Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Council of Governors Meeting

To be held in public on Thursday 24 April 2025 – 10:00- 11:00
Venue: Norfolk and Norwich Boardroom and Microsoft Teams

Agenda

	Item		Lead	Purpose
1.	Welcome	10:00-10:05	Chair	Assurance
2.	Apologies • Apologies - • NEDS Scheduled to attend		Chair	Assurance
3.	Declarations of Interest		Chair	Assurance
4.	Minutes of the meeting held in public on 23 January 2025		Chair	Approval
5.	Action Log and Matters arising from Minutes		Chair	Discussion
6.	Chief Executive's / Chair Report	10:05-10:15	CEO/ Chair	Information
7.	Questions and Responses	10:20-10:25	Chair	Discussion
8.	Finance Report	10.25-1035	CFO	Information
Operational Updates				
9.	Care Assurance and Accreditation for Excellence Audit Programme	10:35-10:50	Suzanne Nurse	Presentation
Business Items				
10.	Terms of Reference	10:50-10:55	RM	Approval
11.	Communications and Engagement Report • Membership update • Charities	10:55-11:00	JB	Information
12.	Any other business		Chair	Discussion

Date and Time of next meeting in public: The next Council of Governors meeting in public will be at 10am on 24 July 2025 in the Boardroom of the Norfolk and Norwich University Hospital

Governors are reminded that copies of the Trust Board papers including minutes, integrated performance report and committee reports can be accessed on the Trust website at: http://www.nnuh.nhs.uk/?s=board+papers&searchSiteSubmit=Search+site

Distribution: Council of Governors, Board of Directors and Trust website
Contact details: Janice Bradfield, Membership Manager, Norfolk and Norwich University Hospitals NHS Foundation Trust, tel 01603 287 634, e-mail membership@nnuh.nhs.uk

Our Values People focused Respect Integrity Dedication Excellence

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MINUTES OF COUNCIL OF GOVERNORS MEETING

HELD ON 23 JANUARY 2025

Present:	Mr T Spink	- Chair
	Mrs S Asghar	- Volunteers/Contracted (staff)
	Mrs E Bailey	- North Norfolk (public)
	Mr C Baxter	- Rest of England (Public)
	Mrs E Betts	- Breckland (public)
	Mrs A Cook	- Norwich (public)
	Mrs C Cubelo	- Nursing and Midwifery (Staff)
	Dr D Epurescu	- Broadland (public)
	Dr B Fleming	- South Norfolk (public)
	Mrs M Frost	- Clinical Support (Staff)
	Mrs I Grote	- Great Yarmouth/Waveney (public)
	Mr K May	- Broadland (Public)
	Mr D McNeil	- Breckland (Public)
	Mrs A Swallow	- Broadland (Public)
	Cllr A Thomas	- Norfolk County Council (partner)
	Mr R Wharton	- Medical (staff)
In attendance:	Mrs E Batchelor	- Assistant to Board Secretary
	Mrs J Bradfield	- Head of Communications
	Prof L Dwyer	- Chief Executive
	Mr J P Garside	- Board Secretary
	Mrs R Millbourne	- Interim Chief of Staff
	Mrs N Gray	- Non Executive Director
	Mrs S Dinneen	- Non Executive Director
	Dr B Brett	- Medical Director
	Mr E Prosser Snelling	- Chief Digital Officer
	Mrs R Cocker	- Chief Nurse
	Mr J Foster	- Non Executive Director

25/001 **APOLOGIES AND DECLARATIONS OF INTEREST**

Apologies were received from Mr Bush, Mrs Edwards, Mr Hind, Mrs Hainey, Mrs Lynch No conflicts of interest were declared in relation to matters for consideration by the Council.

25/002 **MINUTES OF PREVIOUS MEETING HELD ON 24.10.2024**

The minutes of the meeting held on 24 October 2024 were agreed as a true record for signing by the Chair.

25/003 **MATTERS ARISING**

The Council reviewed the Action Points arising from its last meeting as follows:

24/023 – visit to NANOC at an appropriate time - Governors expressed an interest in visiting the NANOC at a suitable opportunity. It was noted that this will need to be managed appropriately to avoid interference with service delivery, but Mrs Bradfield will

explore options. The Governors were taken on a tour of NANOC took place on September 5th. **Action: Closed**

24/028 – Workforce Development strategy - Governors provided feedback on imagery and Mr Jones agreed to circulate his slides to governors after the meeting. The slides were circulated on July 25th. **Action: closed**

25/004 **CEO REPORT**

The Council received a report from Professor Dwyer concerning strategic developments and the performance of the Trust in key areas.

- New Governors
- Performance
- Infections Prevention and Control

Professor Dwyer informed the Council that the trust is facing significant financial challenges and has entered the investigation and intervention regime as a system due to deficit budgets. The trust is implementing stringent controls, including a triple lock regime, to manage finances and improve the financial position, this involves strict approval processes for vacancies and expenditures aiming to reduce the use of temporary staff.

Professor Dwyer called out the staff between the Christmas and New Year period including Mrs Cocker's leadership for managing the demand on the Trust. For the first time ever the whole of East Anglia was in a level 3 response, the was exacerbated by flu and Norovirus however Covid remained stable. Thanks was given to the staff for maintaining safe levels of care within our Trust.

Governors asked if there has been an impact to surgery and elective care due to the use of escalation spaces. Professor Dwyer confirmed that there has been a small impact however we have moved the escalation beds back to their usual wards and made space for the surgery that was planned.

25/005 **ELECTRONIC PATIENT RECORD PROGRAMME UPDATE**

Mr Prosser – Snelling gave an in-depth presentation on the Electronic Patient Record Programme explaining all the processes and decisions that have been completed so far.

The programme aims to improve clinical data quality, encourage firmer diagnoses, highlight comorbidities, identify sepsis early, reduce length of stay, and improve communication with primary care through electronic discharge letters. Staff are involved in the change network, with continuous surveys to ensure engagement. The programme includes a workforce transformation to support the new digital environment. The software is installed and delivered, and the build and configuration are underway. The programme includes four prototypes, each building on the previous one, with frontline staff involved in the design and testing. The go-live date is set for March 26th, 2026, with a single electronic patient record, medication list, allergy list, problem list, scheduling system, ordering tool, and core data repository.

Governors asked when would be the optimum time to bring the software for the Council to see. Mr Prosser Snelling agreed he would come back with a demo presentation as soon as the build has been completed with PAS.

Action: Mr Prosser- Snelling

25/006 **IMPLEMENTING QUALITIY PRIORITIES 2024/25**

The Council received the Quality Priorities report from Mrs Cursons, Mrs Chapman and Mrs Cocker including;

Frailty Pathways:

- Focus on improving frailty pathways to enhance patient care and outcomes.
- Integration with transformation programs to ensure comprehensive support for teams undertaking quality improvement work.

Martha's Rule:
- Implementation of Martha's Rule, allowing patients to raise concerns about their care.
- Rollout of the Call for Concern service within adult inpatient services and modified service for paediatrics.
- Monthly data submission to the national dataset, with ongoing patient engagement to improve understanding of the service.

Infection Prevention and Control (IPC):
- Development of closer operational links between IPC team and operational teams to maintain patient safety and flow.
- Daily reports to manage patient safety and maintain IPC controls.
- Collaboration with Estates and Facilities team to improve cleanliness and environment.

Council Members queried in the other two hospitals are using Marthas rule as well to which they are and all three are signed up to have a standardised approach to this.

25/007 **IP&C ANNUAL REPORT 2023/24**

The Council received a report from Mrs Cursons on the IP&C Annual Report for 2023/24. The Key topics of discussion were;

Operational Links:
- The development of closer operational links between the infection prevention and control (IPC) team and other departments has been highlighted as a significant achievement. This collaboration has been crucial in maintaining patient safety and operational flow, especially during peak times like the period between Christmas and New Year.

Daily Reports:
- The IPC team has implemented daily reports to manage patient safety and maintain IPC controls effectively. This has allowed for better coordination and response to infection-related issues.

Collaboration with Estates and Facilities:
- The IPC team has worked closely with the Estates and Facilities team to address environmental factors that impact infection control. This includes discussions on cleanliness, recording, and patient feedback mechanisms like the five-star rating system on wards and departments.

Challenges and Improvements:
- The report acknowledges the challenges faced in maintaining IPC standards and outlines the continuous efforts to improve patient safety and operational efficiency. The focus is on maintaining high standards of cleanliness and infection control while supporting the operational needs of the hospital.

Future Focus:
- The IPC team is committed to ongoing improvements and maintaining patient safety. This includes working collaboratively with other departments and continuously evaluating and enhancing IPC measures.

25/008 **MEMBERSHIP REPORT**

The Council received a report from Mrs Bradfield for information outlining governor, member and public activities across many areas of the Trust. The report detailed Governors'

briefings and activities. Welcome was given to the new governors however it was reported that Mrs Turner has stepped down to health reasons therefore leaving a vacancy in Breckland. Mrs Bradfield added that there are plans to build activities to make new governors aware of various services that they can get involved with.

There are three main events coming up for the public and for members this year;

- Dementia fair in Mary
- Norfolk show in June
- AGM in October .

Governors were reminded that there is a meeting at Priscilla Bacon Lodge directly after this meeting at 12:30 to gain an overview of the work held there and their link to the hospital.

Mrs Bradfield reminded the council that there is a vacancy in the outpatient forum which is held three to four times a year and other vacancies are picked up in the annual elections.

It was noted that there is a Cancer Care Conference on the 11th of February to which Mrs Bradfield will gather information and circulate this to the Council members.

25/009 **N&N HOSPITALS CHARITY UPDATE**

The Council received a report from Mr Garside on the Hospital Charity. Mr Garside highlighted the importance of the hospital's charity in supporting patients and staff, mentioning that the charity spends around £3,000,000 annually.

The charity's activities over the last year and plans for the coming year were discussed, including major projects like surgical robots, parental accommodation, and cancer acute oncology services.

The charity aims to increase its profile and engage with community groups for fundraising.

Mr Garside requested help from governors to identify local groups and places to increase the visibility of the charity, such as local pubs, libraries, and village shops such as the Lions and Rotary for potential fundraising and awareness activities. Mr Garside stated he would email round the Council with details on how they can assist in engaging with local groups and increasing the charity's visibility and asked that they replied with suggestions of local places where the charity can distribute magazines and collection tins.

Action: Mr Garside and Council Members

It was noted that the onsite accommodation is managed by the Trust and therefore the Trust sets the prices an offline discussion will be held between Mr Garside and Council Members who have questions around this.

Signed by the Chairman: …… Date: ……
Confirmed as a true record by the Council on 24 April 2025

Decisions Taken:

No Formal Decisions were made.

Action Points Arising:

Actions Carried Forward:
Actions Arising on 23.01.2025

25/005 - EPR programme update	Governors asked when would be the optimum time to bring the software for the Council to see. Mr Prosser Snelling agreed he would come back with a demo presentation as soon as the build has been completed with PAS. **Action: Mr Prosser- Snelling**
25/009 – N&N Hospital Charity update	Mr Garside stated he would email round the Council with details on how they can assist in engaging with local groups and increasing the charity's visibility and asked that they replied with suggestions of local places where the charity can distribute magazines and collection tins. **Action: Mr Garside and Council Members**

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Action Points Arising from Council of Governor meeting (Public)

New Actions arising		
25/005 - EPR programme update	Governors asked when would be the optimum time to bring the software for the Council to see. Mr Prosser Snelling agreed he would come back with a demo presentation as soon as the build has been completed with PAS. **Action: Mr Prosser- Snelling**	**On going**
25/009 – N&N Hospital Charity update	Mr Garside stated he would email round the Council with details on how they can assist in engaging with local groups and increasing the charity's visibility and asked that they replied with suggestions of local places where the charity can distribute magazines and collection tins. **Action: Mr Garside and Council Members**	

REPORT TO THE COUNCIL OF GOVERNORS PUBLIC MEETING	
Date	**24 April 2024**
Title	**Chief Executives Report**
Author(s) & Exec Lead	**Professor Lesley Dwyer**
Purpose	**For Information**
Relevant Strategic Objective & BAF Reference	**SO:** 1. Our Patients - Together, we will develop services so that everyone has the best experience of care and treatment. 2. Our Team – together, we will support each other to be the best we can be, to be valued and proud of our hospital for all. **BAF Ref: 1.1, 1.2, 2.2 and 2.3**

1. Background/Context

The purpose of this report is to brief the council of governors on matters which the Chief Executive believes should be brought to their attention.

2. Key Issues, Risks and Actions

2.1. Performance

We have significantly reduced the use of escalation and temporary escalation spaces (TES) beds in recent weeks, which has included a period of five weeks without using TES. This is due to the support from teams who adhere to the documented plan that the medicine division have developed to improve flow, especially at the weekends, which is where escalation spaces are historically used. This plan is reviewed mid-week by the Chief Operating Officer, the Medical Director and Chief Nurse prior to being discussed at Friday's weekend planning meeting.

We submitted our 2025/26 Operational Plan to NHSEngland which sets out our performance delivery for Emergency, Elective, Cancer, and Diagnostic against the targets set. We also provided our plan to deliver against a financial breakeven position which is a requirement for this year. We continue to be supported in the Investigation and Intervention regime and through Hunter Healthcare assistance are working with a Turnaround Director to support identification of improvements schemes.

2.2. Infection Prevention and Control (IP&C)

There has been a reduction in the number of patients in the hospital with Flu and COVID, but there has been outbreaks of Norovirus which has resulted in bed closures. We have conducted several reviews to ensure that all instances were and are being managed appropriately. Communications have been circulated to staff, patients, and visitors to remind about the importance of handwashing.

2.3. Clinical Leadership Structure

The consultation has been completed in forming a Care Group structure to devolve responsibility, accountability and decision-making back to the leaders and teams who are closest to the patients. This has seen a reduction in posts and grades of administrative and clinical leadership roles from the divisional structure. The internal recruitment process for those who will provide leadership to the Care Groups is close to conclusion. It is expected that the Care Groups will be formally in existence from May.

2.4. Reshaping our workforce

You will have seen in the communication that I provided and more recent press, that we are required to reduce our headcount with a specific reduction in corporate headcount by 50%, based on growth since 2019/20. I shared with the staff that the reduction of five hundred posts will be required to support a balanced budget at the end of next year. We are currently working through the process and have invited non-binding expressions of interest to all staff and have been engaging with our Trade Union colleagues. Not all of the 500 posts will be posts that are filled as vacancies throughout the organisation have been managed through the triple lock process, identifying those which have been back filled by temporary or agency staff, this may allow opportunities to redeploy staff instead of redundancies.

2.5. Easter Holiday planning

Public holidays can add additional burden to acute hospital activity, to mitigate against the progress made in board rounds, Red to Green, Frailty assessment and reduced use of escalation spaces, an operational plan for the hospital has been shared widely with all leadership colleagues who are on duty to ensure that we are all on the same page with a tiered approach of how to manage the increased activity with appropriate escalation points to the executive leadership team. A review of the plan will take place after the holidays to see if there is any learning to be identified to improve the plan further for future use. I will provide a verbal update at the meeting.

3. Conclusions/Outcome/Next Steps

To continue with the support from the Executive team to support the establishment of the new Clinical Care Groups and to work with corporate areas to deliver against the operational plan for 2025/26.

As you know we are now establishing the Norfolk and Waveney University Hospitals Group, and I want to acknowledge and thank the Governors for the support to me in being appointed as the Group CEO. I remain part of the NNUH, and I know that you will continue to provide the support and challenge where required to ensure that the quality of care for our patients remains our priority.

Recommendations:

The Council is recommended to:

- Note the content of this report for information.

Ref.	Name	Question	Answer
1	Elaine Bailey	Tom, Sarah, on Friday the Governors had a tour around the new CDC which is a fabulous facility. We all queried the parking arrangements for patients, who we were told are directed to park in the multi storey NCP around the corner, which is a 5-10 minute walk depending on mobility. We met an elderly couple who had come on the bus and needed directions and help to get back to the main concourse, which is quite a walk for the elderly and not straightforward for patients. I also met an 80-year-old patient who walked with a stick later in the afternoon, who was trying to get into the Ella May Barnes building which he thought was the CDC. He was very disappointed to discover that it was a bit further once I had led him around the side and pointed him in the right direction. I believe that the issue of patient parking and access has already been raised, and yes there are disabled spaces and a drop off area to the side, but for the majority of patients (especially those arriving on public transport) it is a real problem. Tom, are the NEDS aware of this problem? I think it would be good to hear that this is being looked into, and the NEDS are aware.	Local authority active travel plans have meant that there is only drop off and disabled parking is available at the centre, this is why the NRP multi storey is advised as the closest car park. The Facilities team and Norwich Research Park colleagues will look at options to improve signage and the CDC team will review its letters to ensure the detail about car parking and directions are clear. The volunteers' office is currently working through a proposal for a shuttle service which will cover the CQC, Centrum and the public car park. The intention is to use a shuttle service like the QEHKL. Patient buggy | The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.

Ref.	Name	Question	Answer
2	Annie Cook	On Tuesday I parked in the car park near the Charity Café ahead of an 8.30 OP appointment in Plastics, in the half hour I sat there I saw 3 members of staff park up and head off into the Trust. At my previous Plastics appointment I parked up in the same area and saw 4 staff parking there, which is what I queried with you as we had always been told it is not appropriate for staff to park in what in essence is patient/visitor's car parks. By the time I came out of clinic at 9.30 people were already circling in the car park looking for spaces. In all the time of working at the Trust I think we have the most car parking available ever, so why are staff parking in the car parks closest to the hospital when patients should be priority? Is there anything that can be done to raise this as an issue please?	A reminder about not using patient/visitor car parking spaces unless absolutely necessary will be issued to staff and Linda Martin, Director of Estates & Facilities (Interim) will review options for staff who may consistently use parking inappropriately.
3	Annie Cook	I've emailed Derek and Peter the 2 other Norwich Governors in respect of the ICB wanting to close the Walk In Center, https://improvinglivesnw.org.uk/changes-to-services-in-norfolk-and-waveney/ Would it be possible to circulate the link to the membership please, with a few words around completing the survey, and the impact should it close.	Detail about this consultation has been provided in our staff and members newsletters with a link to the consultation.

Ref.	Name	Question	Answer
		I appreciate that due to the local election's things are paused, however if we could raise it now and then once they give another date for the closing of the consultation circulate it again, please?	
4	Elaine Bailey	Quick one, when we did the Friends and Family tour of the CDC, you mentioned radiologists would be rotating between the CDC and Main building. I have since heard from one of our Governors, that there will be no radiologists in the CDC at all. Can you please confirm what the real situation is re having radiologists in the new building?	Seshni Mohammed, Imaging Operations Manager has confirmed that Radiologists are already using the CDC for reporting as will reporting Radiographers. Radiologists are not rostered a designated reporting workstation as the teams us an online tool which identifies which workstations are unoccupied and available to use for reporting across the whole estate which includes CDC and the Imaging Academy.
5	Annie Cook	**How many NHS patients are on the surgical waiting list at Spire?** • Are the patients aware that the NHS contract has not been renewed? Whose responsibility is it to update the patients? • How are these patients managed - Are patients taken off the surgical lists for N&N if they are given to Spire? • How does the Trust coordinate these patients to ensure they don't fall into a gap between the 2 organisations? The reason I am asking is that someone only found out that the contract has not been renewed by several calls to Spire for an update on potential dates for surgery. I do appreciate that this is a Trust 'working' issue, however it	We do not remove patients from the NNUH waiting list when they are listed at Spire, they instead have an annotation on the waiting list that treatment will be carried out at Spire and retain their position on the NNUH waiting list and within our governance until completion of treatment is confirmed. All patients who were on the waiting list for treatment at Spire Have now either been: 1. Listed for an operation date at the NNUH and informed. 2. Contacted and informed that their treatment location has been moved back to the NNUH, and they will be given a date for surgery in due course in keeping with their position on the waiting list. There are a small number of patients who have not been contactable that we are still trying contact.

Ref.	Name	Question	Answer
		impacts on our community and so I feel is a valid Governor ask. There seems to me to be a breakdown in communication between the Trust & Spire somewhere along the line, some patients are not comfortable chasing and therefore may be just sitting at home waiting for the date to come through.	Spire Norwich also has their own NHS Choose & Book patients that are totally separate from the NNUH and listed on a separate Spire waiting list.
6	David McNeil	1. Have we established a process for the group model to appoint internal audit? 2. Will there be internal auditors at each hospital level? 3. Are there any remaining internal audit days with the current internal auditors that we can use to: • commission a review of current and proposed governance structures. • report on what other hospital 'mergers' are proposing on governance structures?	Currently, each organisation has its own contract for the internal audit service. It is planned as part of the group model, to work on aligning these, as the contracts come up for renewal, moving to one supplier across the three organisations. As statutory organisations, there will be a requirement for each to receive its own annual report and opinion from the Head of Internal Audit. No, there is an agreed risk-based audit plan in place for 2025/26 which uses all audit days.
7a	Cherry Cubelo	Whilst EDP reported the risk of 500 NNUH staff positions, unsettled staff continue to worry for their job security. As I outreach in QEHKL and JPUH to work, same angst felt among staff. Many approached me as the top tier nurse managers had been re-structured already.	We recognise that this is an unsettling time for staff and as part of the workforce reduction programme, current support is being expanded to widen the support available to staff. This will focus on wellbeing and financial support and be focused towards the workstream.

Ref.	Name	Question	Answer
		Everyone in the lower tier await for the unknown future. Please may we request the Chief Nurse to update us and lay the plan to the Governors in the next meeting so we can cascade information to anxious staff.	For example, the Trusts benefits and wellbeing portal (Vivup) has many resources of support including access to 24/7 confidential, impartial, telephone support, financial support and guidance for staff, to mention a few. Expansion of the current offer will be tailored to the workstream of the programme and will include FAQs for staff, sign posting on CV writing and interview experience, as examples.
7b	Elaine Bailey	In light of potential job losses and organisational changes, can the Non-Executive Directors provide assurance that both directly employed and contracted staff, including their managers, are provided with adequate access to wellbeing support?	The clinical restructure phase one is almost complete, but at this point we are unable to confirm the care group leadership appointments until the recruitment process concludes, which then be published. The workforce reduction programme which includes phase 2 of the care groups, and the administrative and clerical review, plus a review of posts that are currently vacant. These will look at a variety of posts (clinical and non-clinical) at various grades, detail will be shared in the future. The Trust continues working closely with our trade union colleagues concerning the workforce reduction programme and to enable access for support via their offer.
8	Elaine Bailey	Can the Non-Executive Directors provide assurance that the NANOC initiative is aligning with its benefits realisation plan and that it is now effectively delivering its intended outcomes?	All new facilities are assessed against the original plan after 12 months to ensure the benefits are being delivered. More to follow when that process completes.

Ref.	Name	Question	Answer
9	Elaine Bailey	Are the NEDs yet able to advise how decisions made by the Special Purpose Joint Committee will be effectively communicated to governors across all three Trusts, and what mechanisms are in place to ensure governors can contribute to and inform the decisions taken within the committee?	This issue will be picked up in the group workstreams.

REPORT TO THE GOVERNORS

Date	**24 April 2025**			
Title	**Month 11 IPR - Finance**			
Author & Exec lead	**Liz Sanford (Director of Finance – Operations)** **Marcus Thorman (Chief Finance Officer)**			
Purpose	**For Information**			
Relevant Strategic Objective	**5. To deliver our financial plan and recovery programme, supporting the Trust's return to financial sustainability**			
Are there any quality, operational, workforce or financial implications of the decision requested by this report?	**Quality**	**Yes✓ No☐**	These are discussed throughout the document.	
	Operational	**Yes✓ No☐**		
	Workforce	**Yes✓ No☐**		
	Financial	**Yes✓ No☐**		

Context: This paper outlines the Trust's financial performance for February 2025 within the context of the current financial regime the NHS is operating under.

The Trust Finance Report Executive Dashboard for February 2025 is attached for the information of the Council of Governors. The dashboard summary outlines the key financial metrics for the Trust including:

- Income and Expenditure – with the Year to Date showing a £3.2m net deficit on a control total basis, £2.1m adverse to the planned £1.1m deficit.
- Capital – the Year to Date spend is £51.3m, a £8.9m underspend against the planned £60.2m
- Activity – Performance against the value-based activity plan is £6.6m adverse Year to Date
- Efficiency Savings - Year to Date efficiency of £10.7m has been delivered, against a plan of £31.7m, £21.0m adverse
- Key strategic financial risks are captured in the Trusts detailed Costed Risk Register. The aim of identifying the risks and associated financial implications is to ensure that there is visibility of the risks and mitigations inherent in the delivery of the Trusts financial plan. These are plotted on the 5 x 5 matrix to show a risk map. Where risks have crystalised, these are included in the narrative, along with the reference in the risk matrix.

The Council of Governors is requested to read the attached summary and present any questions to the Director of Finance.

Norfolk and Norwich University Hospitals NHS Foundation Trust

Finance Report February 2025

24 April 2025

Marcus Thorman, Chief Finance Officer

1.1 Executive Dashboard

Norfolk and Norwich University Hospitals NHS Foundation Trust

The Trust operational plan for FY24/25 as outlined in Cycle 4 of the 2024/25 planning process is breakeven. Performance is measured against this.

February position is a £9.9m surplus on a control total basis, £9.1m favourable to the planned £0.8m surplus. Recurrent performance is a £2.8m deficit, £3.7m adverse to plan.

Recurrent underperformance is due to CIP under-delivery of £2.4m (£1.6m relates to the budgeted CIP stretch target), divisional overspends of £0.8m (pay is overspent by £1.0m, offset by drugs underspends), and activity under performance of £0.5m, offset by £0.1m of additional interest income. Recurrent under-performance is offset by non-recurrent net mitigations totalling £12.8m, of which the financial recovery plan is £4.5m, and £7.7m of additional support funding with the balance being due to delayed investment and reserve utilisation.

YTD position is a £3.2m deficit on a control total basis, £2.1m adverse to the planned £1.1m deficit. Recurrent performance is a £38.6m deficit, £37.5m adverse to plan.

Recurrent performance is driven by CIP under delivery of £21.0m (of which £13.0m relates to the budgeted CIP stretch target), divisional expenditure is £11.3m adverse (pay is £11.9m of this, offset by drugs underspends), and activity is £6.6m adverse, offset by interest income of £1.8m. Recurrent underperformance is offset by non-recurrent net mitigations totalling £35.4m, of which the Financial Recovery Plan is £12.5m, and £7.7m of additional support funding, with the balance being due to delayed investments and reserve utilisation.

Forecast Outturn: Forecast Outturn is breakeven at Month 11, on plan against the planned breakeven position, and a £8.4m improvement to the £8.4m deficit reported in January, due to £8.4m of Non-Recurrent support funding.

Activity: Value-based activity performance for February was £0.5m adverse to plan (£6.6m adverse YTD) equating to 97% of planned levels (97% YTD). The elective elements were £0.6m adverse (£7.9m YTD) equating to 96% (96% YTD), and other chargeable API (Chemotherapy Delivery and Diagnostic Imaging) activity was £0.1m favourable to plan, 104% (£1.3m favourable YTD, 107%).

Capital Expenditure: Year to date total capital spend is £51.3m, a £8.9m underspend against the planned £60.2m. **Forecast Outturn** for the total capital plan is £70.7m, a £0.9m underspend against the Trust's CDEL allocation of £71.6m and is attributable to the IFRS16 impact of leases. **Forecast Outturn** for central programmes is £2.9m lower than plan which is driven by NANOC 2.

Cash held on 28th February 2025 was £78.2m, £18.5m lower than the FY24/25 submitted forecast as a result of the underlying deficit performance and working capital movements.

	In Month			Year to Date		
	Actual	Plan	Variance	Actual	Plan	Variance
SOCI	£m	£m	£m	£m	£m	£m
Clinical Income	73.7	67.5	6.2	744.8	742.7	2.1
Other Income	13.7	10.9	2.8	126.4	96.2	30.2
TOTAL INCOME	**87.4**	**78.4**	**9.0**	**871.2**	**838.9**	**32.3**
Pay	(46.5)	(48.0)	1.5	(523.1)	(515.4)	(7.7)
Non Pay	(21.2)	(19.3)	(1.9)	(248.2)	(213.6)	(34.6)
Drugs (Net Expenditure)	(3.0)	(3.3)	0.3	(34.2)	(34.6)	0.4
TOTAL EXPENDITURE	**(70.7)**	**(70.6)**	**(0.1)**	**(805.5)**	**(763.6)**	**(41.9)**
Non Opex	(6.7)	(6.9)	0.2	(68.9)	(76.4)	7.5
Control Total Surplus / (Deficit)	9.9	0.8	9.1	(3.2)	(1.1)	(2.1)
Statutory Surplus / (Deficit)	10.5	0.8	9.7	7.5	1.2	6.3
Other Financial Metrics	£m	£m	£m	£m	£m	£m
Cash at Bank (before support funding)	78.2	96.7	(18.5)	78.2	96.7	(18.5)
Capital Programme Expenditure	6.1	5.3	(0.8)	51.3	60.2	8.9
CIP Delivery	2.6	5.0	(2.4)	10.7	31.7	(21.0)
Activity Metrics	£m	£m	£m	£m	£m	£m
Day Case	5.7	5.9	(0.2)	64.8	67.0	(2.2)
Elective Inpatient	4.8	5.3	(0.5)	49.6	55.8	(6.2)
Outpatients - New & Procedures	5.8	5.7	0.1	65.0	64.4	0.5
Other Chargeable activity included within API	1.7	1.6	0.1	19.3	18.0	1.3
TOTAL	18.1	18.6	(0.5)	198.7	205.3	(6.6)

Norfolk and Norwich University Hospitals NHS Foundation Trust

1.2 Executive Dashboard

Risk

The strategic financial risks remain the same in nature as at Cycle 4 of the Business Planning Process.

As part of FY24/25 annual planning there were 15 key strategic and operational risks identified with an initial score of ≥ 12. A review of the risks took place in September consolidating the number of risks with a score of ≥ 12 to eight. The Finance Directorate continues to formally review the Financial Risk Register on a monthly basis. Following the latest review the forecast Financial Impact has increased to £78.9m as a result of the risk of reduced national income support for depreciation expenditure of £1.4m (£1.4m total).

There are six risks rated as 'Extreme' on the risk register which had a potential risk assessed financial impact of £77.5m at Cycle 4 of the Business Planning. This has increased to £78.9m at Month 11, of which £45.4m has crystalised year to date.

The Month 11 crystalised risks are:

CIP Under Delivery (Risk A) is £21.0m adverse year to date - £10.7m delivered against the budgeted plan of £31.7m, comprising of a planning variance of £20.3m and an adverse performance variance of £0.7m, which equates to an underperformance of circa 66%.

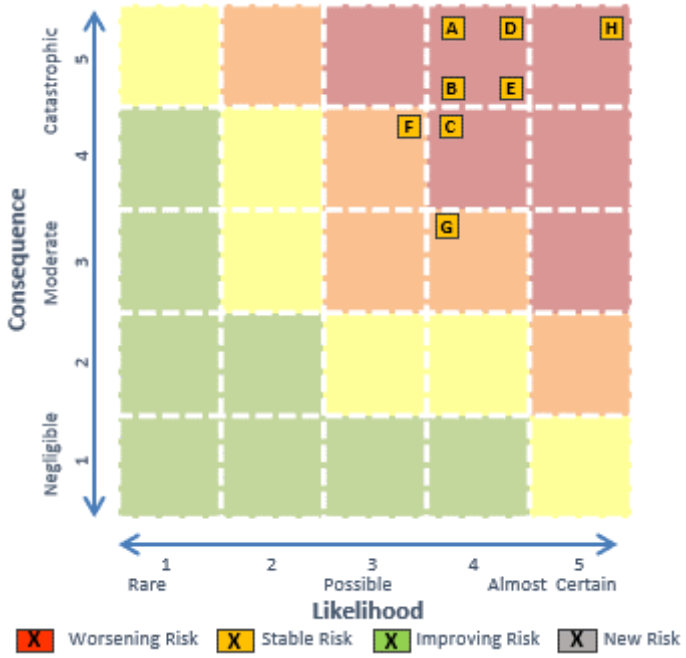
Failure to control expenditure in line with plan (Risk B) has a crystalised impact of £11.7m year to date, due to a Divisional Pay overspend of £11.4m, £0.8m of spend to cover Industrial Action offset by a £0.5m underspend on drugs.

Failure to increase income contracts for service development (Risk C) has a crystalised impact of £0.4m year to date.

Failure to utilise Clinical Space / Workforce in line with the plan (Risk D) has a crystalised impact of £10.9m year to date, due to an under performance in the Elective elements of £7.8m (industrial action had an estimated adverse impact of £0.5m), offset by overperformance in Chemo & Radiology of £1.3m. Reduced Advice & Guidance activity was £0.9m, increased use of the Independent Sector to support the elective activity plan was an additional £1.5m and continued opening of the Discharge Suite and Temporary Escalation Space was £2.0m.

Failure to implement strategic business cases (Risk H) has resulted in £1.3m reduction in the Trust's financial block allocation

Risk Rating		Risks	Financial Impact FY24/25 £m	YTD Crystallised Impact £m	Forecast Further Crystalisation £m	Financial Impact FY24/25 (Revised) £m
Extreme	15+	A, B, C, D, E, H	77.5	45.4	33.5	78.9
High	12-14	F, G	0.0	0.0	0.0	0.0
Moderate	5-11	-		0.0	0.0	0.0
Low	1-4	-		0.0	0.0	0.0
Total			77.5	45.4	33.5	78.9
Mitigation of risk prior to full value crystalising				0.0	(28.5)	(28.5)
Net Total Risk Assessed Impact				45.4	5.1	50.4
Risk mitigated through Non Recurrent YTD underspends & Release of Expenditure Reserves				(23.1)	(2.2)	(25.3)
Risk mitigated through Delivery of Financial Recovery Plan (FRP)				(20.2)	(4.9)	(25.1)
Total Risk Assessed Impact				2.1	(2.1)	(0.0)



Financial Recovery Plan: As a result of the forecast adverse variance to plan a Financial Recovery Plan has been implemented. Year to date delivery is £12.5m, £2.0m favourable to plan, due to a £2.0 overperformance from the review of accounting policies.

Quality Improvement & Clinical Excellence

Suzanne Nurse
Associate Director for Quality Improvement & Clinical Excellence

Care Assurance

- Peer review of clinical areas, supported by Governors, Patient Panel Representatives and external partners
- A set of clearly defined key measures/ indicators of high-quality care
- Triangulation of observations in practice, data, staff and the patient voice
- Used alongside other quality metrics that underpin high quality care
- Aligned with ‘fundamentals of care’ standards

NNUH Accreditation of Excellence Framework

- Evidence based standardised approach
- Brings together key standards of clinical care into one overarching framework
- 'Handbook of quality of care'
- Culture of continuous improvement and empowerment
- Robust governance and ward-to-board assurance of optimal care standards & services

NNUH Accreditation of Excellence framework

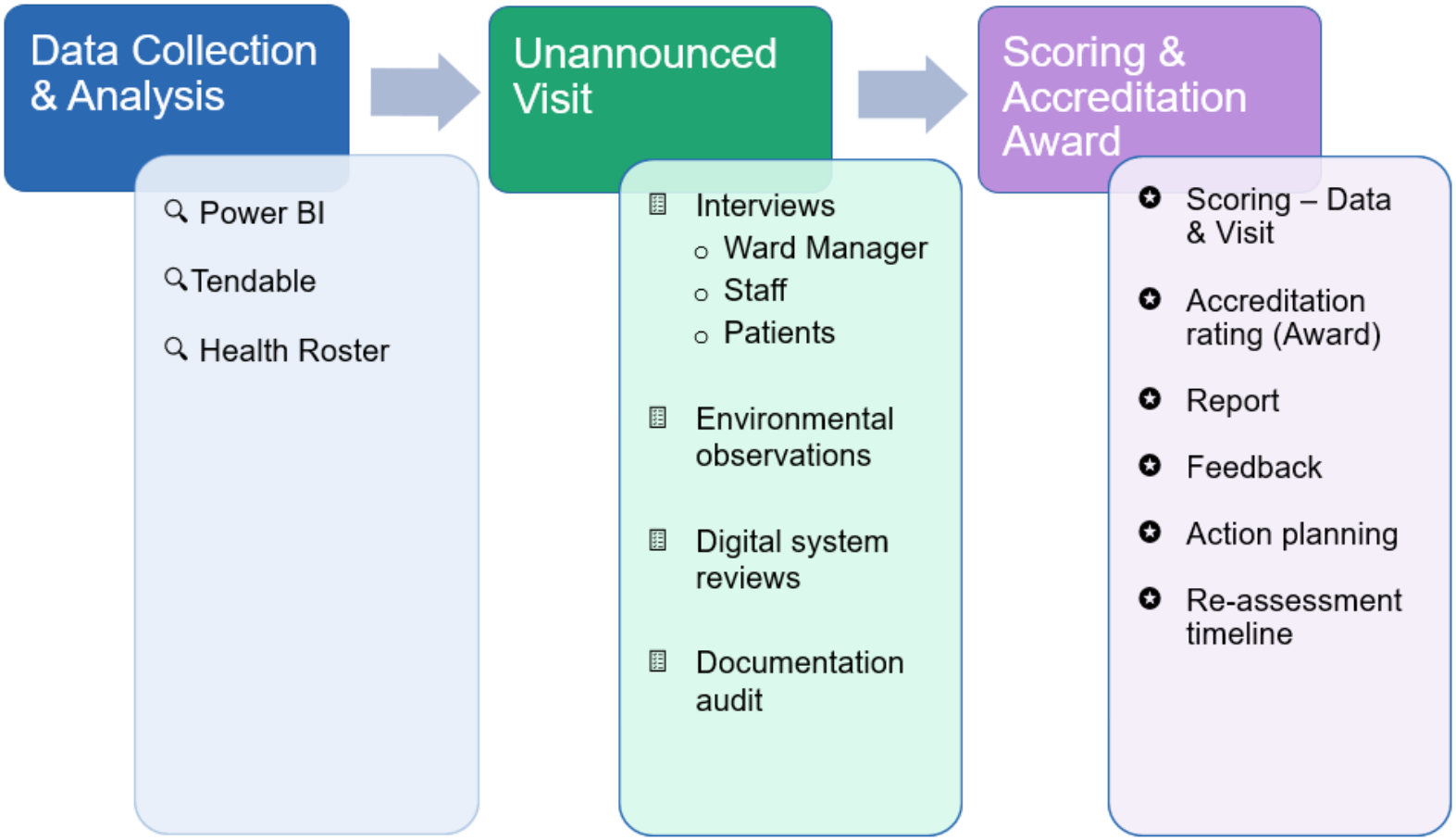
13 Evidence-based standards.

Aligned to:

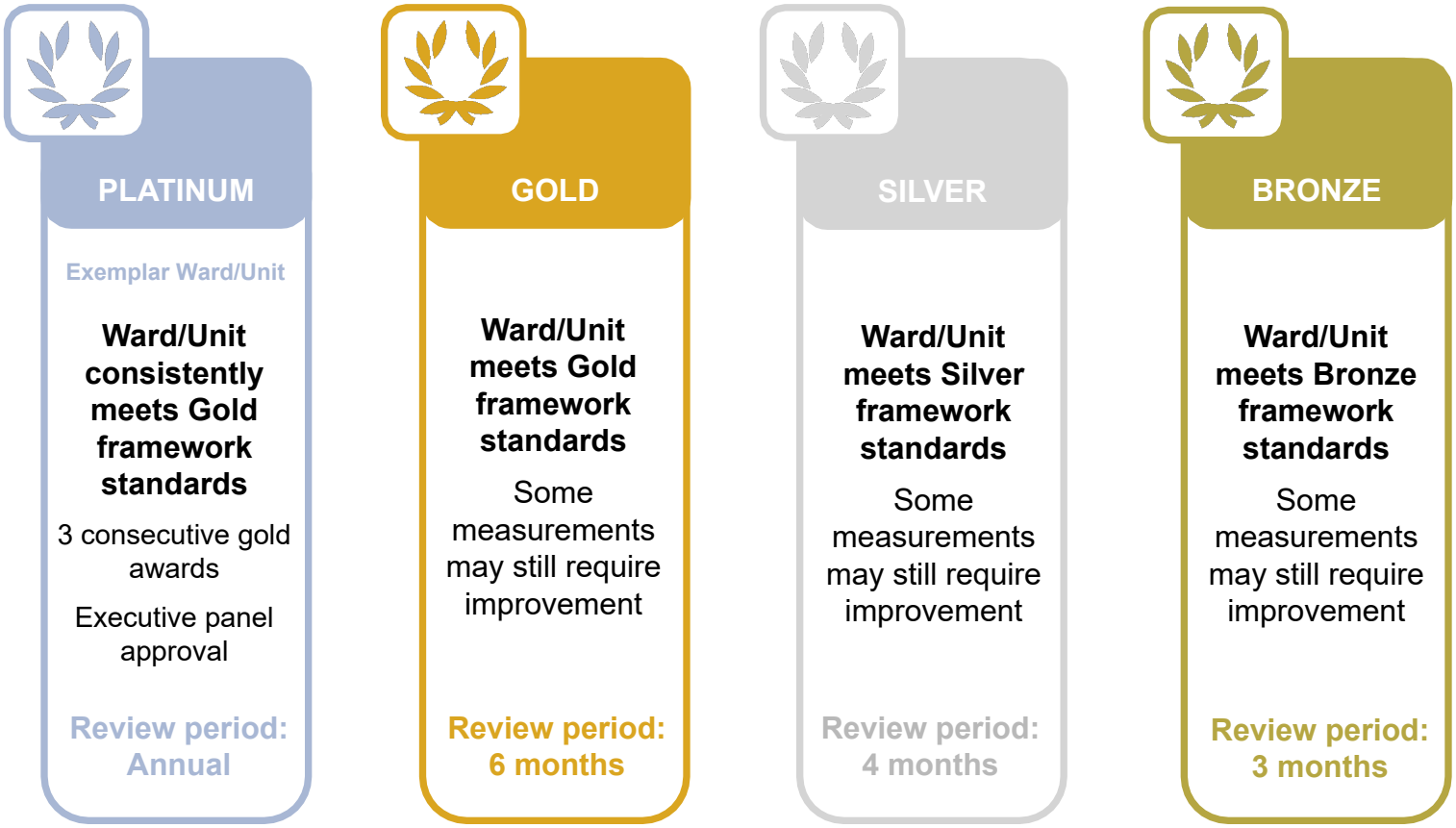
- NNUH Vision & Values
- CQC Key questions & quality statements

Accreditation of Excellence Standards	
1	Well Led
2	Organisational & Operational Management of Clinical Care
3	Safeguarding
4	Patient Safety
5	Nutrition & Hydration
6	Pain Management
7	Palliative & End of Life Care
8	Infection Prevention & Control
9	Medicines Management
10	Patient Centred Care
11	Pressure Ulcer Prevention & Management
12	Elimination
13	Falls

NNUH Accreditation of Excellence process



Accreditation Awards



Working Towards Improvement wards/units

Below the minimum standard expected & large numbers of measures require improvement

Next Steps

- Opening the support for Accreditation of Excellence visits to offer a broader peer review
- Development of an Accreditation framework for Paediatrics & Maternity in-patient areas
- Development of an out-patient Accreditation Framework
- Improved patient voice in the Accreditation framework
- Develop executive panel for platinum awards

The Fifteen Steps

"I can tell what kind of care my daughter is going to get within 15 steps of walking onto every new ward"

- When we first arrive in a healthcare setting, does it inspire confidence in the care that we are about to receive?
- How can first impressions make us feel that we will be safe and cared for?
- What are the first clues to high quality care?
- What does good care look, feel, sound and smell like?

What is Quality Improvement?

What is it?

A **systematic approach** to solve complex problems that uses **specific techniques** through testing & learning, involving those closest to the issue.

- **Structured**
- **Planned**
- **Strategic**

- **QI tools**

Why do it?

Patient experience, Staff engagement, financial gain, capacity provision, service development…

Questions?

REPORT TO THE COUNCIL OF GOVERNORS PUBLIC MEETING	
Date	**24 April 2024**
Title	**Terms of Reference for the Council of Governors (including Appointments and Remuneration Committee)**
Author(s) & Exec Lead	**Rees Millbourne, Chief of Staff (Interim)**
Purpose	**For approval**
Relevant Strategic Objective & BAF Reference	**SO:** 1. Our Patients: Together, we will develop services so that everyone has the best experience of care and treatment. 2. 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. 3. Our Partners: Together, we will join up services to improve the health and wellbeing of our diverse communities. 4. Our Services: Together, we will provide nationally recognised, clinically led services that are high quality, safe and based on evidence and research. 5. Our Resources: Together, we will use public money to maximum effect. **BAF Ref: 1.1,2.1,2.3,2.4,3.1,3.2,4.3,5.1 and 5.2**

1. Background/Context

The purpose of this report is to summarise the changes following a review of the terms of reference for the council of governors.

2. Key Issues, Risks and Actions

2.1. The code of governance for NHS provider trusts was published by NHS England in October 2022 and replaces Monitors Code of Governance. All references from Monitors code of governance have been reviewed and updated to reference the NHS England code of governance.

2.2. References to Monitor have been removed and replaced with the NHS England. In July 2022, organisations previously known as NHS Improvement, Monitor, and the NHS Trust Development Authority (TDA) ceased to operate as distinct entities.

2.3. The term Chairman has been updated to ‘Chair’ to promote equitable and inclusive language.

2.4. The ‘lead’ governor role has been included.

2.5. The Board of Directors and Management Board reporting and accountability structure has been removed as this is out of date.

3. <u>Conclusions/Outcome/Next Steps</u>

To review the tracked changes and approve these terms of reference for a twelve-month period.

Recommendations:

The Council is recommended to:

- Note the content of this report for information
- Approve the updated terms of reference.

COUNCIL OF GOVERNORS

TERMS OF REFERENCE

1 CONSTITUTION AND PURPOSE

In accordance with its Constitution ('the Constitution'), the Trust has a Council of Governors elected by members of the Trust and appointed by partner organisations. As set out in ~~Appendix~~ Annex 6 ofto the Constitution, the Trust has Standing Orders (SO) for the Practice and Procedure of the Council of Governors ~~(SO)~~. For the avoidance of doubt, those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.

In accordance with Statute, all the powers of the NHS Foundation Trust shall be exercised by the Board of Directors on behalf of the Trust. The Purpose of the Council of Governors is to:

i) hold the non-executives, individually and collectively, to account for the performance of the Board of Directors in exercising this duty;
ii) represent the interests of Trust members and the public;
iii) exercise particular functions as specified in legislation and regulations.

In line with the Code of Governance (Appendix B) the council should identify who has been nominated as 'lead' governor. The lead governor has a role in facilitating direct communication between NHS England and the trust's council of governors. Further detail of specific duties and responsibilities for the lead governor can be found in Appendix A of this document.

These Terms of Reference are intended to reflect this Purpose and the duties, roles and responsibilities of the Council of Governors as contained in the Trust's Constitution and the ~~Foundation Trust~~ Code of Governance (the 'Code')[1].

2 MEMBERSHIP

Membership of the Council is determined in accordance with Annex 3 of the Constitution. There will be 26~~5~~ members of the Council of Governors as follows:

- 16 governors elected by members of the public constituency;
- 6 governors elected by members of the staff constituency;
- 4 governors appointed by partner organisations.

3 ATTENDANCE

3.1 The Council may invite non-members to attend its meetings as it considers necessary and appropriate.

3.2 In accordance with the Code of Governance it is expected that the Council will invite the Chief Executive to attend all its general meetings, and that other executive and non-executive directors will be invited as appropriate ~~(Code~~

[1]The Code of Governance for NHS Provider trusts is ~~may be~~ located on ~~Monitor's~~ NHS England's website at ~~http://www.monitor-nhsft.gov.uk/publications~~ https://www.england.nhs.uk/long-read/code-of-governance-for-nhs-provider-trusts/

~~B.1.6).~~

3.3 The Council may require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the Trust's performance of its functions or the directors' performance of their duties.

4 MEETINGS and QUORUM

4.1 The Council shall hold scheduled meetings once a quarter and meetings shall be called in accordance with SO 3.6 and 3.8. No business shall be transacted at a meeting of the Council unless at least one-third of the whole number of governors are present including at least 5 Governors elected from the public constituency, and one Governor not from the public Constituency (SO 3.38);

4.2 Meetings of the Council of Governors will be chaired by the ~~Chairman~~Chair of the Trust who, in the case of any tied vote, will have a casting vote (SO 3.14);

4.3 If, in any circumstance the ~~Chairman~~Chair is unable to Chair a meeting of the Council, or any part of a meeting, due to illness, unavailability or a conflict of interest another Non-Executive Director shall preside in those circumstances and theyhe/she shall exercise all the rights and obligations of the ~~Chairman~~Chair including the right to exercise a second or casting vote (SO 3.16).

4.4 If any matter for consideration at a meeting of the Council relates to the conduct or interests of the ~~Chairman~~Chair or to the conduct or interest of the non-executive Directors as a class, neither the ~~Chairman~~Chair nor any of the non-executive Directors shall preside over the period of the meeting during which the matter is under discussion. In such circumstances, the Governors (excluding the ~~Chairman~~Chair) shall elect one of their number to preside during that period (SO 3.16).

4.5 Meetings of the Council of Governors shall be open to the public unless they are excluded for special reasons, in accordance with the Standing Orders of the Council of Governors (SO 3.1 and 3.2).

5 DUTIES

In order to effectively fulfil its Purpose the duties of the Council will include responsibilities to:

5.1 Act at all times in accordance with the Trust's Constitution and Terms of Authorisation;

5.2 Promote achievement of the Trust's objectives within its Terms of Authorisation and of its Principal Purpose as set out in the Constitution;

5.3 Appoint or reappoint the ~~Chairman~~Chair of the Trust and its non-executive directors in accordance with the Constitution and having due regard to the recommendations of the Appointments and Remuneration Committee of the Council of Governors (~~Constitution~~ Constitution s~~Annexe 8,~~ 20.~~1~~) and having

taken into account the views of the Board of Directors on the qualifications, skills and experience required for each position as non-executive director (Code~~ sC 2.3 and 2.4C.1.6~~);

5.4 Remove the ~~Chairman~~Chair of the Trust or any of the non-executive directors, providing that the Council has first exhausted all other means of resolving any matter at issue, in accordance with the Code of Governance (sC relevant statutory requirements (2.13)~~Code B.1.10~~);

5.5 Approve the appointment of the Trust's Chief Executive by the non-executive directors (sC relevant statutory requirements (2.11)~~Constitution s22~~);

5.6 Decide the remuneration, allowances and other terms and conditions of office, of the Trust ~~Chairman~~Chair and non-executive directors, having due regard to the recommendations of the Appointments and Remuneration Committee of the Council of Governors (Constitution, s27.1);

5.7 Led by the ~~Chairman~~Chair, periodically assess the Council's collective performance and effectiveness (Code~~ sC: 4.8D.2.2~~);

5.8 Regularly communicate to members how the Council has discharged its responsibilities, including advising the Board of Directors on the forward plans for the NHS Trust, and communicating the views of members to the Board of Directors (Code~~ sC: 4.8D.2.2~~);

5.9 Approve significant transactions, mergers, acquisitions, separations and dissolutions proposed by the Board of Directors in accordance with relevant guidance, ensuring that the Board of Directors has followed due process and, through appropriate liaison and communication with members and other stakeholders, is satisfied that the views and interests of members and the public have been taken into account;

5.10 Notify ~~Monitor~~ NHS England if the Council is concerned that the Trust is at risk of breaching its Terms of Authorisation, having first determined that these concerns cannot be resolved at the local level (Code sC4.10~~ B.1.9~~);

5.11 Agree with the Audit Committee of the Board of Directors, the criteria for appointing, reappointing or removing the Trust's External Auditors (Code ~~F.3.4~~sD, 2.3 and 2.5.);

5.12 Having taken into account the recommendations of the Audit Committee, appoint, re-appoint or remove the Trust's External Auditor and approve the remuneration and terms of engagement of the External Auditor (Constitution, s31) (~~Code F.3.5~~Code sD, 2.3 and 2.5);

5.13 Receive the Trust's annual accounts, any report of the auditor on the annual accounts, and the annual report (Constitution, s35, Code, Appendix B s3);

5.14 Consider complaints about any member of the Trust in accordance with Annex 8 of the Constitution and take action, which may include expulsion from membership of the Trust;

5.15 Consider, in accordance with Annex 5 to the Constitution and the ~~Monitor's~~ Code of Governance (~~Code D.2.3~~sB.4.9), the removal from the Council of any Governor who:

- has committed a serious breach of the Trust's Code of Conduct for Directors and Governors or whose behaviour or conduct is incompatible with the values to be expected; or
- has acted in a manner detrimental to the interests of the Trust; or
- fails to disclose any interest that is required to be disclosed; or
- unreasonably fails to attend two meetings of the Council in any financial year; or
- has a conflict of interest incompatible with their position on the Council; or
- fails to discharge their duties as a Governor; or
- the Council considers that it would be in the best interests of the Trust for them to be so removed.

5.16 Engage with the Board of Directors with respect to the above and any circumstances in which the Council has concern about the performance of the Board of Directors, compliance with the Terms of Authorisation or the welfare of the Trust (Code s B.1.2~~7~~).

6 DECLARATION OF INTERESTS

6.1 All members must declare any actual or potential conflicts of interest relevant to the work of the Committee, which shall be recorded in the Minutes accordingly. Members should exclude themselves from any part of a meeting in which they have a material conflict of interest. The Chair will decide whether a declared interest represents a material conflict.

7. COMMITTEE OF THE COUNCIL

7.1 The Council is required by the Constitution to establish an Appointments and Remuneration Committee, which has authority to act in accordance with its Terms of Reference (which are attached at Appendix~~nnex~~ B~~A~~).

8. REPORTING AND REVIEW OF EFFECTIVENESS

8.1 Minutes will be prepared after each meeting of the Council within 14 days and circulated to members of the Council and others as necessary once confirmed by the person presiding as chair.

8.2 The Council will carry out an annual review of its performance and function in satisfaction of these Terms of Reference and report to the Council on any consequent recommendations for change.

Appendix A – Lead Governor

1. The lead governor has a role in facilitating direct communication between NHS England and the NHS foundation trust'scouncil of governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate tocommunicate through the normal channels, which in most cases will be via the chair or the trust secretary, if one isappointed.

2. It is not anticipated that there will be regular direct contact between NHS England and the council of governors in theordinary course of business. Where this is necessary, it is important that it happens quickly and in an effective manner. Tothis end, a lead governor should be nominated and contact details provided to NHS England, and then updated as required.Any of the governors may be the lead governor.

3. The main circumstances where NHS England will contact a lead governor are where we have concerns about the boardleadership provided to an NHS foundation trust, and those concerns may in time lead to our use of our formal powers toremove the chair or non-executive directors. The council of governors appoints the chair and non-executive directors, and itwill usually be the case that we will wish to understand the views of the governors as to the capacity and capability of theseindividuals to lead the trust, and to rectify successfully any issues, and also for the governors to understand our concerns.

4. NHS England does not, however, envisage direct communication with the governors until such time as there is a realrisk that an NHS foundation trust may be in breach of its licence. Once there is a risk that this may be the case, and thelikely issue is one of board leadership, we will often wish to have direct contact with the NHS foundation trust's governors,but quickly and through one established point of contact, the trust's nominated lead governor. The lead governor shouldtake steps to understand our role, the available guidance and the basis on which we may take regulatory action. The leadgovernor will then be able to communicate more widely with other governors. Similarly, where individual governors wish tocontact us, this would be expected to be through the lead governor.

5. The other circumstance where NHS England may wish to contact a lead governor is where, as the regulator, we havebeen made aware that the process for the appointment of the chair or other members of the board, or elections forgovernors or other material decisions, may not have complied with the NHS foundation trust's constitution, or alternatively, while complying with the trust's constitution, may be inappropriate. In such circumstances, where the chair, other membersof the board of directors or the trust secretary may have been involved in the process by which these appointments or otherdecisions were made, a lead governor may provide us with a point of contact.

Appendix ~~NNEX~~ BA~~

APPOINTMENTS AND REMUNERATION COMMITTEE OF THE COUNCIL OF GOVERNORS

TERMS OF REFERENCE

1 CONSTITUTION

In accordance with the Constitution of the Trust (the 'Constitution') and NHS England's Code of governance for NHS Provider trusts ~~Monitor's Code of Governance for Foundation Trusts (2010)~~ (the 'Code')[2], a Committee of the Council of Governors shall be formed to be known as the Appointments and Remuneration Committee (the 'Committee').

Provisions relevant to the Committee are contained in Section 4 of the Standing Orders for the Council of Governors at Annex 6 to the Constitution ('SO'). The Standing Orders of the Council, as far as they are applicable, shall apply with appropriate alteration to meetings of the Committee including those provisions that relate to potential conflicts of interest, such as Standing Orders 5 and 6.

2 AUTHORITY

The Committee has no executive powers.

3 MEMBERSHIP

Membership of the Committee shall consist of:

- the ~~Chairman~~Chair of the Trust; and
- no less than 3 and no more than 5 Governors (SO 4.1) of whom 1 shall be a Governor elected by a staff constituency and 1 shall be an Appointed Governor.

4 ATTENDANCE

The Committee may seek advice and assistance from persons other than members of the Committee and may invite non-members to attend its meetings as it considers necessary and appropriate.

5 MEETINGS and QUORUM

5.1 The Committee will be chaired by the ~~Chairman~~Chair of the Trust (Code C.2~~1~~.3) who, in the case of any tied vote will have a casting vote (SO 13.1).

5.2 If any matter for consideration at a meeting of the Committee relates to the interests of the ~~Chairman~~Chair, the ~~Chairman~~Chair shall not preside over the period of the meeting during which the matter is under discussion. The remaining Committee Members (excluding the ~~Chairman~~Chair) shall elect one of their number to preside during that period and that person shall exercise all the rights and obligations of the ~~Chairman~~Chair including the right to exercise a second or casting vote.

5.3 No business of the Committee shall be transacted at a meeting of the Committee unless at least four members of the Committee are present (SO 4.6).

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[2] A copy of the Code can be found at: https://www.england.nhs.uk/long-read/code-of-governance-for-nhs-provider-trusts/ ~~http://www.monitor-nhsft.gov.uk/publications~~

5.4 If a Governor or the ~~Chairman~~Chair has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (SO 5 or 6) ~~he/she~~ they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in any minutes of the meeting. The meeting must then proceed to the next business (SO 4.6).

6 FUNCTION and PURPOSE

The function and purpose of the Committee will include responsibilities to:

6.1 Concerning appointment of non-executive directors (including ~~Chairman~~Chair of the Trust):

6.1.1 Request, and take into account the views of the Board of Directors on the qualifications, skills and experience required to adequately fill any actual or anticipated vacancy as non-executive director (Code C.2.7~~1.6~~);

6.1.2 Prepare job specifications defining the role and capabilities required for appointment as non-executive director (including ~~Chairman~~Chair of the Trust), including an assessment of the expected time commitment recognising the need for availability in the event of emergencies (Code C.2~~1~~.7);

6.1.3 Receive from the Nominations Committee of the Board of Directors, details of candidates short-listed for interview for appointment as non-executive directors, including ~~Chairman~~Chair of the Trust (SO 4.2);

6.1.4 Interview candidates nominated by the Nominations Committee (as per paragraph 6.1.3 above) and make recommendations to the Council for appointment in accordance with the Constitution (Code C.2~~1~~.4; Constitution 20.1);

6.1.5 Ensure that any non-executive directors (including the ~~Chairman~~Chair) are appointed for specific terms subject to re-appointment thereafter at intervals of no more than 3 years, subject to provisions concerning removal of directors at section 20 of the Constitution (Code C.4.3~~2.2~~).

6.2 Concerning re-appointment of non-executive directors:

6.2.1 Consider the re-appointment of non-executive directors at the conclusion of their term of office and make recommendation to the Council of Governors accordingly;

6.2.2 When considering the re-appointment of non-executive directors, request and take into account the views of the ~~Chairman~~Chair of the Trust on whether the performance of the individual proposed for re-appointment continues to be effective and demonstrates commitment to the role (Code C.2.14~~2.2~~);

6.2.3 When proposing the length of term for re-appointment of any non-executive director, take into account the dates on which the terms of the other non-executive directors are expected to end, with a view to ensuring continuity and an orderly succession of appointments to the Board of Directors (Code C.1);

6.2.4 Propose the re-appointment of a non-executive director beyond a total term of office of 6 years only after particularly rigorous review, taking into account the need for progressive refreshing of the Board (Code C.4.3~~2.2~~);

6.2.5 Propose the extension of the term of office of any non-executive director who has been on the Board for longer than 6 years, only on the condition that it is subject to annual re-appointment (Code C.4.3~~2.2~~).

6.3 Concerning remuneration of non-executive directors:

6.3.1 On an annual basis recommend, for decision at a general meeting of the Council of Governors, the levels of remuneration, allowances and terms of service for the ~~Chairman~~Chair and other non-executive directors ensuring that these reflect the time commitment and responsibilities of their roles (Code E.2.4~~1.2~~, Constitution 27.1, SO 4.7);

6.3.2 Consult external professional advisors to 'market-test' the remuneration levels of the ~~Chairman~~Chair and other non-executive at least once every 3 years or when it is intended to make a significant change to the remuneration of a non-executive (~~Code E.2.3~~);

6.3.3 Develop mechanisms to ensure that the Committee is informed of comparative levels of remuneration for non-executive directors in other organisations and other Foundation Trusts in particular.

6.3.4 Receive reports on behalf of the Council of Governors on the process and outcome of appraisal of the ~~Chairman~~Chair and non-executive directors (SO 4.8).

6.4 The Committee will review these terms of reference annually, making recommendations to the Council as appropriate.

7 CONFIDENTIALITY

No member of the Committee shall disclose information relating to any matter dealt with by, or brought before, the Committee without its prior permission (SO 4.9).

8 REPORTING

The minutes of Appointments and Remuneration Committee meetings shall be formally recorded and submitted to the Council. The Chair of the Committee shall report to the Council on the proceedings of the Committee and any issues that require action.

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

REPORT TO THE COUNCIL OF GOVERNORS	
Date	**24 April 2025**
Title	**Communications & Engagement Report**
Author(s) & Exec Lead	**Janice Bradfield, Head of Communications**
Purpose	**For Discussion**

This report gives a summary of the key communication issues, Governor and member activities, plus an analysis of the Trust's Membership:

- Recent communications and media developments
- Governor activities, including links to the Norfolk & Norwich Hospitals Charity
- Membership update

Recommendations:

The Council is recommended to:

- Note the communications issues
- Comment on the activities taking place for both Governors, members and the charity:
- Comment on the Membership analysis.

1.1 Communications report

Here is an overview of the main news stories over the last few months. More news and information, is available on the Governors' Portal or the Trust's intranet for those with NNUH email addresses: Home Page - the Beat

- The first group appointment was announced on 25 March when Mark Friend was appointed as Interim Group Chair of the Norfolk and Waveney University Hospitals Group. Mark, who is currently Chair of the James Paget University Hospital (JPUH), took up his post on 7 April
- Following consultation, the structure of our 10 Care Groups, which will replace our four current Divisions, was finalised on 31 March
- We welcomed Marcus Thorman to the Trust as our interim Chief Finance Officer (CFO) on 21 March
- The Freedom to Speak Up service was promoted to staff on 20 March with a reminder of how to access the service
- The staff survey results were published on 13 March with a total of 4,508 staff (47%) responding and, overall, results were in line with last year
- The Covid Day of Reflection was marked with an event held by the Chaplaincy Team in March
- At the end of February, we fully opened our Community Diagnostic Centre (CDC).

2.1 Governor activities

It has been an extremely busy past three months for the CoG. Whilst much of our focus has been on supporting the development and initiation of the Norfolk and Waveney University Hospitals Group, governors have done a great job in providing internal observation, review and feedback, undertaking public outreach initiatives and supporting the NNUH charity.

2.2 Welcome to new governors

In January, we welcomed 2 staff governors and 4 elected governors to the Council. The induction meeting took place on January 14th

2.3 Selection and Recruitment of Group Chair

- In line with our statutory responsibilities and with specific reference to the appointing of a Group Chair, governors:
- Noted the decision of the Non-Executive Directors (NEDs) to appoint an interim Group Chair for a period of six months
- Approved that the appointment of the interim chair would be ring fenced to limit applications to the incumbent Chairs
- Approved that CoGs appoint a joint nominations committee to select the preferred Chair candidate
- Noted the proposed approach agreed by the NEDs to the appointment of a Vice/Deputy Chair and that this would be conducted in line with each Trust's constitution.
-

As part of the Governor Nominations and Remunerations Committees in Common, governors:

- Defined the competencies, experience and leadership qualities required for the group Chair role
- Participated in the appointment process via pre-interview candidate presentations to all CoGs, followed by participation within the interview panel
- Recommended the preferred candidate to the full CoG
- Ratification of Group CEO selection and recruitment process
- The CoG also ratified that with reference to the selection and appointment process of the Group CEO, due process had been followed.

2.4 Appointment of NEDs

We have also approved the extension of term for an existing NED and approved the appointment of an existing Associate NED to a NED position.

2.5 Observation at Board Assurance Committees

Governors have attended and observed the following Board Assurance Committees:

- People and Culture
- Finance, Investments and Performance
- Research and Education
- Quality and Safety
- Audit

Governors have participated in the following Care Assurance audits:

- General Surgery OP
- AMU I
- Jenny Lind Outpatients
- EAUS
- Endoscopy QI
- Coltishall Ward
- Kimberley Ward

2.6 Attendance at Patient Panels

Governors continue to play an observational role at patient panel meetings each month.

2.7 Cromer and District Hospital

Governors have continued to lead and participate in the monthly Carers Café. Interest and participation in the event have grown significantly, especially over the last 3 months.

Governors are also supporting the planning work to support NNUH Charity with the Midsummer Fete on June 21.

2.8 Jenny Lind Hospital

We now have two designate link governors now forging strong relationships with Jenny Lind and the CoG

2.9 Sustainability

Our governors continue to support all NNUH sustainability initiatives and participate in regular informal meet ups with the sustainability team.

2.10 Oncology Services

A governor participated in discussions with staff relating to the 2021-26 Cancer Plan

2.11 Outreach to constituencies

The following initiatives have been undertaken to support our public outreach

- Submission of profile for inclusion in the South Norfolk Link magazine in an attempt to reach out to the public in the South Norfolk region
- Governor presence at local PPGs.

2.12 Governor visits

Governors welcomed the opportunity to visit both Priscilla Bacon Lodge in January and the newly opened Community Diagnostic centre in March. On each occasion, the tours were really informative and insightful.

2.13 Development of governor workstreams

In March, governors participated in a governor led forum to scope the potential to develop and implement working groups/task forces. The meeting was very productive and it's hoped these additional get togethers may become a regular part of our calendar going forward.

2.14 NNUH Charity

- Governors continue their great support to the NNUH Charity
- Multiple fundraising events have been supported including raffle ticket sales, N&N Hospitals Charity collection box delivery across the Broadland area and support with the planning of the Cromer Hospital Midsummer Fayre
- In early April, the lead governor met with the Head of Charity to scope how best the governor group might further support fund raising initiatives going forward. This work will be included within the proposed workstreams going forward.

3.1 Future events

Here are the key dates for events in 2025:

- 80th anniversary of VE Day – 11am on Thursday 8 May on the plaza with the chaplaincy team

- Dementia Fayre – Wednesday 21 May
- The N&N Hospital Charity has organised a marquee at Norfolk Show – Wednesday 25 and Thursday 26 June
- AGM – Wednesday 1 October.

3.2 Future meeting dates for Council of Governors

All meetings held from 10am to 12pm (in the Boardroom) or on MS teams

- 10am to 12pm on Thursday 24 July
- 10am to 12pm on Thursday 23 October.

3.3 Dates for informal meetings with Governors

All meetings are held in the boardroom or online:

- Thursday 22 May 10am to 12pm
- Thursday 11 September 10am to 12pm
- Thursday 20 November **9am to 11am.**

3.4 Trust Board meetings (start at 9.30am)

Governors are welcome to observe the public Trust Board meeting and join online from 9.30am to 11.30am:

- 4 June
- 10 September
- 5 November.

4.1 Membership analysis

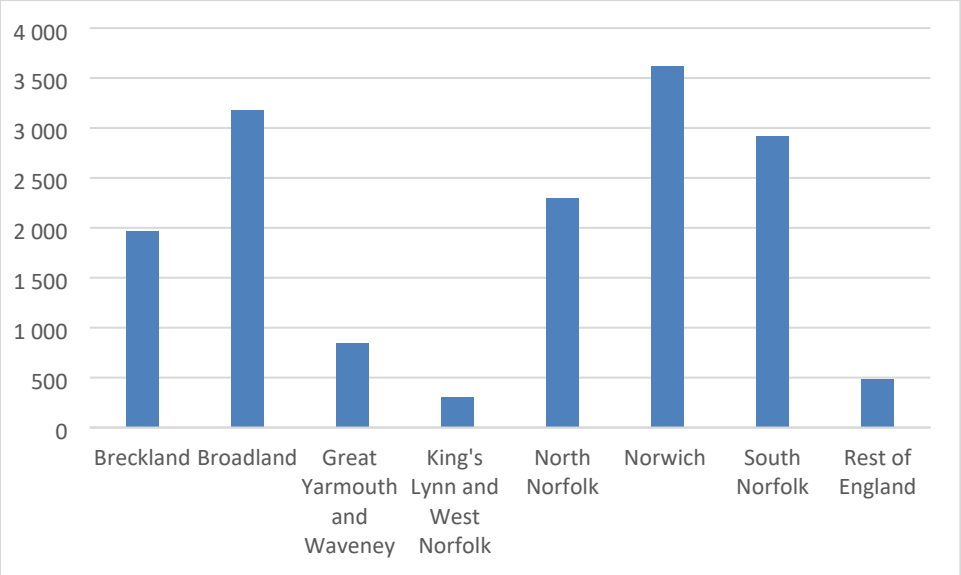
The Trust has an obligation to ensure that its Membership is representative of the population served by the Trust.

4.2 Breakdown by geography

The Trust's Membership is divided into constituencies which are consistent with local authority boundaries. Our current Public Membership numbers are as follows:

Constituency	Number of members
Breckland	1851
Broadland	2994
Great Yarmouth and Waveney	807
King's Lynn and West Norfolk	266
North Norfolk	2,101
Norwich	3,387
South Norfolk	2,816
Rest of England	317
Total	**14,539**

As previously discussed, and as may be expected, our membership is proportionately low in the constituencies to the east and west of the County, where there is an alternative local foundation trust membership available.



4.3 Breakdown by demography

The table below shows a breakdown of our public membership is under-represented compared to the local population is in the younger age groups and amongst ethnic minority groups.

Age	Total 14,539	% membership	% of population
17-21	101	0.6%	5.46%
22+	10,001	68%	76.6%
Unknown	4437		

Age bands	
22-29	338
30-39	784
40-49	872
50-59	1,603
60-74	2,661
75+	3,743

Gender	Total 14,539	% membership	% of population
Male	6,621	45.5%	49.1%
Female	7,916	54.4%	50.9%
other	2	0%	

Ethnicity	**Numbers**	**membership**	**Norfolk population**
Asian	116	0.7%	1.5%
Black	52	0.3%	0.5%
Mixed	74	0.5%	1.2%
Other ethnic group	262	1.8%	0.3%
White	6,721	46.2%	96.5%
Not specified	7,576		
Monitor classifications for socio-economic group			
AB	4,025	28.0%	18.06%
C1	4,134	28.4%	29.28%
C2	3,178	21.8%	25.21%
DE	3,174	21.8%	27.46%