result of the change in the funding regime due to Covid. There is a reduction in Covid Reimbursement and Top-Up Funding (within note 4) which off-sets some of this

Substantially all income from activities comes from the provision of mandatory services.
NHS injury cost recovery scheme income is subject to a provision for impairment of receivables of 23.76% (2020/21: 22.43%) to reflect expected rates of collection.

Overseas patients (non-reciprocal) income is amounts received by the Trust, where the overseas patient is liable for the cost. This occurs when there is not a national reciprocal arrangement with the country that the patient is a national of.

Substantially all income arises in the UK. There are two (2020/21: two) main customers of the Trust who each account for the majority of its income from activities. They are NHS Norfolk and Waveney CCG (71.39%) and NHS England (24.28%). In 2020/21, they were NHS Norfolk and Waveney (68.98%), NHS England (27.43%).

3.2 Income from activities by category

	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Block contract / system envelope income	704,267	627,829
High cost drugs income from commissioners	19,237	7,621
Other NHS clinical income	9,572	1,274
Private patient income	1,612	1,469
Additional pension contribution central funding	18,390	17,653
Other clinical income	1,442	1,695
Total income from activities	**754,520**	**657,541**

3.3 Overseas Visitors (patient charged direct by the Trust)

	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Income recognised this year	308	341
Cash payments received in year (all years)	253	55
Amounts added to provision for impairment of receivables (all years)	20	229
Amounts written off in-year (all years)	522	-

3.4 Income from Commissioner Requested Services

Operating income includes income from Commissioner Requested Services as follows:

	Year ended 31 March 2022	Year ended 31 March 2021
Commissioner Requested Services	752,430	655,616
Non-Commissioner Requested Services	2,090	1,925
	754,520	**657,541**

4. Other operating income

	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Research and development	6,066	5,506
Education and training	28,038	26,392
Donations/grants of physical assets (non-cash) - received from NHS charities	-	237
Donations/grants of physical assets (non-cash) - received from other bodies	139	2,089
Donated equipment from DHSC for COVID response (non-cash)	442	6,189
Cash donations for the purchase of capital assets - received from NHS charities	1,884	-
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	1,925	8,901
Rental revenue from operating leases	211	147
Reimbursement and top up funding	6,917	53,929
Other:		
Staff recharges	22,870	18,378
Car parking	813	644
Pharmacy sales	736	799
Staff accommodation rentals	921	762
Clinical tests	145	97
Clinical excellence awards	539	465
Grossing up consortium arrangements	19,239	17,055
Other income	3,354	4,238
Total other operating income	**94,239**	**145,828**

5. Total operating income

Total operating Income is from the supply of services. 89% (2020/21: 82%) is income from activities and 11% (2020/21: 18%)

6. Operating expenses

	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Purchase of healthcare from NHS and DHSC bodies	20	18
Purchase of healthcare from non NHS bodies	3,982	259
Employee expenses - non-executive directors	153	147
Employee expenses - staff and executive directors	460,105	449,419
Supplies and services - clinical	79,899	75,214
Supplies and services - general	14,314	14,086
Establishment	8,348	8,318
Research and development	6,106	5,627
Transport	687	578
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	27,626	26,466
Premises	25,212	23,369
Movement in credit loss allowance: contract receivables	120	973
Movement in credit loss allowance: all other receivables	112	70
Change in provisions discount rate(s)	83	113
Inventories written down	213	252
Inventories consumed	94,160	81,353
Rentals under operating leases	13,164	10,751
Depreciation on property, plant and equipment	21,591	16,882
Impairments	38	7,201
Audit fees payable to the external auditor*		
audit services- statutory audit	164	103
Clinical negligence	16,337	13,626
(Gain) / Loss on disposal of non-current assets	(234)	250
Legal fees	147	100
Consultancy costs	831	604
Internal audit	150	149
Education and training - notional expenditure funded from apprenticeship fund	1,411	1,046
Training, courses and conferences	1,560	1,262
Patient travel	1,919	1,631
Redundancy	150	118
Insurance	57	95
Other services, eg external payroll	1,667	1,486
Grossing up consortium arrangements	19,239	17,055
Losses, ex gratia & special payments	17	13
Other	3,023	6,261
Total operating expenses	**802,371**	**764,895**

* The audit contract signed on 24th September 2021 states that the liability of KPMG LLP, its members, partners and staff (whether contract, negligence or otherwise) in respect of services provided in connection with or arising out of the audit shall in no circumstances exceed £5,000k in the aggregate in respect of all such services.

6.1 Auditor's Remuneration

	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Audit Fees- statutory audit	164	103
TOTAL	**164**	**103**

The Trust's auditors, KPMG LLP (2020/21 KPMG LLP), also audit the associated charity (Norfolk and Norwich Hospitals Charity) for a fee of £11k (2020/21 £9k).

7. Operating leases

7.1 As lessee

Payments recognised as an expense	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Minimum lease payments	13,164	10,751
Total	**13,164**	**10,751**

Total future aggregate minimum lease payments	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Payable:		
Not later than one year	12,312	9,293
Between one and five years	42,690	33,646
After 5 years	20,016	21,898
Total	**75,018**	**64,837**

7.2 As lessor

The Trust leases the retail units at its Colney Lane site to a third party. The contract is for a period of 30 years and was entered into in 2002.

Rentals, recognised as other operating income	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Rents recognised as income in the year	87	87
Contingent rents recognised as income in the year	124	60
Total	**211**	**147**

Total future aggregate minimum lease payments	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Receivable:		
Not later than one year	87	87
Between one and five years	350	350
After 5 years	438	525
Total	**875**	**962**

8. Employee costs and numbers

8.1 Employee costs

	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Salaries and wages	351,853	346,334
Social security costs	35,074	32,917
Apprenticeship levy	1,753	1,669
Employer's contributions to NHS pensions	41,932	40,412
Pension cost - employer contributions paid by NHSE on provider's behalf	18,390	17,653
Pension cost - other	86	73
Termination benefits	150	118
Agency/contract staff	11,016	10,360
Total	**460,254**	**449,536**

Above total excludes costs of non-executive directors.
Details on the remuneration of key management personnel can be found in note 29.

8.2 Monthly average number of people employed

	Year ended 31 March 2022 Number	Year ended 31 March 2021 Number
Medical and dental	1,328	1,281
Administration and estates	1,399	1,386
Healthcare assistants and other support staff	2,610	2,600
Nursing, midwifery and health visiting staff	2,498	2,493
Nursing, midwifery and health visiting learners	61	2
Scientific, therapeutic and technical staff	713	713
Healthcare science staff	365	365
Other	5	6
Total	**8,979**	**8,846**

The above numbers are based on whole-time equivalents.

8.3 Staff exit packages

Staff exit packages for the year ended 31 March 2022

	Number of compulsory redundancies
£10k - £25k	2
£100k - £150k	1
	3

Staff exit packages for the year ended 31 March 2021

	Number of compulsory redundancies
<£10k	3
£100k - £150k	1
	4

9. Pension costs

Past and present employees are covered by the provisions of the two 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 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports

10. Retirements due to ill-health

During 2021/22 there were 8 (2020/21: 3) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements are £449k (2020/21: £87k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

11. Better Payment Practice Code

11.1 Better Payment Practice Code - measure of compliance

This note has been moved to page 88 of the annual report.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust made payments of £nil under this legislation in the year (2020/21: £nil)

12. Finance income

	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Interest receivable on bank deposits	61	-
Total	**61**	**-**

13. Other gains and losses

	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
(Gain) / Loss on disposal of plant and equipment	(234)	250
Total	**(234)**	**250**

14. Finance expense - financial liabilities including unwinding of discount on provisions

	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Interim Revenue Support Facility Cost - Dept. of Health	-	34
Finance leases	11	3
Finance Costs in PFI obligations:		
- Main finance costs	16,261	16,571
- Contingent finance costs	16,963	14,727
Unwinding of discount on provisions	(39)	(29)
Total	**33,196**	**31,306**

15. Property, plant and equipment

	Land £000	Buildings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2021	**11,611**	**278,444**	**7,953**	**91,082**	**153**	**41,607**	**1,649**	**432,499**
Additions - purchased	-	17,406	9,207	6,586	1	6,747	111	**40,058**
Additions - donated	-	1,167	-	713	-	55	88	**2,023**
Additions - equipment donated from DHSC for COVID response	-	-	-	442	-	-	-	**442**
Reclassifications	-	2,693	(2,714)	50	-	(29)	-	**-**
Impairments	-	-	-	-	-	(38)	-	**(38)**
Revaluation	1,328	(1,059)	130	-	-	-	-	**399**
Disposals	-	-	-	(5,438)	(45)	(126)	(15)	**(5,624)**
Cost or valuation at 31 March 2022	**12,939**	**298,651**	**14,576**	**93,435**	**109**	**48,216**	**1,833**	**469,759**
Accumulated depreciation at 1 April 2021	**-**	**5,367**	**-**	**57,187**	**88**	**19,938**	**898**	**83,478**
Provided during the year	-	8,832	-	5,262	9	7,341	147	**21,591**
Revaluation Eliminated	-	(7,956)	-	-	-	-	-	**(7,956)**
Disposals	-	-	-	(5,300)	(35)	(115)	(15)	**(5,465)**
Accumulated depreciation at 31 March 2022	**-**	**6,243**	**-**	**57,149**	**62**	**27,164**	**1,030**	**91,648**
Net book value								
NBV - Owned at 31 March 2022	12,939	76,872	14,576	27,285	47	20,948	716	**153,383**
NBV - PFI at 31 March 2022	-	202,218	-	-	-	-	-	**202,218**
NBV - Donated at 31 March 2022	-	13,318	-	9,001	-	104	87	**22,510**
NBV total at 31 March 2022	**12,939**	**292,408**	**14,576**	**36,286**	**47**	**21,052**	**803**	**378,111**
Net book value								
NBV - Owned at 1 April 2021	11,611	74,345	6,054	24,577	65	21,598	742	**138,992**
NBV - Finance lease at 1 April 2021	-	-	-	37	-	-	-	**37**
NBV - PFI at 1 April 2021	-	187,510	-	-	-	-	-	**187,510**
NBV - Donated at 1 April 2021	-	11,222	1,899	9,281	-	71	9	**22,482**
NBV total at 1 April 2021	**11,611**	**273,077**	**7,953**	**33,895**	**65**	**21,669**	**751**	**349,021**

Land and buildings are deemed to fall within the definition of protected assets.

15. Property, plant and equipment (continued)

	Land £000	Buildings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2020	**11,563**	**220,349**	**7,864**	**76,619**	**127**	**26,969**	**870**	**344,361**
Additions - purchased	-	61,087	5,945	12,868	20	14,054	774	**94,748**
Additions - donated	-	278	1,899	85	-	57	7	**2,326**
Additions - equipment donated from DHSC for COVID response	-	-	-	6,189	-	-	-	**6,189**
Impairments	-	(6,259)	-	(942)	-	-	-	**(7,201)**
Reclassifications	-	7,229	(7,755)	(5)	6	527	(2)	**-**
Revaluation	48	(4,240)	-	-	-	-	-	**(4,192)**
Disposals	-	-	-	(3,732)	-	-	-	**(3,732)**
Cost or valuation at 31 March 2021	**11,611**	**278,444**	**7,953**	**91,082**	**153**	**41,607**	**1,649**	**432,499**
Accumulated depreciation at 1 April 2020	**-**	**4,029**	**-**	**55,869**	**80**	**15,413**	**858**	**76,249**
Provided during the year	-	7,656	-	4,653	8	4,525	40	**16,882**
Reclassifications	-	(1)	-	1	-	-	-	**-**
Revaluation Eliminated	-	(6,317)	-	-	-	-	-	**(6,317)**
Disposals	-	-	-	(3,336)	-	-	-	**(3,336)**
Accumulated depreciation at 31 March 2021	**-**	**5,367**	**-**	**57,187**	**88**	**19,938**	**898**	**83,478**
Net book value								
NBV - Owned at 31 March 2021	11,611	74,345	6,054	24,577	65	21,598	742	**138,992**
NBV - Finance lease at 31 March 2021	-	-	-	37	-	-	-	**37**
NBV - PFI at 31 March 2021	-	187,510	-	-	-	-	-	**187,510**
NBV - Donated at 31 March 2021	-	11,222	1,899	9,281	-	71	9	**22,482**
NBV total at 31 March 2021	**11,611**	**273,077**	**7,953**	**33,895**	**65**	**21,669**	**751**	**349,021**
Net book value								
NBV - Owned at 1 April 2020	11,563	45,492	7,864	15,992	47	11,527	7	**92,492**
NBV - Finance lease at 1 April 2020	-	-	-	209	-	-	-	**209**
NBV - PFI at 1 April 2020	-	159,625	-	-	-	-	-	**159,625**
NBV - Donated at 1 April 2020	-	11,203	-	4,549	-	29	5	**15,786**
NBV total at 1 April 2020	**11,563**	**216,320**	**7,864**	**20,750**	**47**	**11,556**	**12**	**268,112**

Land and buildings are deemed to fall within the definition of protected assets.

15. Property, plant and equipment (continued)

During the year assets to the value of £2,023k (2021: £2,326k) were purchased using charitable support. In addition £442k (2021: £6,189k) of equipment relating to the Trust's COVID response were donated by DHSC.

Plant and Equipment mainly consists of low value equipment with short asset lives. It is therefore considered that Depreciated Historic Cost is appropriate to be used as a proxy for Depreciated Replacement Cost and for Fair Value.

A full valuation of the PFI hospital was performed as at 31 March 2020 by the Trust's externally appointed independent valuer, Montagu Evans, Chartered Surveyors.

The revaluation basis for all of the Trusts Land and Buildings was depreciated replacement cost as a Modern Equivalent Asset, with the exception of the Residential Accommodation on the hospital campus and the office accommodation within the main hospital building. These were valued as non specialised assets and were valued on a market value for existing use basis.

The valuation was accounted for in the 2019/2020 accounts. An indexation based valuation was undertaken in 2020/21 for inclusion in those accounts.

For 2021/22, the valuation has been subject to a desktop valuation by Montagu Evans, to assess the valuation movement over the year to 31 March 2022. This movement has been reflected in the 2021/22 accounts, along with capital additions in the financial year.

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23 - Borrowing Costs. Assets are revalued and depreciation commences when the assets are brought into use.

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

The economic lives of the depreciable items of property, plant and equipment is disclosed in the table below:

	Minimum Life (years)	Maximum Life (years)
Buildings excluding dwellings	5	82
Plant and machinery	3	20
Transport equipment	10	12
Information technology	1	10
Furniture & fittings	5	20

Assets under construction are not depreciated until they are brought into use.

Land is not depreciated.

16. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these accounts:

	31 March 2022 £'000	31 March 2021 £'000
Property, Plant and Equipment	8,885	7,534
Total	**8,885**	**7,534**

17. Inventories

17.1. Inventories

	31 March 2022 £'000	31 March 2021 £'000
Drugs	4,777	4,170
Consumables	7,897	8,597
Consumables donated from DHSC	136	362
Total	**12,810**	**13,129**

17.2 Inventories recognised in expenses

	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Inventories recognised as an expense in the year	158,465	139,355
Write-down of inventories (including losses)	213	252
Total	**158,678**	**139,607**

18. Trade and other receivables

18.1 Trade and other receivables

	31 March 2022		31 March 2021	
	Current £'000	Non - Current £'000	Current £'000	Non - Current £'000
Contract receivables invoiced	13,205	-	12,253	-
Contract receivables (not yet / non invoiced)	5,154	1,071	14,031	2,684
Allowance for impaired contract receivables	(2,287)	-	(2,932)	-
Allowance for impaired contract receivables (not yet / non invoiced)	(2,018)	-	(2,001)	-
Prepayments (non-PFI)	9,470	-	8,282	-
PFI prepayments:				
Lifecycle replacements	-	48,126	-	58,033
Interest receivable	15	-	-	-
VAT receivable	2,392	-	1,811	-
Clinician pension tax provision reimbursement funding from NHSE	420	2,052	131	1,746
Other receivables	1,717	-	685	-
Total	**28,068**	**51,249**	**32,260**	**62,463**

The significant majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

18.2 Provision for impairment of receivables

	31 March 2022 £'000	31 March 2021 £'000
At 1 April as previously stated	**4,933**	**3,961**
Increase in provision	374	1,235
Amounts utilised	(860)	(71)
Unused amounts reversed	(142)	(192)
At 31 March	**4,305**	**4,933**

19. Cash and cash equivalents

	Year ended 31 March 2022 £'000	Year ended 31 March 2021 £'000
Balance at 1 April	68,945	13,432
Net change in year	26,385	55,513
Balance at 31 March	**95,330**	**68,945**
Comprising:		
Cash at commercial banks and in hand	127	95
Cash with the Government Banking Service	95,203	68,850
Cash and cash equivalents as in statement of financial position and statement of cash flows	**95,330**	**68,945**

20. Trade and other payables

	31 March 2022 Current £'000	31 March 2021 Current £'000
Trade payables	23,924	32,986
Amounts due to other related parties	5,867	5,679
Capital payables	8,137	16,247
Social security costs	9,730	9,388
Accruals	58,629	49,972
PDC dividend payable	10	-
Total	**106,297**	**114,272**
Of which payables from NHS and DHSC group bodies:		
Current	10,226	20,287
Non-current	-	-

Included in Amounts due to other related parties at 31 March 2022 is £5,867k (31 March 2021: £5,679k) of outstanding pension contributions.

21. Borrowings

	31 March 2022 Current £'000	31 March 2022 Non-current £'000	31 March 2021 Current £'000	31 March 2021 Non-current £'000
Obligations under finance leases	-	-	66	-
Obligations under Private Finance Initiative contracts	5,698	176,669	4,971	182,368
Total	**5,698**	**176,669**	**5,037**	**182,368**

Details of the PFI schemes comprising the liabilities detailed above can be found in note 24.

22. Other liabilities

	31 March 2022 Current £'000	31 March 2022 Non-current £'000	31 March 2021 Current £'000	31 March 2021 Non-current £'000
Deferred Income	27,991	1,654	16,734	2,128
Total	**27,991**	**1,654**	**16,734**	**2,128**

23. Finance lease obligations

	31 March 2022 Minimum Lease Payments £'000	31 March 2022 PV of Minimum Lease Payments £'000	31 March 2021 Minimum Lease Payments £'000	31 March 2021 PV of Minimum Lease Payments £'000
Gross lease liabilities				
of which liabilities are due:				
- not later than one year;	-	-	79	79
- later than one year and not later than five years;	-	-	-	-
Finance charges allocated to future periods	-	-	(13)	(13)
Net lease liabilities	**-**	**-**	**66**	**66**
Split into:				
- not later than one year;	-	-	66	66
- later than one year and not later than five years;	-	-	-	-
Net lease liabilities	**-**	**-**	**66**	**66**

24. Private Finance Initiative contracts

24.1 PFI schemes on-Statement of Financial Position

New Hospital

On 9 January 1998 the Trust concluded contracts under the Private Finance Initiative (PFI) with Octagon Healthcare Limited for the construction of a new 809 bed hospital and the provision of hospital related services. In addition, and as a consequence of revised patient activity projections, the Trust entered into a contract variation with Octagon Healthcare Limited to extend the new hospital by a further 144 beds. This contract variation was approved by the Department of Health and was signed on 14 July 2000.

The PFI scheme was approved by the NHS Executive and HM Treasury as being better value for money than the public sector comparator. Under IFRIC 12, the PFI scheme is deemed to be on Statement of Financial Position, meaning that the hospital is treated as an asset of the Trust, that is being acquired through a finance lease. The payments to Octagon in respect of it have therefore been analysed into finance lease charges and service charges. The accounting treatment of the PFI scheme is detailed in accounting policy 1.8.

The service element of the contract was £27,600k (2020/21: £26,500k), with contingent rent being £17,000k (2020/21: £14,700k).

The estimated value of the scheme at inception was £222,600k. Payments under the scheme commenced on 15 August 2001. In 2003/04 the Trust entered into and concluded a refinancing arrangement with Octagon Healthcare Ltd on the investment in the hospital. This resulted in an extension of the minimum term of the scheme from 30 to 35 years and a reduction in the annual charge by £3,500k per annum.

24.2 PFI schemes on-Statement of Financial Position (on-SoFP)

Total obligations for on-statement of financial position PFI contracts are:

	31 March 2022 £000	31 March 2021 £000
Gross PFI, LIFT or other service concession liabilities	**785,699**	**810,267**
Of which liabilities are due:		
- not later than one year;	44,612	42,529
- later than one year and not later than five years;	189,886	181,019
- later than five years.	551,201	586,719
Lifecycle Maintenance expenditure	(56,877)	(61,645)
Finance charges allocated to future periods	(546,455)	(561,284)
Net PFI, liabilities	**182,367**	**187,338**
- not later than one year;	5,698	4,971
- later than one year and not later than five years;	28,354	26,031
- later than five years.	148,315	156,336
	182,367	**187,338**

Gross PFI liabilities includes £56,877k (2020/21: £61,645k) in respect of lifecycle maintenance expenditure on the hospital PFI scheme. These are payments to replace components of the hospital infrastructure throughout the course of the PFI agreement.

Finance charges include both interest payable and contingent rent payable. Contingent rent is variable, dependent on the future rate of inflation using the Retail Prices Index (RPI). The Trust has assessed the future rate of RPI with regard to historical trends and current forward-looking estimates.

24.3 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2022 £'000	31 March 2021 £'000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,290,599**	**1,304,830**
Of which payments are due:		
- not later than one year;	73,281	68,488
- later than one year and not later than five years;	311,909	291,507
- later than five years.	905,410	944,834

24.4 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	31 March 2022 £'000	31 March 2021 £'000
Unitary payment payable to service concession operator	**70,590**	**68,093**
Consisting of:		
- Interest charge	16,261	16,571
- Repayment of balance sheet obligation	4,971	3,172
- Service element and other charges to operating expenditure	27,626	26,466
- Contingent rent	16,963	14,728
- Addition to lifecycle prepayment	4,769	7,156
Total amount paid to service concession operator	**70,590**	**68,093**

25. Provisions

	Current 31 March 2022 £'000	Non-current 31 March 2022 £'000	Current 31 March 2021 £'000	Non-current 31 March 2021 £'000
Pensions - Early departure costs	93	598	111	784
Pensions - Injury benefits	129	2,271	128	2,295
Legal claims	98	-	98	-
VSS & Redundancy	320	777	-	-
Clinician pension tax	420	2,052	131	1,746
Other	1,191	4,311	-	3,262
Total	**2,251**	**10,009**	**468**	**8,087**

2021/22

	Pensions £'000	Legal claims £'000	VSS & Redundancy £'000	Clinician Pension Tax Reimbursement £'000	Other £'000	Total £'000
At 1 April 2021	3,318	98	-	1,877	3,262	**8,555**
Change in the discount rate	83	-	-	-	-	**83**
Arising during the year	61	8	1,097	595	2,336	**4,097**
Utilised during the year	(221)	(8)	-	-	(21)	**(250)**
Reversed unused	(111)	-	-	-	(75)	**(186)**
Unwinding of discount	(39)	-	-	-	-	**(39)**
At 31 March 2022	**3,091**	**98**	**1,097**	**2,472**	**5,502**	**12,260**
Expected timing of cash flows:						
Within one year	222	98	320	420	1,191	**2,251**
Between one and five years	886	-	465	769	4,311	**6,431**
After five years	1,983	-	312	1,283	-	**3,578**
	3,091	**98**	**1,097**	**2,472**	**5,502**	**12,260**

Pensions covers liabilities in respect of former staff members. Due to the nature of the obligation (pension related) there is uncertainty over the expected timing of cash flows, duration and magnitude.

Legal claims include Employer's Liability and Public Liability claims. Incidents occurring after 1 April 1999 are covered by the NHS Litigation Authority Liabilities to Third Parties Scheme.

The NHS Litigation Authority holds provisions at 31 March 2022 of £423,045k (31 March 2021; £319,509k) in respect of clinical negligence liabilities of the Trust.

The clinician pension tax reimbursement relates to clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in this tax year (2019/20) face a tax charge in respect of the growth of their NHS pension benefits which will be paid for by the NHS Pension Scheme. Accordingly, we have reflected the provision for this liability. It will be met in full by the NHS Pension Scheme. There is an equal and opposite asset in income accruals.

Other provisions largely consist of provisions for HMRC determinations.

25. Provisions (continued)

2020/21

	Pensions £'000	Legal claims £'000	VSS & Redundancy £'000	Clinician Pension Tax Reimbursement £'000	Other £'000	Total £'000
At 1 April 2020	3,329	94	3	1,599	-	**5,025**
Change in the discount rate	113	-	-	-	-	**113**
Arising during the year	145	57	-	278	3,262	**3,742**
Utilised during the year	(240)	(53)	(3)	-	-	**(296)**
Reversed unused	-	-	-	-	-	**-**
Unwinding of discount	(29)	-	-	-	-	**(29)**
At 31 March 2021	**3,318**	**98**	**-**	**1,877**	**3,262**	**8,555**
Expected timing of cash flows:						
Within one year	239	98	-	131	-	**468**
Between one and five years	952	-	-	282	3,262	**4,496**
After five years	2,127	-	-	1,464	-	**3,591**
	3,318	**98**	**-**	**1,877**	**3,262**	**8,555**

26. Financial Instruments

26.1 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	16,505	-	-	**16,505**
Cash and cash equivalents at bank and in hand	95,330	-	-	**95,330**
Total at 31 March 2022	**111,835**	**-**	**-**	**111,835**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	24,851	-	-	**24,851**
Cash and cash equivalents at bank and in hand	68,945	-	-	**68,945**
Total at 31 March 2021	**93,796**	**-**	**-**	**93,796**

26. Financial Instruments (continued)

26.2 Carrying values of financial liabilities

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2022			
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	182,367	-	**182,367**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	96,495	-	**96,495**
Other financial liabilities	-	-	**-**
Provisions under contract	7,705	-	**7,705**
Total at 31 March 2022	**286,567**	**-**	**286,567**

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2021			
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under finance leases	66	-	**66**
Obligations under PFI, LIFT and other service concession contracts	187,338	-	**187,338**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	104,884	-	**104,884**
Other financial liabilities	-	-	**-**
Provisions under contract	5,294	-	**5,294**
Total at 31 March 2021	**297,582**	**-**	**297,582**

26.3 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value of the above financial assets and liabilities.

26.4 Maturity of financial liabilities

	31 March 2022	31 March 2021
	£000	£000
In one year or less	143,113	147,961
In more than one year but not more than two years	192,007	182,252
In more than two years but not more than five years	-	-
In more than five years	554,780	590,311
Total	**889,900**	**920,524**

26.5 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 Clinical Commissioning Groups and the way those Clinical Commissioning Groups 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.

26.5.1 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.

26.5.2 Interest rate risk

The Trust has borrowings in the form of PFI arrangements and a Finance Lease. For both types of borrowings, the interest rate is fixed, resulting in a low level of associated risk. Contingent rent does apply to the PFI scheme, as it is indexed through a twice yearly application of RPI. There is therefore an interest rate risk associated with that, though it is deemed to be low due to its comparative size.

26.5.3 Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2022 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 advice is taken from it's investment advisers so as to ensure that there is a very low level of risk associated with cash and any deposits with financial institutions.

26.5.4 Liquidity risk

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

27. Events after the reporting year

There have been no events after the reporting year that have had a major impact on these accounts.

28. Capital cost absorption rate (PDC)

The Trust incurs a charge on the balance of any funding received from the government. This is in the form of a PDC dividend charge that is broadly calculated as 3.5% of the Trust's average net relevant assets. In 2021/22 this equated to a £3,331k charge (£0k in 2020/21).

29. Related party transactions

The Norfolk and Norwich 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 with which we have had dealings. They are: Norfolk and Waveney CCG, NHS England, HMRC and NHS Pension Schemes.

Related Party Transactions	**Income Year ended 31 March 2022 £'000**	**Expenditure Year ended 31 March 2022 £'000**	**Income Year ended 31 March 2021 £'000**	**Expenditure Year ended 31 March 2021 £'000**
Value of transactions with board members	-	-	-	-
Value of transactions with key staff members	-	-	-	-
Value of transactions with other related parties:				
- Charitable Funds	-	-	484	-
- Other	1,425	7,340	1,235	8,441
- NHS Shared Business Services	-	-	-	-

Related Party Balances	**Receivables 31 March 2022 £'000**	**Payables 31 March 2022 £'000**	**Receivables 31 March 2021 £'000**	**Payables 31 March 2021 £'000**
Value of balances (other than salary) with related parties in relation to doubtful debts	(2,018)	-	(2,001)	-
Value of balances (other than salary) with related parties in respect of doubtful debts written off in year	-	-	-	-
Value of balances with other related parties:				
- Charitable Funds	552	-	226	-
- Other	872	311	866	788
- NHS Shared Business Services	-	-	-	3

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 2022 £'000	**Year ended 31 March 2021 £'000**
Short term employee benefits (pay)	1,307	1,250
Post-employment benefits (employers pension contribution)	48	90

The highest paid Director in 2021/22 received remuneration of £273k, excluding pension related benefits and exit packages, for their services as Medical Director including an element relating to their non-managerial role. In 2020/21 the highest paid Director received remuneration of £271K, not including pension related benefits and exit packages, for their services as Medical Director including an element relating to their non-managerial role.

Further details on remuneration of the Board of Directors can be found in the Remuneration Report.

In addition, the Trust had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions were with HM Revenue & Customs in respect of the deduction and payment of PAYE and with South Norfolk Council in respect of rates.

The Trust has also received revenue and capital payments from the Norfolk and Norwich Hospitals Charity, the Corporate Trustee of which is the Trust. These payments are outlined below.

29. Related party transactions (continued)

The services of the Norfolk and Norwich University Hospitals NHS Foundation Trust have benefited from payments of £1,742k for enhancement of the patient environment, investment in staff, additional equipment, and research (2020/21: £1,303k) from the Norfolk and Norwich Hospitals Charity.

During the year net assets to the value of £2,023k (2020/21: £8,515k) were donated to the Foundation Trust, of which £1,190k (2020/21: £237k) came from the Norfolk and Norwich Hospitals Charity.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has recharged the sum of £242k (2020/21: £247k) to the Norfolk and Norwich Hospitals Charity for the provision of the administration and management of the

The Norfolk and Norwich University Hospitals NHS Foundation Trust has received payments of £0k (2020/21: £30k) from the Eastern Academic Health Science Network. The Chief Executive Officer is a member of the board of this network.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has made payments of £563k (2020/21: £546k) to Norwich Research Partners LLP. The Chief Executive Officer and a Non-Executive director are members of the board of this organisation.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has made payments of £3,295k (2020/21:£4,536k) to the University of East Anglia and received income of £1,425k (2020/21:£1,205k). A Non-Executive director is the Vice-Chancellor of this organisation.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has made payments of £2,909k (2020/21:£2,816k) to QI Partners Ltd. The Chief Executive Officer is a member of the board of this organisation.

30. Third Party Assets

The Trust held £2k (2020/21: £2k) cash at bank and in hand at 31 March 2022 which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

31. Losses and Special Payments

There were 7,455 cases of losses and special payments totalling £994k paid during the year (2020/21: 3,346 cases totalling £1,320k).

	31 March 2022		31 March 2021	
	Number	£'000	Number	£'000
			* restated	* restated
Losses				
Cash losses (including overpayments, physical losses, unvouched payments and theft)	181	141	-	-
Bad debts and claims abandoned (excluding cases between FT and other NHS bodies)	7,224	623	1,331	19
Stores losses (including damage to buildings and other properties as a result of theft, criminal damage and neglect)	3	212	3	153
Special Payments				
Ex gratia payments	47	18	57	1,148
	7,455	**994**	**1,391**	**1,320**

These amounts are recorded on an accruals basis but excludes provisions for future losses.
* Prior year values restated to include confirmed Flowers payments.

32. Contingent Assets and Contingent Liabilities

There are no contingent assets or contingent liabilities.

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

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