

# Council of Governors (Public) - 24 July 2025

Thu 24 July 2025, 10:00 - 11:00

Boardroom

## Agenda

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**10:00 - 10:00** **Agenda**

0 min

 DRAFT 24 July 2025 COG Public Agenda.pdf (2 pages)

**10:00 - 10:00** **1. Welcome**

0 min

*Information* *Chair*

**10:00 - 10:00** **2. Apologies**

0 min

*Information* *Chair*

**10:00 - 10:00** **3. Declarations of Interest**

0 min

*Information* *Chair*

**10:00 - 10:00** **4. Minutes of the meeting 24 April 2025**

0 min

 Unconfirmed Public COG 24.04.2025.pdf (6 pages)

**10:00 - 10:00** **5. Action Log and Matters Arising from Minutes**

0 min

*Information* *Chair*

 COG Actions Update Table Public.pdf (2 pages)

**10:00 - 10:00** **6. Group Chief Executive Report**

0 min

*Information* *Lesley Dwyer*

**10:00 - 10:00** **7. Group Chair Report**

0 min

*Information* *Mark Friend*

**10:00 - 10:00** **8. Executives Managing Directors Report**

0 min


*Information* *Tracey Bleakley*

**10:00 - 10:00** **9. Finance Update Report YTD**

0 min

*Information* *Marcus Thorman*


 Governors Cover Sheet - M2 Finance Report.pdf (1 pages)

 Trust Finance Report M02 - Governors.pdf (2 pages)

**10:00 - 10:00** **10. Annual Report**

0 min

*Information Adam Gretton*

 Annual report and accounts - July 2025.pdf (1 pages)

 NORWICH Annual Report and Accounts 2024-25 - Signed.pdf (208 pages)

## 10:00 - 10:00 **11. Membership Update and Engagement Report**

0 min

*Information Adam Gretton*


 membership paper - July 2025.pdf (9 pages)

## 10:00 - 10:00 **12. Patient Panel Update**

0 min

*Information Sarah Higson*

 Patient Panel Annual Review 23 24(V3)240681.pdf (16 pages)

 Patient Panel Terms of Reference[18697.7].pdf (5 pages)

## 10:00 - 10:00 **13. Questions and Responses**

0 min

*Information Chair*

## 10:00 - 10:00 **14. Communications**

0 min

*Information Joanna Hannam*

## 10:00 - 10:00 **15. Any Other Business**

0 min

## Council of Governors Meeting

To be held in public on Thursday 24 July 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 <ul style="list-style-type: none"> <li>Apologies -</li> <li>NEDS Scheduled to attend</li> </ul>		Chair	Assurance
3.	Declarations of Interest		Chair	Assurance
4.	Minutes of the meeting held in public on 24 April 2025		Chair	Approval
5.	Action Log and Matters arising from Minutes		Chair	Discussion
6.	Group Chief Executive's	10:05- 10:15	CEO	Information
7.	Chair Report		Chair	Information
<b>Operational Updates</b>				
8.	Executive Managing Directors Report	10:15- 10:20	TB	Information
9.	Finance update report (YTD)	10:20- 10:30	MT	Information
10.	Annual Report	10:30- 10:35	AG	Information
<b>Strategic Items</b>				
11.	Membership Update and Engagement Report	10:35- 10:50	AG	Information
12.	Patient Panel Update	10:50- 10:55	SH/RM	Information
13.	Questions and Responses		Chair	Information
<b>Business Items</b>				
14.	Communications	10:55- 11:00	JH	Information
15.	Any other business		Chair	Discussion

**Distribution:** Council of Governors, Board of Directors and Trust website

**Contact details:** Janice Bradfield, Membership Manager, Norfolk and Norwich University Hospitals  
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**Date and Time of next meeting in public:** The next Council of Governors meeting in public will be at 10am on 23 October 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>

DRAFT

## MINUTES OF COUNCIL OF GOVERNORS MEETING

HELD ON 24 APRIL 2025

<b>Present:</b>	Mr M Friend	- Interim group Chair
	Mr T Spink	- Vice Chair
	Mrs S Asghar	- Volunteers/Contracted (staff)
	Mrs E Bailey	- North Norfolk (public)
	Cllr C Baxter	- Rest of England (public)
	Mrs E Betts	- Breckland (public)
	Mrs A Cook	- Norwich (public)
	Mrs C Cubelo	- Nursing and Midwifery (staff)
	Mrs C Edwards	- North Norfolk (public)
	Dr B Fleming	- South Norfolk (public)
	Mrs M Frost	- Clinical Support (staff)
	Mrs I Grote	- Great Yarmouth/Waveney (public)
	Mrs C Hailey	- Nursing and Midwifery (Staff)
	Mr C Hind	- South Norfolk (public)
	Mrs G Lynch	- Admin & Clerical (staff)
	Mr K May	- Broadland (public)
	Mr D McNeil	- Breckland (public)
	Mr D Moncur	- Norwich (public)
	Cllr A Thomas	- Norfolk County Council (partner)
	Mr R Wharton	- Medical (Staff)
<b>In attendance:</b>	Mrs J Bradfield	- Senior Communications & Membership Manager
	Mrs E Batchelor	- Assistant to Board Secretary
	Mrs L Dwyer	- Chief Executive
	Mrs R Millbourne	- Interim Chief of Staff
	Mrs N Gray	- Non-Executive Director
	Mrs S Dinneen	- Non-Executive Director
	Prof P Baker	- Non-Executive Director

25/010 **APOLOGIES AND DECLARATIONS OF INTEREST**

Apologies were received from Mrs Swallow, Mr Bush, Dr Epurescu. No conflicts of interest were declared in relation to matters for consideration by the Council. It was Noted that Mr Friend will provide a Declaration of Interest form to Mrs Batchelor to be shared and uploaded to the Trust Website.

25/011 **MINUTES OF PREVIOUS MEETING HELD ON**

The minutes of the meeting held on 23.01.2025 were agreed as a true record for signing by the Chair.

25/012 **MATTERS ARISING**

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

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: Carried Forward 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: Carried Forward Mr Garside and Council Members**

### 25/013 **CEO REPORT**

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

- Performance – Professor Dwyer highlighted the organisation's efforts in reducing escalation spaces and improving recovery plans post-Easter and mentioned the submission of the 25/26 operational plan and the focus on cost improvements and risk mitigation.
- Infection preventions and Control - Professor Dwyer discussed the infection prevention and control response, noting positive feedback from the ICB
- Clinical Leadership Structure – Professor Dwyer outlined the new clinical leadership structure, emphasising care group formation and recruitment
- Reshaping our Workforce – Professor Dwyer addressed the reshaping of the workforce, explaining the need to reduce headcount and the process for voluntary expressions of interest, assuring that the organisation is working to support staff through this transition and emphasised the importance of communication. Governors asked if the numbers in the report are related directly to the Norfolk and Norwich in which they are. The requirement is to reduce by around 500 and corporate will be 100 of this. The Trust will need to ensure that there is a balance in skill mix and the voluntary redundancies are looked at on a case by case basis. There is a national timeline for October for the ICB, NHS England and some Trusts to have formed a new shape and however some areas will move at a faster pace.
- Easter holiday Planning

Professor Dwyer expressed gratitude to the governors for their support.

Councillor Thomas informed the governors that in her position as a cabinet member for adult social care she has been having ongoing talks with Iain Wake the Executive Director and the chance for him to come and talk at our informal meeting to share his oversight and visions of the transformation for social care. It was suggested this could also been done at James Pagett and Queen Elizabeth.

**Action: Cllr Thomas and Mr Spink**

Mr Friend briefly noted that the Group intentions are not to be a thin layer it is to be leadership across the three Trusts including Place and Group. Mr Spink will stay at the Norfolk and Norwich. The group are looking to move to certainty about some of the other group roles fairly quickly.

### 25/014 **QUESTIONS AND RESPONSES**

During the meeting, several advance notice questions were addressed. Key topics included the CDC access and patient mobility challenges, with discussions on improving signage, lighting, and potential solutions like volunteer-driven buggies and designated parking spaces. Concerns

about the Spire contract and patient communication were raised, highlighting the need for better synchronisation between the Trust and Spire. The importance of effective communication during the workforce reshaping process was emphasised, with suggestions for clear timelines and addressing staff anxieties. Additionally, the need for better support and communication for staff during the accreditation process was discussed, ensuring that the process is seen as supportive rather than punitive. All advance notice questions will receive a written response and these will be available to the governors in the Governor Portal.

The Supreme Court ruling was briefly discussed in the context of its definition of male and female sex. Mr Fleming raised a question about whether the Trust is addressing this ruling in terms of its staff. Professor Dwyer responded that the Board has not formally sought assurance yet but plans to discuss it at the next board meeting and a paper will be presented to the Board regarding this matter.

The governors held a discussion on Nanoc covering several key points. Professor Dwyer mentioned that Nanoc 1 has seen increased utilisation, although recruitment for anaesthetics remains a challenge due to national shortages. Efforts are being made to address this with specific work on anaesthetics. Nanoc 2 is progressing, with the major projects group now handling its development alongside major trauma and mechanical thrombectomy for stroke. The importance of using Nanoc 1 effectively was emphasised to ensure future funding for Nanoc 2.

#### 25/015 **FINANCE REPORT**

The Governors received the finance report for month 11 from Mrs Sanford which indicated a year-to-date deficit of £3.1 million, which is £2.1 million adverse to the planned position. The forecast was adjusted to a break-even position due to additional non-recurrent income support. The accounts for 2024-2025 will be submitted with a break-even position. The target savings for 2025-2026 are set at £44 million, which is challenging but necessary for financial sustainability. The impact of the PFI contract was discussed, noting that renegotiation is not possible, but potential savings could be explored in Soft FM services.

The finance team are continuing working with turnaround colleagues to convert non-recurrent savings into recurrent savings for long-term sustainability and will be exploring potential savings in Soft FM services as part of the ongoing review.

Professor Dwyer informed the council that NHS England have been clear they will look at each Trust individually as statutory requirements will remain at each Trust but going forward for the next financial year, there is likely to be commissioning for each service at the Group level. The Group will work with each Trust to determine what this means for the individual Trusts.

#### 25/016 **CARE ASSURANCE AND ACCREDITATION FOR EXCELLENCE AUDIT PROGRAMME**

Mrs Nurse provided an overview of the care assurance framework, which has been in place since 2021, focusing on inpatient and outpatient areas. The framework includes peer reviews supported by internal and external members, patient panels, governors, and the ICB. It covers clinical practice, staff data, patient voice, environmental factors, IPC, quality, and safety. The care assurance framework has led to significant improvements, particularly in outpatient areas.

The accreditation of excellence was introduced, focusing on clinical care quality, empowering ward leaders, and providing organisational support. The accreditation process involves visiting wards over several days, triangulating data, talking to staff and patients, and observing care practices.

The accreditation framework includes 13 standards aligned with CQC quality statements and organisational priorities. Next steps include expanding accreditation to maternity, women's and

children's teams, outpatient areas, and incorporating patient voice through the 15 steps challenge.

Mr May asked about data trends between different parts of the organisation and whether outcomes are trended between wards. Mrs Nurse confirmed that data is trended and themes are identified across clinical areas.

Mrs Edwards inquired about the involvement of Cromer in care assurance visits. Mrs Nurse confirmed that her team is currently at Cromer and working with Anita to develop accreditation frameworks.

Mr Wharton expressed concerns about the stress and well-being of ward sisters and charge nurses during the accreditation process to which Mrs Nurse acknowledged the stress but emphasised the support provided to staff and the importance of highlighting organizational improvements.

Mrs Cook raised concerns about the weighting of questions in care assurance visits, particularly the patient voice and Mrs Nurse agreed that weighting is a challenge and emphasised the need to improve patient voice in the accreditation framework.

Mr Fleming asked about the purpose of the accreditation process and whether it is competitive. It was explained that the process aims to ensure high-quality care and identify areas for organisational support.

The Governors discussed this at length and Mrs Nurse took on all the feedback and will reflect this back to her team.

#### 25/017 **TERMS OF REFERNECE**

The Council received the Term of Reference from Mrs Millbourne

The terms of reference for the Council of Governors were reviewed and updated to align with new guidance. Key changes included the inclusion of appointed governors, clarification on the maximum term for governors (nine years), and the timing of appraisals for non-executive directors and the chair.

The Council of Governors **Approved** the updated terms of reference with these changes, and it was noted that further alignment with the governance models of the other trusts would be beneficial.

It was noted that the appraisal timing guidance for NEDS has just been issued and Mr Spink confirmed that the dates and in the diary for the non executives 360s.

#### 25/018 **COMMUNICATIONS AND ENGAGEMENT REPORT**

The governors received the communications report which highlighted the introduction of a governor's portal, which will serve as a centralised hub for key dates, news links, and documents. This portal aims to streamline information access for governors. Additionally, there is an initiative to transition more members to receive the Pulse magazine digitally, which is part of the department's efforts to enhance savings and efficiency. The report also addressed the need for improved communication strategies to mitigate the spread of misinformation and ensure staff and governors are well-informed about ongoing changes, including restructuring and the group model.

It was asked if The Beat would be added to the portal however due to this being for staff and without an NNUH email address this can not be accessed therefore if there is anything the

Governors would like to see then they should inform Mrs Bradfield who can then add that to the portal.

Mr Friend expressed how impressed he is with how active the Governors are and how it is all linked back.

25/019 **ANY OTHER BUSINESS**

Mrs Bailey formally welcomed Mr Friend as the new chair and congratulated Professor Dwyer on their Group appointment. Mrs Bailey also expressed gratitude to Mrs Millbourne for their extraordinary efforts in organising and supporting the team.

Mr Friend acknowledged the pace of changes and thanked everyone for their patience and time. Mr Friend confirmed that Mr Spink will lead the Governor assurance model change activity.

25/020 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Council of Governors will be held on 24 July 2025 in the Boardroom of the Norfolk and Norwich University Hospital

Signed by the Chairman: ..... Date: .....  
Confirmed as a true record by the Council on 24 July 2025

**Decisions Taken:**

25/011 – Minutes of the Previous Meeting	The minutes of the meeting held on 23.01.2025 were agreed as a true record for signing by the Chair.
25/017 – Terms of Reference	The Council of Governors <b>Approved</b> the updated terms of reference with these changes, and it was noted that further alignment with the governance models of the other trusts would be beneficial.

**Action Points Arising:**

<b>Actions Carried Forward:</b>	
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.  <b>Action: Mr Prosser- Snelling</b>
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

	<p>charity's visibility and asked that they replied with suggestions of local places where the charity can distribute magazines and collection tins.</p> <p><b>Action: Mr Garside and Council Members</b></p>
<p><b>Actions Arising on 24.04.2025</b></p>	
<p>25/013 – Chief Executive Report</p>	<p>Councillor Thomas informed the governors that in her position as a cabinet member for adult social care she has been having ongoing talks with Iain the Executive Director and the chance for him to come and talk at our informal meeting to share his oversight and visions of the transformation for social care. It was suggested that this could also been done at James Pagett and Queen Elizabeth.</p> <p><b>Action: Cllr Thomas and Mr Spink</b></p>

### Action Points Arising from Council of Governor meeting (Public)

Actions Carried Forward:		
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.  <p style="text-align: right;"><b>Action:</b> <b>Mr Prosser- Snelling</b></p>	<b>On going</b>
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.  <p style="text-align: right;"><b>Action: Mr Garside and Council Members</b></p>	
New Actions from 24 April 2025		
25/013 – Chief Executive Report	Councillor Thomas informed the governors that in her position as a cabinet member for adult social care she has been having ongoing talks with Iain the Executive Director and the chance for him to come and talk at our informal meeting to share his oversight and visions of the transformation for social care. It was suggested that this could also been done at James Pagett and Queen Elizabeth.  <p style="text-align: right;"><b>Action: Cllr Thomas and Mr Spink</b></p>	



## REPORT TO THE GOVERNORS

Date	24 <sup>th</sup> July 2025		
Title	Month 2 IPR - Finance		
Author & Exec lead	Marcus Thorman (Group 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 May 2025 within the context of the current financial regime the NHS is operating under. The Trust Finance Report Executive Dashboard for May 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 £4.5m net deficit on a control total basis, £1.7m adverse to the planned £2.8m deficit.
- Capital – the Year to Date spend is £1.8m, a £10.2m underspend against the planned £12.0m
- Activity – Performance against the value based activity plan is £0.4m adverse Year to Date
- Efficiency Savings - Year to Date efficiency of £1.9m has been delivered, against a plan of £4.8m, £2.9m adverse

The Council of Governors is requested to read the attached summary and present any questions to the Group Chief Finance Officer

# Finance Report May 2025

## 24 July 2025

**Marcus Thorman, Chief Finance Officer**

## 1. Executive Dashboard

The Trust operational plan for FY25/26 as outlined in Cycle 3 of the 2025/26 planning process is breakeven. Performance is measured against this.

**May position is a £1.1m deficit on a control total basis, £0.2m adverse to the planned £0.9m deficit.**

Income is £2.8m favourable to plan, including £2.1m of pass-through income. Pay is £0.9m adverse, including £0.5m of redundancy costs and £0.4m under-delivery of CIP. Non-pay is £3.4m adverse, including £1.2m under-delivery of CIP and £2.1m of pass-through costs. Net drugs expenditure is £0.7m favourable. Non-Operating costs are £0.5m favourable.

**Year to date position is a £4.5m deficit on a control total basis, £1.7m adverse to the planned £2.8m deficit.**

Income is £3.2m favourable to plan, including £3.0m of pass-through income. Pay is £0.9m adverse, including £1.2m under-delivery of CIP and £0.6m adverse care group pay, offset by undistributed reserves of £0.7m and a £0.5m favourable variance on pass-through costs. Non-pay is £4.8m adverse, including £2.3m under-delivery of CIP and £3.4m of pass-through costs, offset by £1.5m of undistributed reserves. Net drugs expenditure is £0.1m favourable. Non-operating costs are £0.7m favourable.

**Activity:** Value-based activity performance for May was £0.2m adverse to plan (£0.4m adverse YTD). The elective elements were £0.5m favourable (£0.5m favourable YTD), and other chargeable API (Chemotherapy Delivery and Diagnostic Imaging) activity was £0.7m adverse to plan (£0.9m adverse YTD).

**CIP:** Year to date CIP delivery is £1.9m against a budgeted plan of £4.8m, an adverse variance of £2.9m, comprised of an adverse planning variance of £2.8m and an adverse performance variance of £0.1m. As at 10<sup>th</sup> June 2025, the programme consists of £17.3m of Gateway 2 approved schemes. This is £26.4m adverse to the planned £43.7m full year CIP requirement.

**Capital Expenditure:** Year to date total capital spend is £1.8m, a £10.2m underspend against the planned £12.1m. This is as a result of delivery of scheme milestones running behind plan assumptions across the central, core and IFRS16 lease programme.

**Cash** held on 31<sup>st</sup> May 2025 was £97.2m, £25.3m higher than the FY25/26 submitted. This higher cash balance is as a result a £9.0m PFI contractual payment that has slipped in to June, £7.0m of prior year gas invoices remain outstanding with the balance due to various working capital movements.

	In Month			Year To Date		
	Actual	Plan	Variance	Actual	Plan	Variance

SOCI						
	£m	£m	£m	£m	£m	£m
Clinical Income	68.5	68.1	0.4	136.3	136.1	0.2
Other Income	12.1	9.6	2.5	23.0	20.0	3.0
<b>TOTAL INCOME</b>	<b>80.5</b>	<b>77.7</b>	<b>2.8</b>	<b>159.3</b>	<b>156.1</b>	<b>3.2</b>
Pay	(50.0)	(49.1)	(0.9)	(99.9)	(99.0)	(0.9)
Non Pay	(23.1)	(19.7)	(3.4)	(45.1)	(40.3)	(4.8)
Drugs (Net Expenditure)	(2.4)	(3.1)	0.7	(6.0)	(6.1)	0.1
<b>TOTAL EXPENDITURE</b>	<b>(75.4)</b>	<b>(71.9)</b>	<b>(3.6)</b>	<b>(151.0)</b>	<b>(145.4)</b>	<b>(5.6)</b>
Non Opex	(6.2)	(6.8)	0.5	(12.8)	(13.5)	0.7
<b>Control Total Surplus / (Deficit)</b>	<b>(1.2)</b>	<b>(0.9)</b>	<b>(0.2)</b>	<b>(4.5)</b>	<b>(2.8)</b>	<b>(1.7)</b>
<b>Statutory Surplus / (Deficit)</b>	<b>(0.6)</b>	<b>(0.4)</b>	<b>(0.2)</b>	<b>(3.5)</b>	<b>(2.0)</b>	<b>(1.5)</b>

Other Financial Metrics						
	£m	£m	£m	£m	£m	£m
Cash at Bank (before support funding)	97.2	71.9	25.3	97.2	71.9	25.3
Capital Programme Expenditure	0.4	7.0	6.6	12.0	1.8	(10.2)
CIP Delivery	1.7	2.7	(1.0)	1.9	4.8	(2.9)

Activity Metrics						
	£m	£m	£m	£m	£m	£m
Day Case	5.9	5.7	0.2	11.4	11.4	0.0
Elective Inpatient	4.8	4.8	0.0	9.2	9.6	(0.4)
Outpatients - New & Procedures	5.8	5.4	0.4	11.7	10.8	0.9
Other Chargeable activity included within API	1.7	2.4	(0.7)	4.1	4.9	(0.9)
<b>TOTAL</b>	<b>18.2</b>	<b>18.3</b>	<b>(0.2)</b>	<b>36.3</b>	<b>36.6</b>	<b>(0.4)</b>

## REPORT TO THE COUNCIL OF GOVERNORS

<b>Date</b>	<b>24 July 2025</b>
<b>Title</b>	<b>Annual Report and Accounts 2024/25</b>
<b>Author(s) &amp; Exec Lead</b>	<b>Janice Bradfield, Head of Communications</b>
<b>Purpose</b>	<b>For Discussion</b>

### **1 Background/Context**

- The Trust produces an Annual Report and Accounts in line with national guidance. This has been approved by the Board of Directors and laid before Parliament.
- In accordance with the Code of Governance for NHS Providers (and associated legislation), the Council of Governors is required to receive:
  - the annual accounts
  - the report of the auditor on the accounts
  - the annual report.

### **2 Key Issues, Risks and Actions**

- The Annual report & Accounts is a lengthy document with contents largely determined by national guidance and requirements.
- It was subject to audit/review by the External Auditors, before review by the Audit Committee and approval by the Board.

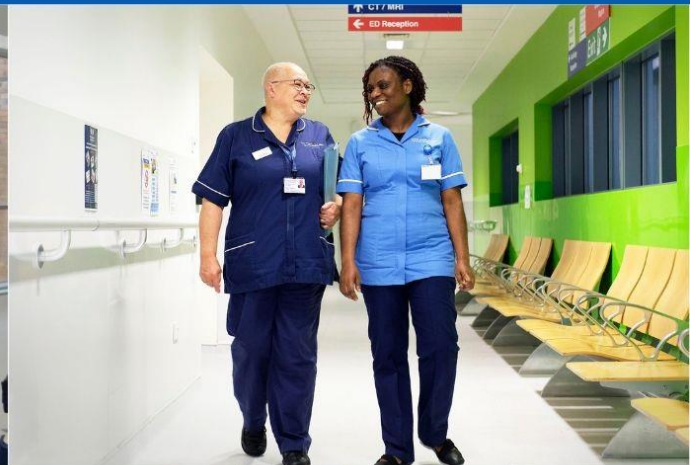
### **3 Conclusions/Outcome/Next Steps**

- The Annual Report has been drafted in compliance with national guidance. This results in a long document which is not ideal for public consumption.
- The Annual Report will be presented at the AGM on Thursday 25 September. A summary version will be prepared, which will be more accessible to the public.

### **Recommendations:**

- The Council is recommended to receive the Annual Report and Accounts 2024/25.

# Annual Report and Accounts 2024/25





Norfolk and Norwich University Hospitals NHS Foundation Trust

Annual Report and Accounts 2024/25

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

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# Performance Report



## Chair's Statement



Welcome to our review of 2024/25, the end of which marks a year of change as we come together with Norfolk and Waveney's other two acute hospitals, the James Paget University Hospital and the Queen Elizabeth Hospital, King's Lynn, into a group model.

Much of the progress described in this report took place under the leadership of Tom Spink, who served as Chair of NNUH throughout the year. I would like to formally acknowledge and thank Tom for his commitment and leadership, particularly as he helped guide the Trust through the early phases of transition to the Group model.

As the Interim Chair for all three NHS Foundation Trusts, I take up this role at a pivotal moment. The Group model now being implemented reflects a shared ambition: to strengthen our collective resilience, enhance patient outcomes, and create a more sustainable foundation for acute hospital care across Norfolk and Waveney.

During the year, we have seen some leadership changes and we are in a strong position to move ahead as part of the group.

Professor Lesley Dwyer has brought great experience and leadership flair to the role of NNUH chief executive, since she was appointed in March 2024. She has extensive experience of working in large-scale healthcare systems and I am delighted that she will be leading all three hospitals as Group CEO.

Lesley's leadership and vision have helped us to drive performance and move the Trust to a firmer financial position which is essential for making the new partnership a success.

The NNUH performance on urgent and emergency care has been strong and we are making good progress in planned care and cancer services.

The staff survey results are moving in the right direction and we have the potential to do better in future. I would like to offer my sincere thanks to our staff and volunteers for the compassionate care they deliver to our patients.

It has also been an excellent year in terms of research with increasing numbers of important research projects underway, often involving our key partners such as the UEA. Similarly, it has been encouraging to hear the progress we have been making in providing better training to our Resident Doctors.

Although we have reached a breakeven position for 2024/25, there is more work to do in eliminating our underlying deficit and reaching financial balance across the system.

I recognise the impact of uncertainty on individuals concerning potential job losses and so we are determined to move quickly to minimise this period of uncertainty.

As we move to a group model there are opportunities to improve further with greater networking of services, new patient pathways, shorter waiting times and the promise of digital and infrastructure investment. It will make it easier for us to recruit scarce clinical experts to our system with a wider base from which to offer speciality services and greater research opportunities.

Bringing together our corporate and non-clinical staff groups will enable us to offer a more efficient and cost-effective service, embracing best practice from across the three organisations. Joint purchasing of goods and services will give us economies of scale and help us to make the financial savings we need to deliver.

There are great opportunities ahead with two new hospitals to replace the ageing structures at the James Paget University Hospital and the Queen Elizabeth Hospitals. As part of the Norfolk and Waveney ICS (Integrated Care System), we are working with these hospitals on a joint Electronic Patient Record (EPR). I am pleased to say that we have also opened three state of the art Community Diagnostic Centres in the last year – one at each hospital site.

The national direction of travel for the NHS is a move to preventing illness, delivering more services in the community and embracing digital services. Patients should only come to hospital if they really need to be there and, in future, there will be some services that are better provided in a community setting.

With our older population, particularly in North Norfolk, we are focusing on frailty and how we can work with partners to offer wrap-around care for patients and avoid hospital admission.

I would like to pass on my thanks to our Trust Board members, Governors and the leadership team for their focus and dedication throughout this year in what has been a period of great change. I am confident that the new group arrangements will bring great benefits to the people of Norfolk and Waveney when the new Board becomes operational later in 2025.



**Mark Friend**  
**Interim Chair of**  
**Norfolk and Norwich University**  
**Hospitals NHS Foundation Trust,**  
**James Paget University Hospitals NHS**  
**Foundation Trust,**  
**Queen Elizabeth Hospital King's Lynn**  
**NHS Foundation Trust**

## Chief Executive's Statement



Since joining as Chief Executive in March last year, I've been struck by the immense dedication and commitment of my colleagues here at NNUH, who deliver fantastic care every day for our patients.

We are, however, facing significant challenges and need to find a way to continue to give the best care to the people of Norfolk and Waveney well into the future.

To achieve this, we must work collectively with our colleagues at the James Paget University Hospital in Gorleston and the Queen Elizabeth Hospital, King's Lynn, and that's why our three trusts have formed the Norfolk & Waveney University Hospitals Group, where I was privileged to be appointed as Group Chief Executive from 5 May 2025.

While each trust will remain an independent statutory organisation with its own leadership team, coming together formally will enable us to serve our community by delivering high quality, transformative and more efficient services.

We already provide a wide range of services to a population of more than one million people in a very rural area. Working together will give us more opportunities to support each other operationally and make our services more resilient, and it will be easier to attract and retain high-calibre people by offering interesting roles and development opportunities.

We'll be building on a successful track record of working together with, for example, shared laboratory services under the Eastern Pathology Alliance and staff already working across our trusts to run clinics and shared care of patients in services like cancer and paediatrics.

Our ambition is to deliver more complex care locally, such as a major trauma centre at NNUH, and reduce the need for patients to travel outside Norfolk and Waveney for their care.

We are working with the other two hospitals on two major programmes: delivering new hospitals at JPUH and QEH and delivering an Electronic Patient Record. Improved digital capability will enable us to make patients' clinical information more easily available to healthcare professionals across the three Trusts from 2026.

Our Acute Services Collaborative is also bringing clinicians together to create networks of services, giving patients the benefit of expertise from all three hospitals wherever they are treated.

## **Research**

Research is hugely important as to future patient outcomes and experience. Our position on the Norwich Research Park provides a unique opportunity to develop a shared science strategy with the University of East Anglia, the Quadram Institute Bioscience and other local colleagues with research at their heart.

Together, we can be more impactful and seek solutions to some of the preventative health issues the Government is keen to see.

Already our clinicians are working on seven joint research programmes with the Quadram Institute to see how food and microbes interact to improve gut health and prevent disease. These ground-breaking projects include the role of the gut microbiome in pregnancy, the microbiome in relation to liver disease and decreasing the risk of urinary tract infections in patients with type 2 diabetes.

As a university hospital group, there will be many further opportunities to bring together the efforts of all three acute Trusts and develop our full potential as places of research and learning.

## **National direction**

The Government is clear on the new model of care it expects us to deliver, and working as a group will help us enormously in achieving this. More services will move from hospital into the community and we must focus on the prevention of sickness wherever possible. Maximising our use of technology and innovation is the key to efficient services that work well for patients and staff.

In delivering this change, we must ensure that all patients in Norfolk and Waveney have equal access to good quality, safe care. We have one of the oldest

populations in the country in North Norfolk and significant pockets of deprivation. Led by the medical director, we are working with colleagues in the Integrated Care Board on reducing inequalities for children and addressing the health needs of vulnerable groups across Norfolk and Waveney.

Boosting screening rates, identifying adults with cardiovascular disease and addressing smoking rates are some of the practical steps we can take for our population.

In addition, we are focusing on the way we care for patients with frailty with a successful pilot scheme to identify patients who are frail and provide the additional care they need. This work will lead to new pathways in the hospital and improve working with our community partners.

## **Performance**

Waiting times are another big focus for the NHS to meet the 18-week waiting time standard by 2029. Our waiting lists for planned care are large and we're focusing on productivity gains and following national best practice to make further progress.

Throughout the year, our performance on urgent and emergency care has compared well with others across the region and the country as a whole. In fact, we have featured regularly in the top 10 Trusts nationally in 2024 for performance on the four-hour standard.

Unfortunately, despite everyone's best efforts, there have been times when the hospital has become congested. That's hampered the efforts of our teams in providing the best care and experience for patients, especially when we've used escalation areas and temporary escalation spaces away from bed head services.

Our performance on the cancer standards is improving and our new Community Diagnostic Centre will support the earlier diagnosis of cancer and other conditions, following its opening in February 2025 (for more information on performance, go to page 18).

### **Staff report**

Our scores for the 2024 Staff Survey remain broadly similar to previous years and they're below where we want to be in terms of staff experience.

Our ambition is to do better for our staff - being rated as average compared to other acute Trusts is not good enough! We are improving our processes, through the Best Care for Every Patient Programme, to reduce the use of escalation areas and make better use of digital systems that will improve staff experience. Embracing artificial intelligence is also part of our strategy to bring benefits to both patients and staff, providing a useful tool to reduce mundane tasks and process large volumes of data, such as those used in research.

Poor behaviours are another contributory factor in terms of staff experience. We're running open discussions and providing training and support to give staff the tools and the confidence they need to manage difficult situations, being clear about what's appropriate and what's not.

Productivity is a key theme across the NHS for 2025 and we employ significantly more staff now than we did in 2019. National planning guidance requires us to reduce our corporate cost growth by half the amount from the year before the pandemic.

We are running a voluntary exit scheme for staff who would like to go with a package and carefully scrutinising any vacancies for posts that can be removed, which will minimise any compulsory redundancies.

At the same time, we've established our new Care Groups, based around similar services, to make us more agile and improve our response to patient needs and concerns. It will bring decision making closer to where care and services are delivered.

In doing this, we're reducing the layers of management, which puts us in good shape as we enter our group model with just five layers between patient-facing colleagues and the new group executive team.

### **Finance**

Extra investment in the NHS will be limited in the foreseeable future so we will need to address the financial deficit in our system, as well as generate funds for investment, through cost-cutting and the redesign of services. This will require a different mindset for the NHS where the established pattern has been to bid for more funds to develop a service.

We'll be looking for creative solutions using national best practice, digital and changes to our skill mix to deliver high-quality care within our financial constraints.

At the year end, we reached a breakeven position using a range of measures to control costs, such as vacancy controls where only critically important roles are filled. A series of one-off savings has helped to reach financial balance. Work is already under way to make us financially sustainable, with a programme in place to make our services more efficient and cost effective.

**Conclusion**

This is an exciting time to be establishing a hospital group and bringing together all the expertise and commitment across Norfolk and Waveney.

There is so much we can achieve for our local population whether that's treating more complex health conditions locally, reducing long waits or moving care closer to home.

I feel privileged to be leading the hospital group at such a pivotal moment and I am determined that we will deliver the best care for the people of Norfolk and Waveney.

A handwritten signature in black ink, appearing to be 'LD', written in a cursive style.

**Professor Lesley Dwyer**  
**Chief Executive**

# Overview of Performance

Welcome to our 2024/25 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

Our Trust is one of the busiest in the region, with over 10,000 staff treating a million patients a year. In addition, we have around 500 committed and enthusiastic volunteers, who 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, Central Norwich Eye Clinic, Adelaide Street Pain Management Centre, mobile breast screening lorries, mobile cancer treatments and Community Midwifery.

We are part of the newly formed Norfolk and Waveney University Hospitals Group, linking more closely with the James Paget University Hospital and the Queen Elizabeth Hospital, King's Lynn. A priority for us is to work more closely with GP, community, and voluntary organisations currently as part of the Norfolk and Waveney Integrated Care System and in future with the Norfolk and Suffolk Integrated Care System which is being established.

Research is important to us as a University Teaching Trust and we are building joint partnerships with the institutes on the Norwich Research Park, including the University of East Anglia (UEA) and the Quadram Institute of Bioscience (QIB). 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.

## Brief History

The Norfolk and Norwich Hospital was founded in 1772 and 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. The Jenny Lind Children's Hospital is part of NNUH and was founded on 3 April 1854, joining with the N&N Hospital in 1975.

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

Our Trust strategy, [Caring with PRIDE](#), sets out our vision and approach for how we will improve our hospitals for our patients, our staff and our partners and ensure that we are delivering the best care for every patient. Central to this strategy are five commitments that guide our decisions and the choices we make to improve our care:

### **The commitment to Our Patients:**

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

This commitment focuses 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 hospital, 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, which has supporting plans focusing on the long-term investment in the strength, 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 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 seeks to ensure that we best meet the essential hospital needs of people who live in Norfolk and Waveney. We are doing this 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

This commitment is about ensuring that we effectively use all of 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.

As we continue to establish a group model to respond to the collective challenges faced across Norfolk and Waveney, we remain committed to providing the best care for every patient. However, we will need to adjust our approach and prioritise our actions to realise the opportunities presented by the group model in terms of the options for care and how they are provided.

### **Key issues and risks**

One in four people living in Norfolk and Waveney are aged 65 and over, and this group will grow faster than any other group over the next ten years (+17% population aged 65-84 by 2033<sup>1</sup>). Despite having a population that lives longer than the national average, people in Norfolk and Waveney spend more years in ill health than the average, with higher rates of long-term conditions such as asthma, COPD, hypertension, rheumatoid arthritis and stroke<sup>2</sup>. There are also high levels of deprivation throughout Norfolk and Waveney with the most acute levels of health inequality in Norwich and Great Yarmouth.

The demand for healthcare is greatest in these groups and we must ensure our hospitals are able to offer equal access to high quality care when it is needed and, wherever possible, in our communities. One of our key risks is large waiting lists and seeing our patients in a timely way will reduce the risk of emergency admission, particularly for vulnerable groups. Increasing demand during the winter months sees a peak in demand for hospital care and the use of escalation beds which impact the quality of care and patient experience. Finding ways to support frail patients to live well at home with the right support is part of our strategy (for more information see page 18).

We continue to evolve and improve our services to respond to these issues – this year we opened our new £86m Community Diagnostic Centre that will offer 150,000 additional appointments each year, treated our 5,000th patient through our virtual ward service, and opened the Norfolk and Norwich Orthopaedic Centre to deliver an additional 2,500 orthopaedic cases per year. These are in addition to our commitment to continuous improvement, driving change and improvement across all aspects of our care.

### **Working as a partner**

We can only deliver the best care by working in partnership and ensuring that our care meets the needs of our populations and complements activity across our wider care system. For example, our Community Diagnostic Centre forms part of a network with our group partners, James Paget University Hospitals and Queen Elizabeth Hospital King's Lynn.

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<sup>1</sup> Source: ONS; CF Analysis

<sup>2</sup> Source: Fingertips, QOF Data NHS England; CF Analysis

We work in partnership across our clinical and corporate activities. This year we deployed an enhanced purchase-to-pay system across the Norfolk & Waveney Integrated Care System, featuring a shared catalogue, product information management, and common inventory tools.

Over 3,000 users were trained, leading to 94% of purchase orders being dispatched automatically, a 150% reduction in requisition time, and over 95% of spend placed on purchase order—delivering £3.9 million in cash-releasing savings. The programme was recognised nationally, reaching finalist status in the HSJ Partnership Awards, HSJ Digital Awards and the Health Tech Newspaper Awards.

We will continue to deepen these collaborations. Our shared Electronic Patient Record will create a single digital system across the Norfolk and Waveney acute hospitals. We have also established clinical networks from across these three hospitals to deliver equal access to high quality care. As we move to a group model, we will build upon and enhance these activities by publishing our first joint Acute Clinical Strategy to set out how we will deliver high quality and sustainable care in Norfolk and Waveney by working together.

### **Our care**

We are a major centre for specialist care in the East of England. We must meet the needs of our patients to ensure they can access specialist care in their hospitals and we remain committed to growing and improving our specialist services; recently we secured investment to develop mechanical thrombectomy capability on our site, improving outcomes for stroke patients. Improving our specialist care in cancer, women and children's services, and stroke remain priorities and we continue to develop our case to be recognised as the second major trauma centre in the East of England.

In the group model we will improve and evolve the care we offer for our patients in Norfolk and our specialist care to ensure that our patients have equal access to high quality care that is delivered sustainably. Through the clinical networks formed with our group partners at the JPUH and QEH we will identify opportunities to level up care across Norfolk & Waveney and are working with our wider health and care partners to ensure equal access to high quality and safe care.

### **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

Overall we have had strong performance in our urgent and emergency care areas, with an improving picture in electives and cancer care. Service improvements are being made through the Best Care for Every Patient transformation programme, encompassing the Trust's five strategic programmes of work: Urgent and Emergency care, Elective Care, Frailty, Models of Care and Financial sustainability (see page 33 for more information on finance).

Further process and productivity improvements will be driven through a change to the way in which we manage our services and bringing decision making closer to the patient. The establishment of Care Groups later in 2025 will bring a more detailed focus to individual services.

## **Use of escalation areas**

Through the winter months, we have experienced pressure on our services with extra escalation areas used on the Jack Pryor Unit and Gunthorpe Ward. Capacity has also been flexed by using beds in Temporary Escalation Spaces (TES) away from the bed head services, often near the nurses station on the ward. This is not an ideal situation for our patients, visitors or staff and efforts were made to reduce our reliance on TES beds in a reset event in February 2025. At the peak, we were using about 45 TES beds across the Medicine Division and they have been gradually phased out through March 2025, except for occasionally peaks in pressure.

There has also been progress in bringing down the number of patients with no Criteria to Reside which was close to 200 patients during the winter months. In future, there will be more community capacity to support us in the new Willow Unit being operated by Norfolk Community Health and Care. It offers 48 beds to help patients regain their independence following a hospital stay.

There has been a greater focus on discharging patients through our Best Care for Every Patient programme which has helped us to simplify the process for transfers of care to the community. Embedding a daily rhythm has been the key with morning Red2Green meetings used to identify patients who could go home and reducing any delays.

## **Frailty assessments**

Norfolk and Waveney has comparatively high rates of frailty – six of its eight local authority districts have higher rates of pre-frail and frail people compared with the England average.

We have changed the way in which we assess patients when they come to the Emergency Department and are admitted to hospital. A new approach has been taken to measure a patient's frailty and place them in wards that have more expertise in meeting their needs. This move away from an age-based system to a new model has been successful in helping us to target more support to patients, particularly on discharge.

## **Urgent and Emergency Care**

We continue to be one of the top performing hospitals in the country for the A&E four-hour performance standard, which is testament to the work of our multi-disciplinary Emergency Department teams, specialities and in-patient wards.

During February 2025, 80.7% of patients were seen in our Emergency Department, Walk in Centre and Cromer Minor Injuries Unit within four hours, which is great for patients and is above the national average.

We have reconfigured our services, having senior clinicians triaging patients at the front doors of Emergency Department, which has really helped our patients to get a quicker diagnosis and start treatment earlier.

However, we know we have more work to do in reducing ambulance handover delays. This includes a focus on patient flow, increasing the proportion of hospital discharges before midday and maximising Virtual Ward capacity.

## **Planned care**

We have continued to run our elective programme through the winter, despite the bed pressures the hospital has faced over those months. We were asked to meet the 65-week waiting time standard by 29 December and we have worked hard to complete the treatment pathways for the remaining 200 patients.

Across the NHS, there is a drive to improve productivity and look for ways to treat more patients within the financial envelope we have. The Government has also set milestones for a return to the 18-week waiting time standard by 2029.

In outpatients, we are adding an additional patient to each clinic where it is appropriate to do so and running large scale clinics in specialties where we need to boost performance. The use of Patient Initiated Follow Ups is being expanded where suitable patients take control of their own follow-up appointments which also helps ease pressure on our waiting lists.

We are increasing the utilisation of our operating theatres which are now in the top 10 in the country in terms of this performance measure, resulting in performance of 83.5% in February 2025. As we move through 2025, further work will be taking place to embed best practice with a series of workshops held with key staff who will train the rest of the team. Work is also under way to increase our capacity for pre-operative assessments with more telephone assessments, changes to work patterns and using space more efficiently on the hospital site.

Our Ambulatory Procedure Unit is treating more patients as day cases by extending the working day. In terms of day case procedures, we are performing above the national standard, delivering 86.3% of elective activity as day cases in February 2025 which is in line with previous months and remains above the 85% target.

Other measures to boost capacity include:

- Maximising the use of the Norfolk and Norwich Orthopaedic Centre
- Two new children's theatres have already helped to increase productivity by 40% at the Jenny Lind Children's Hospital in the first year of the paediatric theatres complex opening

## **Cancer Care**

A rapid diagnosis is what we want to see for all our patients, where we can either rule out cancer promptly or commence treatment without delay.

We are seeing an improving picture on the 28-day Faster Diagnosis Standard for cancer with performance in January 2025 at 66.7%, rising to 82.2% in February which is above the national target of 77%.

For the 62-day referral to treatment standard, we have reduced patient waits and improved our position in national comparisons with fewer patients waiting in a backlog for treatment. We have seen a rise in referrals and the measures taken to cope with demand have included more robotic surgery sessions in urology, streamlining patient pathways in gynaecology and for lower GI conditions such as bowel cancer.

We are making improvements in line with the national cancer strategy by forming clinical networks across Norfolk and Waveney in order to offer patients the best treatment pathways. This work will make the most of digital services, robotic surgery and workforce opportunities to deliver more personalised care and support for patients.

## **Diagnostics**

The Community Diagnostic Centre opened on the Norwich Research Park site in February 2025, increasing our ability to support electives and inpatient care through greater capacity for imaging.

## **Emergency Preparedness, Resilience and Response - (EPRR)**

We are a Category One Responder and 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, 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), the Health and Care Act 2022 and the NHS Constitution.

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 EPRR Framework - July 2022 and NHS England Core Standards for EPRR (Core Standards). The Trust is audited annually regionally and by NHS England on these Core Standards and in 2024 the Trust was again fully compliant.

## **Long term planning**

The Government launched a consultation in Autumn 2024 with staff, patients and public to gather views for the NHS long term plan which is due out in Spring 2025.

At the end of January 2025, there were several documents released to NHS providers. The first being the *Government Mandate to the NHS – Road to Recovery* which outlined the key priorities, and the three shifts required which are:

- Hospital to community
- Analogue to digital
- Sickness to prevention

One of the key commitments was to elective care, instructing providers to achieve the 18 week standard by March 2029, with a key milestone being 65% performance by the end of March 2026. This also includes continued improvement on cancer access standards.

Alongside this, NHSE published neighbourhood health guidelines 2025/26 which set out key requirements for systems to:

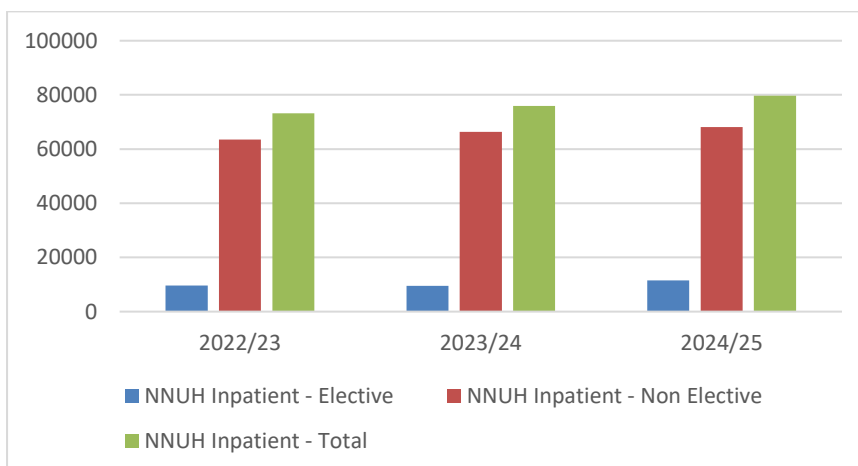
- Plan a neighbourhood health and care model, with an initial focus on people with the most complex health and care needs.
- For more mature systems, develop an integrated neighbourhood delivery plan across core components, including workforce planning, commissioning models and evaluation.

NHSE is set to provide further details of a national implementation programme over the coming months, with the full vision set out in the 10-Year Health Plan.

### Detailed performance

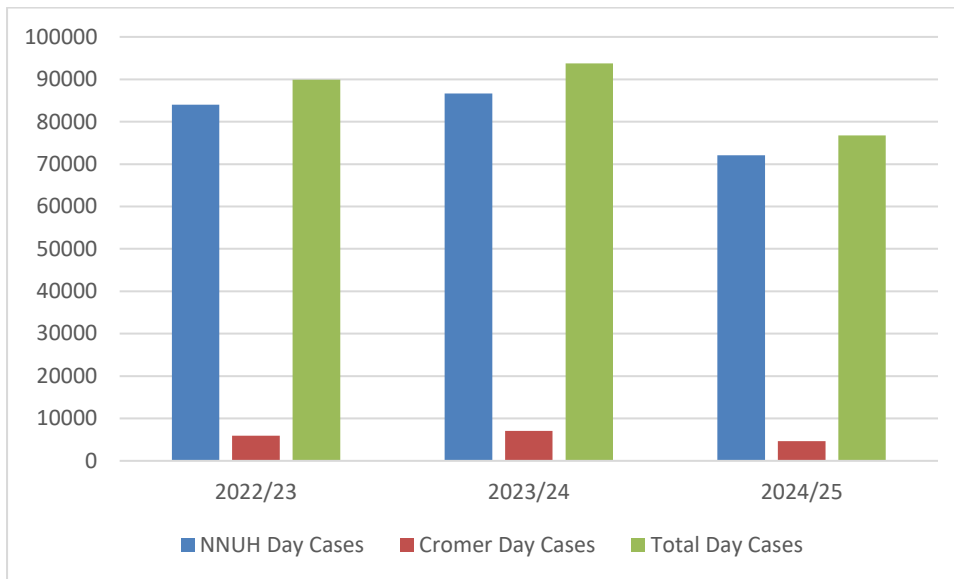
	2023/24	2024/25
Elective and non elective	75,897	79,653
Outpatient appointments (new and follow ups)	747,403	788,929

### Inpatient activity



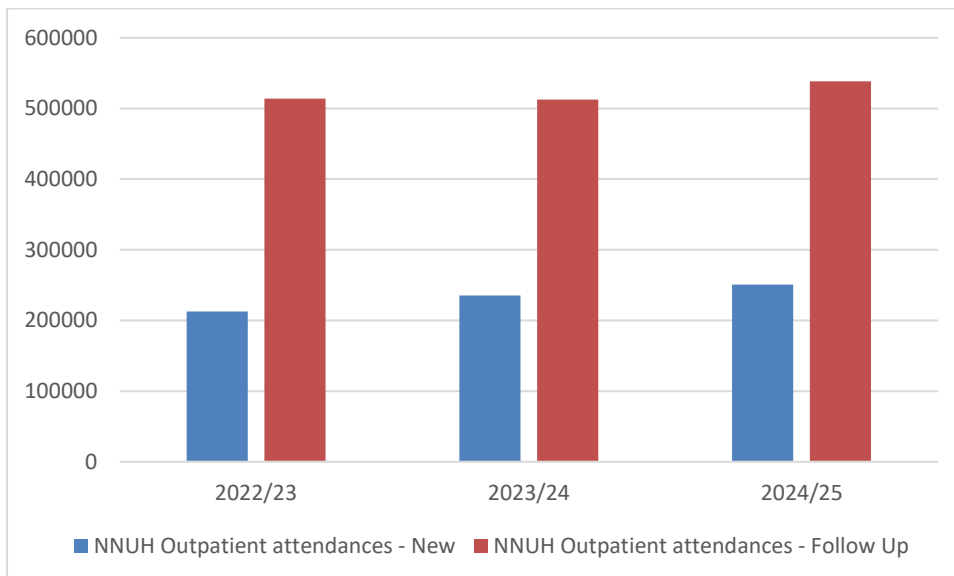
In 2024/25, we treated 11,498 patients for planned care compared to 9,549 patients in 2023/24 and 68,155 non electives compared to 66,348 in 2023/24 (urgent or emergency care).

## Day cases



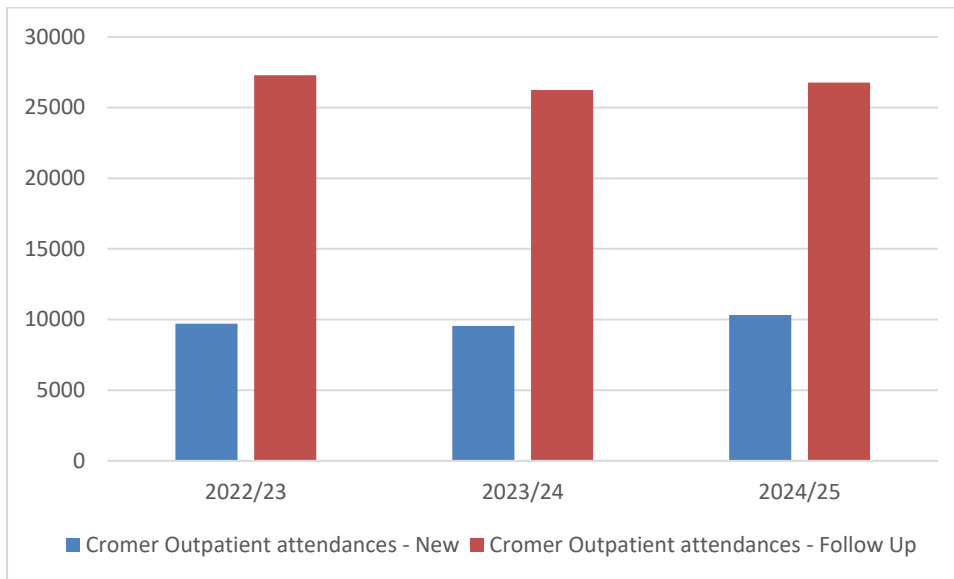
In 2024/25, we treated 72,103 day cases at the N&N Hospital and 4,673 at Cromer Hospital. This compared to 2023-24, when we treated 86,678 day cases at the N&N Hospital and 7,057 at Cromer Hospital.

## Outpatient attendance



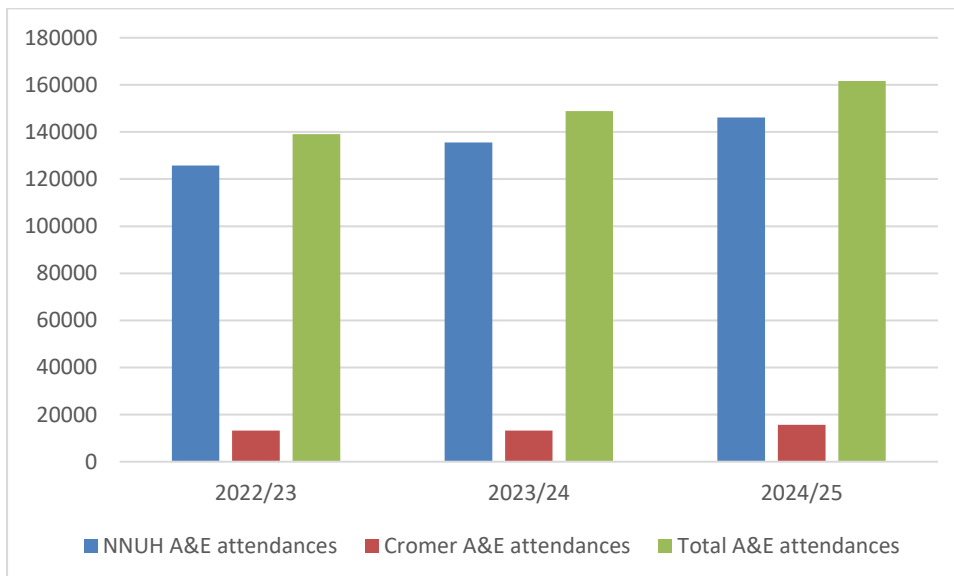
In 2024/25, we saw 250,739 new patients and 538,190 follow ups. This compares to 2023/24 when we saw 235,098 new patients and conducted 512,305 follow up appointments.

## Cromer Hospital



In 2024/25 Cromer Hospital saw 10,317 new patients and 26,756 follow ups. This compares to 2023/24 where Cromer saw 9,559 new patients and conducted 26,255 follow up appointments.

## Emergency attendances

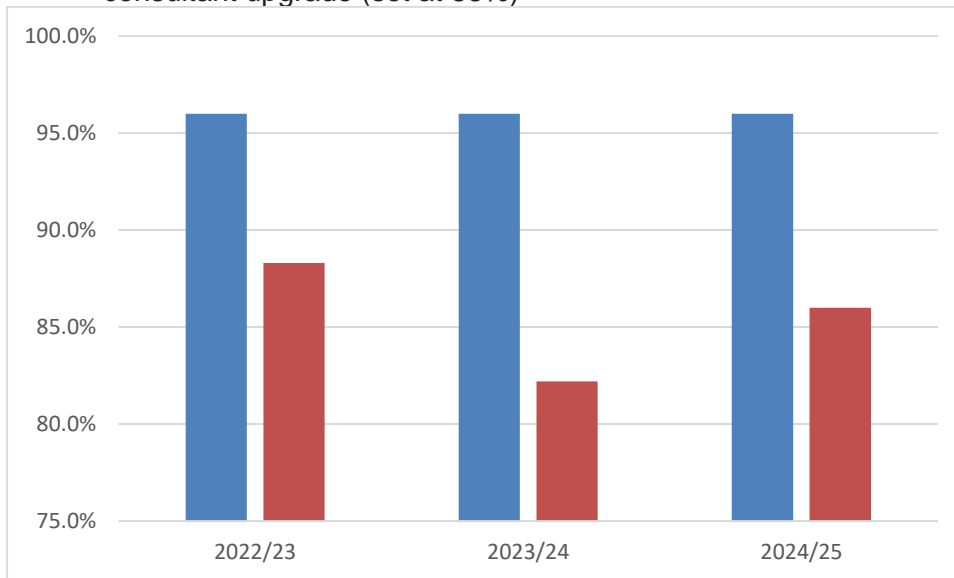


In 2024/25, we saw 146,081 patients at the N&N's Emergency Department and 15,601 patients at Cromer's Minor Injury Unit. This compare with 2023/24, when we saw 135,572 patients at the N&N and 13,260 patients at Cromer.

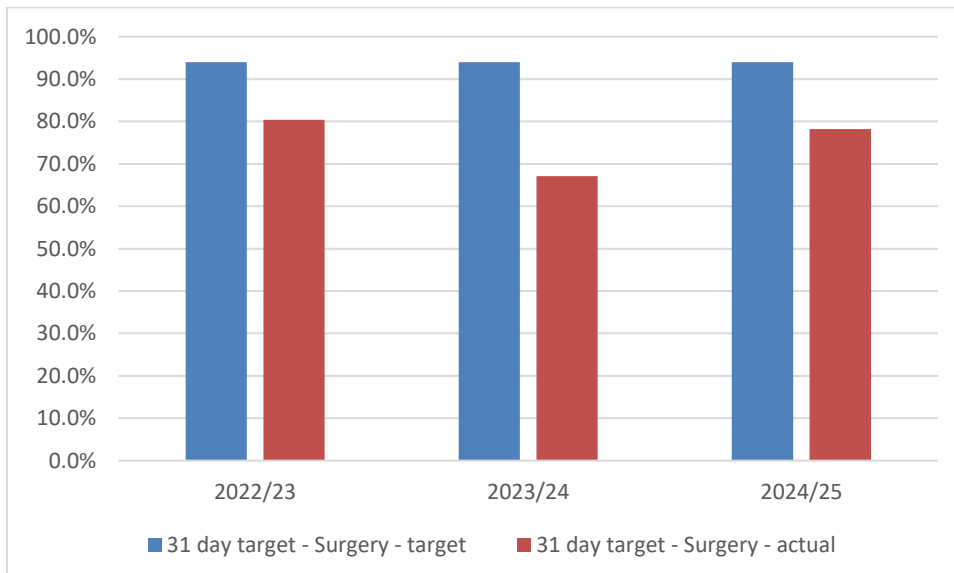
## Cancer standards

The NHS has three cancer standards:

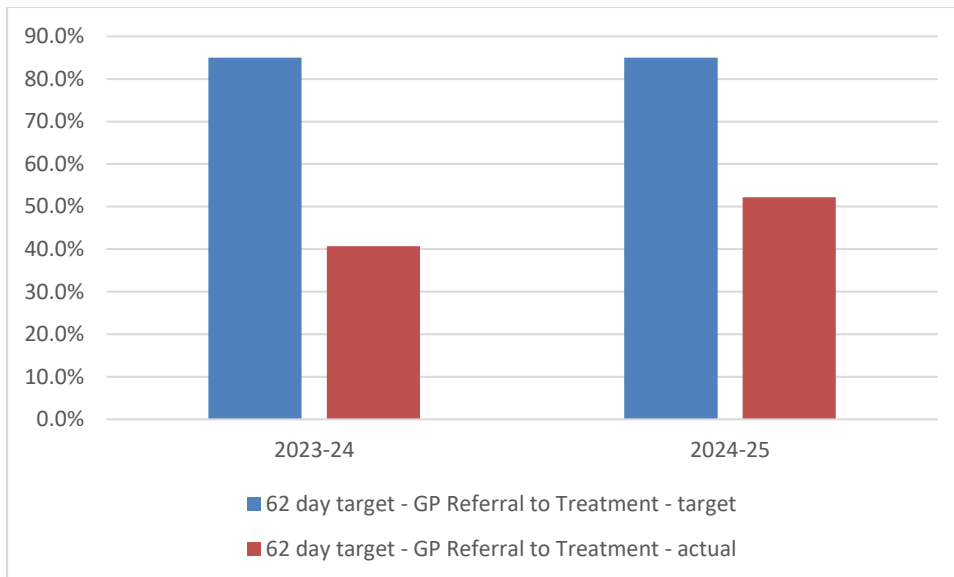
- Faster Diagnosis Standard: a diagnosis or ruling out of cancer within 28 days of referral (set at 75%)
- 31-day treatment standard: commence treatment within 31 days of a decision to treat for all cancer patients (set at 96%)
- 62-day treatment standard: commence treatment within 62 days of being referred or consultant upgrade (set at 85%)



For the 31-day diagnosis to treatment standard, in 2024/25 our performance was 86% against the standard of 96%, compared to 2023/24 when our performance was 82.2%.



For the 31-day standard for surgery, in 2024/25 we achieved 78.2% against the national standard of 94%. This compares to 2023/24 when we achieved 67.1% against the national standard.



For the 62-day standard for GP referral to treatment, in 2024/25 we achieved 52.2% against the national standard of 85%. This compares to 2023/24 when we achieved 40.7% against the national standard.

### New developments

The new state-of-the-art Norfolk and Norwich Orthopaedic Centre (NaNOC) welcomed its first patients in July 2024.

The unit has been developed with its own facilities including same day admissions unit, treatment rooms, two laminar flow theatres, Post Anaesthetics Care Unit, a 21-bedded ward, called Ashill, physiotherapy rooms and a pharmacy and dispensing room for the embedded Pharmacy Team.



Some of the most up to date surgical equipment has been provided by the N&N Hospitals Charity which supported the build with a £2m grant – the biggest single grant in its history.

At full capacity, the NaNOC team will carry out around 2,500 orthopaedic cases a year for patients who need ankle, foot, hip, knee or shoulder operations. To help with this work four new consultants – experts in hip, knee, shoulder and hand surgery, have been employed to bring the most innovative techniques to the team.

### Diagnostic capacity

We opened a new Community Diagnostic Centre in February 2025 with MRI and CT scanners as well as X-ray and Ultrasound imaging.

These are used for diagnosis and monitoring of a very wide range of conditions, including cancer, heart disease, stroke, respiratory diseases, trauma, musculoskeletal diseases, and neurology. To help deliver the scans, there will be more staff recruited including radiographers, radiologists and support staff.

The Norfolk and Norwich Hospitals Charity is also kindly supported the Community Diagnostic Centre by pledging £1.6m for imaging equipment. This collaborative approach between hospitals and the wider Integrated Care System to deliver these services will:

- Increase capacity for diagnostic imaging
- Separate GP referrals and out-patient appointments from in-patient and emergency demand, improving waiting times
- Improve health outcomes with earlier diagnoses
- Provide modern, bright facilities and state-of-the-art equipment to improve the experience for patients and staff
- Standardise practices and collaborative working in Imaging services across the three hospitals.

### **Cancer care**

Patients undergoing radiotherapy are benefiting from a new treatment which reduces treatment time whilst increasing accuracy and patient comfort.

Surface Guided Radiotherapy (SGRT) was introduced in September 2024 and offered to patients receiving radiotherapy for breast cancer and thoracic cancers. The system, Allign RT, uses specialist cameras to create a unique 3D outline of the surface of a patient's body. The new equipment has been installed in all five TrueBeam linear accelerators (linacs) and the department's dedicated CT scanner.

The benefits of SGRT are quick and accurate patient positioning, no requirement for tattoo marks and less X-ray image exposure to patients.

### **Maternity care**

Our maternity services were highlighted by the Care Quality Commission (CQC) for best practice in a new national report.

The regulator published a series of online resource materials aimed at sharing good practice and encouraging improvement in NHS hospital maternity services which sit alongside a new report that presents the findings from its national maternity inspection programme.

Our maternity services, which were rated as 'Good' following an inspection in November 2023, have been highlighted in the CQC's latest report for good practice in managing safety incidents.

The report said: "The trust moved to the Patient Safety Incident Response Framework (PSIRF) on 1 September 2023 and leaders triaged all incidents daily and RAG (red, amber, green) rated them in alignment with PSIRF guidance.

Any incidents that were of moderate or severe harm, required further information or met national priorities were presented by the divisional weekly incident group to discuss the appropriate response and identify any lessons learned. Cases were then escalated to the trust complex case review group, as required."

### **Treatment for Parkinson's disease**

Our hospital has treated one of the first patients in the region to benefit from a new NHS treatment to control the symptoms of advanced Parkinson's disease.

NHS England approved Produodopa earlier this year so that some people with advanced Parkinson's can benefit, which involves wearing a portable kit 24 hours a day.

The treatment is a combination of two drugs – foslevodopa and foscarbidopa – and helps manage Parkinson's symptoms, such as excessive movement or tremors. The continuous infusion enters the patient's bloodstream through a cannula under the skin and is controlled by an automatic pump, releasing a steady flow of the treatment 24 hours a day to stay on top of symptoms. It also has the option of a manual boost if needed.

### **Milestone for Virtual Ward**

The Virtual Ward reached its 5,000th patient milestone at the beginning of November 2024. Since its inception in 2021, our Virtual Ward, has saved more than 41,000 bed days.

This has helped us to improve Urgent and Emergency care flow and reduce pressure on in-patients areas, one of our key priorities in our "Best Care for Every Patient" programme.

The Virtual Ward monitors patients remotely using technology (Feebris). Patients can be monitored continuously or intermittently, depending on their condition. The kit is set up for the patient, so they do not need to be tech-savvy. The team can manage IV antibiotics, dressings, blood monitoring, facilitate inpatient diagnostics – essentially, any patient not requiring a physical inpatient bed can be managed at home. All patients are discussed during the Consultant Ward round.

## **Research**

### **Skin cancer vaccine**

We are taking part in a world-first to develop a personalised vaccine against the deadliest form of skin cancer.

The oncology department is one of eight in the UK trialling a personalised mRNA vaccine which is designed to recognise and wipe out any remaining cancerous cells for patients with melanoma.

The vaccine uses the same technology as current Covid vaccines and is being tested in final-stage Phase III trials. Two patients have so far been recruited onto the study at NNUH.

The treatment is not yet available routinely on the NHS outside of clinical trials.

The vaccine is created to match the unique genetic signature of a patient's tumour and works by instructing the body to make proteins or antibodies that attack markers or antigens found only on those cancer cells. In the trial, it is combined with the standard-of-care immunotherapy drug, Pembrolizumab.

### **Dizziness diagnosis device**

A device invented at NNUH, which aims to help the diagnosis of dizziness problems, is being tested by patients across the country in a research study.

The Continuous Ambulatory Vestibular Assessment (CAVA) device has been created in partnership between ourselves and UEA to speed up the diagnosis of the most common causes of dizziness by analysing hours of eye and head movement data.

The lightweight and durable device has been developed over the last six years by a team led by ENT Consultant John Phillips at NNUH and Prof Stephen Cox in the School of Computing Sciences at UEA and is supported by the National Institute for Health and Care Research (NIHR).

Around 20 hospitals across the country are taking part in the latest clinical trial, which involves hundreds of patients wearing the device who have the most common causes of vertigo to help train an AI algorithm to identify moments of dizziness from several hundred hours of data.

CAVA is designed to be worn daily for many weeks by dizziness sufferers, and the data it records is then analysed by a computer to identify periods of dizziness and to suggest their possible cause.

### **Tackling inequalities**

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

Health inequalities are unfair and avoidable differences in health outcomes between different groups of people. Differences in outcomes may be influenced by many factors, or a combination of factors. These factors may be fixed (eg heritage, other protected characteristics), or unfixed (eg currently homelessness, current smoker, prisoner).

NHS England is taking the lead through the Core20 Plus 5 approach which defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

According to the Norfolk County Councils' analysis, 42 communities have been identified where some or all the population live in the 20% most deprived areas in England.

Forty percent of the populations of Great Yarmouth and Norwich live in the most deprived areas in England compared to 16% for Norfolk and Waveney as a whole.

### **NNUH approach to inequalities**

In common with the rest of the NHS, we're following NHS England's approach focusing on five clinical areas for adults as part of Core20 Plus: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension.

For children and young people the key clinical priorities are asthma, diabetes, epilepsy, oral health and mental health.

We have formed a health inequalities working group led by one of the Deputy Medical Directors. A Board baseline assessment was undertaken last year with a series of actions with partners and at Place level to be implemented. Further work is taking place to establish our locally developed initiatives within the organisation, to inform a collaborative approach across all three acute Trusts and the Integrated Care Board to reduce health inequalities.

### **Complex Health Hub**

Our Complex Health Hub is another excellent example of how to address health inequalities in a hospital setting. The team supports collaborative working across hospital teams creating a single pathway for patients requiring extra support such as older people with dementia, patients with learning disabilities, mental health issues, inpatients from prisons and people with substance misuse issues.

The aim is to influence better health outcomes by our specialist services working together to provide an integrated care team.

### **Listening to under-represented communities**

Another valuable piece of work is listening to what patients have to say about their care. Patient and family feedback and working in partnership is vital to help us improve the care we provide. See page 42 for more information.

### **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 Patient Experience Governance Sub-Board.

## How we measure performance

Our services are undergoing a change to bring decision making closer to the frontline and enable managers to make changes more easily.

During 2024/25, we have had four divisions: Medicine; Surgery, Critical and Emergency Care; 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, supported by a Divisional Operations Director and a Divisional Nursing/Clinical Services Director. That model is being applied in future to ten ‘Care Groups’ based on smaller collections of services such as children’s services and maternity. As part of the changes, the management structure is being simplified with fewer layers between the executive team and staff delivering care.

## Integrated Performance Analysis

A monthly integrated performance report is produced by the Trust which provides details of how the Trust is performing on key standards such as infection control, cancer waiting times, urgent and emergency care, plus finance and staffing issues.

It is shared widely with the Trust Board, Management Board, and the Council of Governors. Key themes are shared with staff on the intranet and as part of the Management Board Update which also goes to all staff as part of a weekly staff e-newsletter. The aim is to keep everyone informed on how the Trust is performing and describe our progress towards meeting standards or introducing new quality initiatives.

Example of a summary slide from the integrated performance report:

The slide features the NHS logo and the slogan 'Our Vision The best care for every patient'. The title is 'Best Care for Every Patient – Elective Actuals (6<sup>th</sup> January – 12<sup>th</sup> January 2025)'. It includes a header with programme details and a main table with performance metrics.

Programme	Best Care for Every Patient		Prog. SRO & Prog. Lead		Chris Cobb and Nancy Oliver		Month	December 24
Sub Programme	Elective H2 Plan		Sub Programme Lead		Harjit Lalli			
Outpatients - Trust Level	Actual	Plan	Variance to Plan	Actual Prior Year	Variance to Prior year	Description/Notes/Analysis		
PIFU Rate	5.26%	N/A	N/A	5.86%	-0.6%	Slight decrease against the same week last year		
Cancelled outpatient appointments with less than 6 weeks' notice	165	N/A	N/A	126	39	Significant increase against the previous year		
Outpatient appointment DNA rate	2.94%	N/A	N/A	3.12%	-0.18%	Minor improvement in overall outpatient appointments DNA'd when compared against the same week last year		
Advice and Guidance performance	86.07%	N/A	N/A	67.18%	18.89%	Significant increase against the previous year		

During the year, we have been meeting with our regulator NHS England 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.

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 Norfolk and Waveney Acute Hospital Collaborative)
- Research and Education Committee.

For more information, see the Directors' section on page 58 and the Annual Governance Statement on page 123).

## Quality of care

### **Tendable**

Tendable is a digital audit and inspection tool used across the NNUHFT to provide assurance to patients, clinical teams, and our board, that we are delivering consistent quality care.

### **Quality dashboard**

A quality dashboard is available to support wards and teams to have data available to them to make informed decisions about quality and safety. Staff training and support is offered to ensure good understanding of the data.

### **Care assurance**

The care assurance audit is used in our out-patient areas. It provides an assurance report to each area visited, to complement other data sets and information to make further improvements. In-patient care assurance has ceased now that we have launched the Accreditation of Excellence program in our in-patient areas.

## **Accreditation of Excellence**

In March 2024 we launched the Accreditation of Excellence program in adult in-patient areas. Accreditation brings together key standards of nursing and clinical care into one overarching, evidence-based framework that measures the quality of care and levels of improvement at ward or unit level.

As a driver of continuous improvement accreditation provides:

- A platform for continuous improvement in patient safety, experience and outcomes
- A structured and evidence-based approach to help ward managers and clinical staff understand what the expected standards are, and how well their ward/unit is delivering across the standards
- Improved team accountability and shared governance, enabling ward managers and teams to focus collectively on the key risks and actions required for quality improvement
- Shared learning from the dissemination of excellent practice
- A culture of pride and accomplishment, boosting staff morale and motivation.

We are currently developing a specific accreditation framework for Paediatrics and Maternity in-patient areas; these will be launched in the next 6 months. This will then be followed by the development of an out-patient Accreditation framework.

## **Clinical documentation**

A new Adult Inpatient booklet was launched at the end of April 2024. The booklet has been produced to bring together all adult initial assessment information, mandatory risk assessments, nursing needs assessments and the daily evaluation of care into one booklet. This allows us to enhance patient safety and provide assurance of the initial patient assessment and develop an individualised plan of care. We are at the final stages of developing an adult in-patient 3-day surgical booklet, bringing together all documentation from pre-assessment, admission to Same Day Admissions Unit and the post-op ward.

## **Care Quality Commission (CQC)**

In August 2024, we received three reports from the CQC following an inspection in November 2023. Overall, our ratings remain unchanged - as a Trust that's "Requires improvement", and we're "Good" for "Caring" and "Effective" and remain "Requires Improvement" for "Well led", "Safe" and "Responsive".

Inspectors visited Diagnostic Imaging, Surgery and Out-patient services, all of which were also rated "Requires improvement". The maternity report was published in February 2024 and Maternity services were rated as 'Good' for both safety and well-led following the inspection in November 2023.

## **Our Financial Performance**

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 breakeven financial plan in line with the Operational Planning Guidance.**

The plan assumed a breakeven financial position after reflecting the NHS 'block' and the variable Elective Recovery Funding. On an NHS reporting basis, a breakeven plan was achieved, which was in line with our forecast outturn.

### **Thus, the reported financial position for the full year was breakeven compared to a breakeven plan.**

## **Financial Improvement**

Throughout the financial year, the Trust has been active in developing efficiency plans responsive to different operational scenarios. For the year ended 31 March 2025, £43.7m of efficiency savings were delivered against a plan of £50.1m. 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**

The generation of cash from operations and the receipt of capital cash funding has resulted in closing cash of £93.4m.

## **Capital Expenditure**

The Trust invested £70.6m in new and replacement capital assets (excluding leases) during the year (2023-24: £35.8m). The most notable investments were:

- Electronic Patient Record – £17.8m
- Clinical Equipment Replacement – £7.0m
- Diagnostic Assessment Centre – £31.9m
- Other digital investments – £3.6m

## **Overseas operations**

The Trust does not have any overseas operations.

## Charitable Funding

The Trust is supported by several charities and most particularly the Norfolk and Norwich Hospitals Charity. In 2024/25, the Trust benefitted from £4.7m of charitably donated assets (2023-24: £0.2m). The N&N Hospitals Charity has awarded a further £0.8m in charitable grants to enhance patient care and facilities in the Trust. The Trust is truly grateful to everyone who has donated to the N&N Charity to make this possible.



## Operational Future

The Trust continues to be heavily focused on improving services for our patients whilst ensuring that taxpayers money is spent wisely. The Trust is working closely with system partners to plan and deliver locally against NHS England's priorities for the 2025/26 year ahead, with key areas of focus for us being:

**Recovery of services** – System recovery plans must set out actions to recover elective, emergency, and primary care services.

**Reduce spend on temporary staffing and support functions** through increased workforce productivity and robust review of establishment growth, whilst implementing all elements of the People Promise to improve working lives and increase staff retention and attendance.

**Improving productivity** by reducing unnecessary processes and discharge delays, tackling unwarranted variation, and improving procurement, contract management and prescribing.

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 2025/26 that provides clarity over funding arrangements and supports the Trust, along with system partners, to deliver these priorities. The Trust has submitted a breakeven plan for 2025/26, and the Integrated Care System has also submitted a breakeven plan.

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 2024/25

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

### Better Payment Practice Code - measure of compliance

	Year ended 31 March 2025		Year ended 31 March 2024	
	Number	£'000	Number	£'000
Total Non-NHS trade invoices paid in the year	142,496	487,783	152,811	442,493
Total Non-NHS trade invoices paid within target	133,206	463,292	140,893	393,767
Percentage of Non-NHS trade invoices paid within target	94%	95%	92%	89%
Total NHS trade invoices paid in the year	2,858	54,913	2,672	45,343
Total NHS trade invoices paid within target	2,589	51,517	2,393	42,946
Percentage of NHS trade invoices paid within Target	91%	94%	90%	95%

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

Disclosures relating to any interest paid can be found in note 12 to the accounts.

# Social and Community

We aim to be at the heart of our community serving the changing needs of Norfolk and Norwich urban and rural areas. We have the privilege of touching the lives of patients, carers, service users, visitors, volunteers and employers; all contributing to a patient centred approach to care.

Local people can get involved in a number of ways, primarily through our large membership scheme, but also through our patient engagement activities which includes our Patient Panel, Carers Forum, Military Community Working Group, Maternity and Neonatal Voices Partnership, Together Against Cancer Forum as well as a range of innovative volunteer roles. During 2024/25 the Trust launched a Youth Forum who are now meeting monthly and are keen to be involved in improvement projects across the Trust.

Patient and family feedback and working in partnership is vital to help us improve the care we provide, and we do this several ways outlined on the following pages.

## **Patient, Carer and Family Feedback**

We have continued to work with our patients, service users, families and carers, gathering thousands of pieces of feedback in ways that are accessible for our communities.

During the year our community engagement activities, primarily led by our Patient Engagement and Experience Team, have continued to focus on hearing from our local communities, especially those who are less well heard.

The team attended a total of 35 engagement events in 2024. These ranged from Carers Information Days at The Forum, Norwich PRIDE to hear from lesbian, gay, bisexual, transgender communities; PositiviTea events in north Norfolk focusing on Dementia, People Living with Longterm Conditions and Grieving; Armed Forces Event; visits to HMP Wayland, HMP Bure and HMP Norwich and Cromer Carers Meetings at Cromer Hospital.

The team also organised the Trust's Armed Forces Day event in June 2024 and worked with the Spiritual Health Team to organise a Remembrance Service in November that was attended by over 500 NNUH staff, patients and visitors.

We also continued networking, raising awareness, including to create a collaborative patient story in partnership with Age UK and service users covering falls prevention and the need to tackle this as a system; presenting the outcomes from our Health Inequalities focused MNVP partnership work at NHSE's Experience of Care Week and running our largest Patient Led Assessment of the Care Environment (PLACE) to date with 19 Patient assessors taking part across three days.

This year the team built on the work with colleagues in the Complex Health Hub collecting feedback from prisoners who use our hospital services. By the end of March 2025 we had completed four visits to the prisons in our catchment area. We ask prisoners what has gone well with their care at NNUH and what could be improved.

The feedback received from these visits has resulted in an action plan being formed to create improvements in communications between the prisons and the hospital.

**Patient Panel** - A group of volunteers with a range of lived experiences of NNUH services as Patients, Carers and people with a passion and interest in ensuring *the best care for every patient* at NNUH

### **The role of the Panel**

- Work on behalf of all patients, carers, relatives and visitors in order to improve patient and carer experience in partnership with staff.
- Act as the independent and constructive ‘voice of the patient/carer’.
- Contribute to the continuous improvement of quality and services delivered by the Trust ensuring that the views of service users are sought, co-ordinated, fed back and used.

The Panel’s breadth and depth of involvement and engagement across NNUH has grown enormously over the last year.

As well as meeting together on a monthly basis members have become even more ‘embedded’ across the organisation as they have developed their understanding of how best they can be ‘deployed’ to support and work with clinical and non-clinical staff across the Trust - whether on a Committee, Task & Finish Group or as part of a multi-disciplinary team undertaking audits, ward visits or improvement projects. Members’ ‘portfolios’ reflect both the needs of the organisation and Patient/Carer Voices as well as reflecting the passions, interests and expertise of Panel members. This creates a mutual aid and benefit feeling for all involved. Positively supporting a shared ambition of working together as described in the Trust Strategy “Caring with Pride” and our commitment to patients that “together we will develop services so that everyone has the best experience of care and treatment.”

The Panel has remained crucial to the Patient Led Assessment of the Care Environment (PLACE) annual audits alongside regular Care Assurance Visits which sees members, alongside clinical colleagues, visits wards and departments to observe and talk with patients and families about their experiences.

Members sit on a number of committees, working and project groups including the Patient Engagement & Experience Group, Mental Health and Complex Care Board, Dementia Strategy Group, Food & Drink Group, Health Inequalities Group and Infection Control Committee as well as supporting the production of appropriate patient information via the Patient Information Forum.

### **Carers Forum**

The Carers Forum meets bi-monthly and has continued to work on improving identification of and recognition of carers and support for them when the cared for person is accessing hospital care. We have been re-accredited the Carer Friendly Award Tick-Health from Caring Together.

The forum and the Patient Experience team supported the system wide co-production of a Carers Identity Passport, now in use across Norfolk and Waveney. This is supporting teams and staff with better identification of carers alongside continued carer awareness training. The forum has supported an ongoing review our Carers' Policy and have supported the co-production of projects providing valuable input to shape our service delivery. We partnered with Caring Together to deliver five online Carers Awareness Trainings to colleagues across the trust.

### **Military Community Working Group**

The Military Community Working Group (MCWG) has been set up in order to improve experiences of care for patients, staff and carers who have a military background. Supported by an Executive Lead the group is co-chaired by Veterans – a staff member and a Patient Panel member. The priority for the group this year has been to support the Veteran Aware (VA) reaccreditation award.

Our newly adopted action plan will continue to support staff with veteran awareness training and support for staff who are veterans. In March 2024, the MCWG supported a SSAFA (armed forces charity) caseworker (Mandy Small) who visited the hospital, supporting patients and families who are veterans to support discharge and community support. This year Mandy held numerous awareness stands on site where she spoke to 74 employees and over 80 patients/Carers/relatives. In her work on site Mandy referred two patients to Op Courage for ongoing mental health support and referred seven patients to SSAFA and a further eight to other local charities. Mandy also delivered training sessions to the Dementia and Substance Misuse teams about SSAFA and their services

### **Divisional working**

The hospital's clinical divisions have been strengthening their local patient and carer engagement further throughout the year:

The Clinical Support Services Division have strengthened their own patient panel, promoting co-production in quality improvement projects; involvement in research projects, reviewing department patient feedback, external validation of services, sustainability in Pharmacy and capital build projects, including the prestigious new Community Diagnostic Centre (CDC).

*One member who was invited on to the CDC Signage Task and Finish Group to resolve a variety of issues said: "I was asked my views on what the inside was going to look like, layout, seating areas and exits. I was shown round the site at the end of 2024. Seeing the building in the flesh and what we had talked about in the meetings I was amazed. It looks fantastic and the layout is really good for flow with colour-coded areas all on one level. It was really interesting to be involved. It is a great facility, which I'm sure it will benefit everyone who needs to access it."*

The Maternity department has continued to develop and strengthen their relationship with Maternity and Neonatal Voices Partnership (MNVP) supported by the Patient Experience Team. This strong partnership working with the MNVP and the Maternity Department has gone from strength to strength and the new way of working is fully embedded. The innovative Volunteer Outreach roles are working well and have embedded themselves nicely into the community.

There have now been five volunteers recruited, with more on the way!

The MNVP have made agreements with 30 community groups in the area to host a volunteer at their regular meet ups and they attend groups monthly. MNVP volunteers have attended 22 groups and 5 one-off events in 2024 which supports our aims to amplify people's voices within the NNUH maternity team.

The focus of their engagement is on the local maternity and neonatal service Equity and Equality Needs Assessment to ensure they focus on underrepresented communities. Attending these groups has led to an increase in anecdotal feedback that we wouldn't have heard without this level of community engagement.

This has also helped develop trusted community connections including the 'mini futures' project located in the heart of the Marlpit Housing Estate. MNVP and NNUH maternity attend regular stay and play sessions at the centre which provides vital support to one of the most disadvantaged areas in the UK. They have also created links with the local Bengali community and plan to develop this further to encourage and offer opportunities for them to feedback their experience.

A particular highlight this past year has been that the Women's and Children's Division recruited a Youth Worker who has put together a Youth Forum to work on a range of co-production improvement initiatives.

### **Youth Forum progress**

The Youth Forum has been actively engaging young people in shaping healthcare services for just over a year. The forum comprises seven dedicated members who have contributed to various initiatives aimed at enhancing the hospital experience for children and young people.

### **Achievements in 2024:**

- **Jenny Lind Website Enhancement:** The forum provided valuable feedback on updating the Jenny Lind Children's Hospital website, ensuring it is more informative and user-friendly for patients and families.
- **Christmas Fundraising Initiatives:** Members organised fundraising activities to purchase gifts for older age groups during the Christmas season, fostering a sense of community and care among patients.
- **Children and Young People's Plan Development:** Collaborating with the service lead for paediatrics, the forum played a pivotal role in shaping the Children and Young People's Plan, aligning hospital services with the needs and preferences of young patients.
- **Podcast Participation:** The forum contributed to the "Behind the Curtains" podcast, sharing insights and experiences to raise awareness and inform listeners about youth perspectives in healthcare.
- **Community Building:** Through regular meetings and collaborative projects, the forum has fostered a supportive community, providing members with a platform to connect, share ideas, and work collectively towards common goals.

## Planned Initiatives for 2025:

- **15 Steps Challenge:** The forum plans to participate in the 15 Steps Challenge, an initiative that allows patients and visitors to experience care environments from a patient's perspective, providing feedback to improve services.
- **Adolescent Room Development:** Members will continue their involvement in the development of the adolescent room, aiming to create a space that meets the unique needs of teenage patients, enhancing their hospital experience.
- **Media Collaboration:** The forum aims to collaborate with local radio stations to promote its activities and raise awareness about the importance of youth engagement in healthcare, reaching a broader audience and encouraging more young people to get involved.

The NNUH Youth Forum has demonstrated a strong commitment to improving healthcare services for young patients. Through their diverse initiatives, members have not only contributed to tangible improvements within the hospital but have also built a supportive community that empowers young people to actively participate in shaping their healthcare experiences.

## Friends and Family Test

Every day we collect feedback via the Friends and Family Test. This is a nationally endorsed question asking about the quality and experience of care received. In the last year we had over 45,470 responses. 93% were positive with the Trust highly rated for staff attitude.

There are multiple routes to collect this including SMS txt messages, QR codes, postcards, links on our website and volunteers playing a crucial role in collecting feedback on wards and via post-discharge phone calls.

Feedback collected from FFT has been used for example by our Divisional Nursing Directors to understand the impact of open visiting, follow a quality improvement methodology and test changes to our approach based on feedback from both staff, visitors and patients.

## Healthwatch Norfolk

Visits from Healthwatch Norfolk continued in several areas within the hospital. In 2024 Healthwatch Norfolk visited the Colney Centre, Acute Medical Units and Maternity Services. You can view all the [reports produced by Healthwatch Norfolk on their website](#). Feedback collected from the visits and via the website is shared at the Patient Engagement and Experience Group sub-board quarterly. The Healthwatch Norfolk team also supported us with the PLACE assessment by joining two of the three assessment days, collected [patient opinion on the Major Trauma Centre proposals](#) and supported with our Equality Delivery System (EDS) submission by visiting the Elsie Bertram Centre and the Audiology Department. Healthwatch Norfolk staff gathered feedback from Diabetes and Audiology patients which informed our EDS report about those services.

### **Equality Delivery System – checking how we support people from all communities, especially those less well heard.**

Our work with divisions and communities has continued, using the Equality Delivery System as a tool to measure how we are performing against key equality priorities. The EDS tool has again been utilised by the Patient Engagement and Experience team to gather evidence and evaluate the patient focused Domain 1. The three areas chosen for a focused review this year were Diabetes, Audiology and Maternity.

The grading and evidence contribute evidence to the system wide EDS submission. This work will support the trust wider Health Inequalities work supporting the most vulnerable and seldom heard communities.

### **Increased Provision for Interpreting Services**

During the year, following feedback from patients and staff, we worked with our Interpreter provider to expand the provision of Virtual Interpreting – we now have a network of 25 'Interpreters on Wheels' (IOW) enabling on demand access to over 240 languages via audio 24/7 and over 40 languages via video. The technology is also available to use on all trust iPhones and iPads.

Since we introduced this new technology into the trust it's been used over 494 times across the hospital. The shortest call was 1 minute and the longest lasted 289 minutes. We've received glowing feedback from the departments who initially trialled the IOW devices in Radiology and Maternity.

*"It was worth more than its weight in gold for us when we had an unexpected IUFD present with a family that spoke no English. The fact that it was so simple to connect, had an excellently clear loudspeaker and was portable made the process remarkably easier. It was honestly invaluable as a source of effective communication and easy to use."* – Delivery Suite Midwife

*"We have been using an IoW device in Radiology since April. The device has been really well received with feedback from the different areas where it has been used being positive, and staff commenting that they love using it. The IOW has enabled patients to be examined efficiently rather than having to be rebooked and interpreters organised. The face-to-face function of IOW has been well received by patients. And the moveability/flexibility of the device has enabled patients to access an interpreter whilst laying on the scanning beds."*- Radiology Department

### **Family Liaison**

The Family Liaison Service came to an end in October 2024. We took lessons learnt from the service and created a Family Liaison Practice Facilitator role to embed the learning and approach at ward level directly. The post was supported by SCEC and Medicine divisions and works closely with Deputy Divisional Nurse Directors to develop a programme of support to divisions, wards and departments. The initial focus will be on supporting opening up visiting and the review of the role of ward clerks and how they are instrumental in improving patient, family and carer communication.

## **PALS and Complaints Service**

Responding to concerns and complaints is a key component of a caring and responsive organisation. The PALS and Complaints team are central to this and have continued to support patients and families raising concerns and providing support and answers to complaints and concerns and delivering resolution meetings between families and clinicians and other colleagues.

We received over 4,600 PALS contacts and over 900 formal complaints during the year. PALS contacts range from simply signposting someone for further information or advice eg to the Cancer Information Hub or checking on appointments and test results or other waiting times through to more complex, here and now concerns and queries from for eg an inpatient or their family. This is often then resolved by the ward Sister or area Matron intervening to support directly with a response.

The formal complaints received are varied but all require a bit more looking into or deeper investigation and involve the clinical and administrative teams across divisions with written responses coordinated by the Complaints team.

The divisions report to Patient Engagement and Experience Group on how they use the feedback from complaints and PALS to inform learning and improvements. For example: themes around caring for patients in corridors at times of intense pressure which led to the provision of essential extra equipment such as 'big mack' portable bells, improved risk assessments and senior oversight. They also identified improvements for end-of-life care including 'home from home' boxes supporting 'hospice type care in acute settings and a fast-track home checklist. There have also been improvements made to pain management services and spinal care management training.

Through our joint collaboration with the Roald Dahl Marvellous Children's Charity, we employed our own Children with Medical Complexities Clinical Nurse specialist to support our patients and families to navigate our multifaceted NHS services, enabling them to have more time as a family and alleviate the stresses often involved with attending multiple appointments and being under multiple professional teams. Improving support for new dads and meeting the needs of post-natal mothers has also been addressed.

The team has continued to work adhering to the PHSO (Parliamentary and Health Service Ombudsman) framework. We continue to work closely with our Divisions to share themes and fluctuation via monthly meetings.

Training from the PALS team is provided for front line staff to enable 'point of care' resolution of concerns through their bespoke Let's Resolve It Together training.

## **Patient Safety Partners (PSP)**

During the year we expanded to two Patient Safety Partners at the Trust. This is a new role, drawing in people with lived experience to focus specifically on patient safety strategy issues and initiatives. The two PSPs operate at a strategic level as members of the Quality and Safety Committee and Clinical Safety and Effectiveness Sub-Board and support the review and sign off for the new Patient Safety Incident Investigations.

## 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 500 volunteers (across five 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 disabilities 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.

Patient Panel members are all volunteers and we have been developing a number of unique roles to support for example outreach volunteers with the MNVP (Maternity and Neonatal Voices Partnership) for community engagement as well as Patient Assessors for the Patient Led Assessment of the Care Environment (PLACE) assessment team.

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, while another team of volunteers provide wayfinding, carparking and general information on our outpatient reception desks.

Fundraising volunteers have been assigned to Norfolk and Norwich Hospitals Charity and assist with all kinds of fundraising events and activities which helps raise funds for projects hospital wide.

We also provide volunteer support in some more specialist roles:

### **Patient experience volunteers**

There are a variety of volunteer roles available to help improve patient experience. These volunteers could be visiting the wards with iPads to collect feedback from patients, calling patients following discharge to ask for their feedback on their stay or supporting with the admin around the friends and family test (FFT) such as collecting cards, stamping cards, packing for collections and small amounts of data input. We also have some unique volunteer opportunities such as experts by experience giving people the opportunity to share their lived experience to improve care for others and PLACE volunteers who join a yearly assessment looking at how the environment impacts on patient care.

### **End of Life Butterfly Volunteers**

We are very proud of our 'Butterfly Volunteers' who provide compassionate care and emotional support for patients at the end of life across the hospital. The volunteers provide support to patients and their loved ones who have been recognised as needing palliative care or who are in the last days and hours of their life. Butterflies 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 patient's 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 two 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 virtual ward by delivering kits and transporting their patients.

### **Inpatient Wards**

Volunteers support the prevention of deconditioning by providing a wide range of enrichment activities for patients on wards including puzzles and interactive games on smart screens and tablets. They support the dementia support team by calling patients' next of kin to discuss and complete 'This is Me' booklets, which can tell staff and visitors about patients' backgrounds, likes and dislikes and enable a more person-focussed approach to care and support. They also provide mealtime assistance to support good hydration and nutrition by cutting up food and encouraging patients to eat.

### **Pets As Therapy Dogs**

Research provides evidence that dogs can have a positive effect on our patients' wellbeing and assist a speedier recovery and 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. Feedback from the wards is extremely positive, the PAT dogs lift the mood of our long stay patients and staff morale is always greatly improved.

### **Emergency Department**

Volunteers support all areas of the Emergency department. They can support patients who may be alone and anxious, patients who are elderly and confused, homeless or struggling with their mental health and even those at end of life.

They support staff in a wide range of tasks such as providing refreshments, escorting patients, stocking up clinical areas, taking telephone calls, finding wheelchairs, basic admin tasks and collecting patient feedback.

### **Welfare and safety netting calls**

Volunteers call patients post discharge to check on their wellbeing. They ask 10 short questions to assess how they are managing back at home. This can range from asking the patient if they are eating, drinking and sleeping ok, whether they have enough food in the house, if they have any concerns about medications or wound care and if they are feeling lonely or isolated. Patient concerns are fed back to a coordinator who can signpost to further support in the community to ensure the patient is supported at home and potentially reducing any potential readmissions.

### **Outpatient Clinic Calls**

Volunteers support our clinics by calling patients a few days ahead of an appointment to check if they are intending to attend, if they understand the preparation for the appointment, if they have any barriers to attending or any concerns about the procedure. Patient concerns are fed back to the bookings teams who are able to address any queries and ultimately avoid non-attendance.

### **Membership scheme**

As a foundation trust, we have a membership scheme with over 14,000 public members. Members receive a copy of our magazine The Pulse, they are invited to participate in surveys and invited to events such as the Dementia Fayre and Annual General Meeting. More information about membership is given in the Council of Governors' section of the Director's report on pages 85.

### **Norfolk & Norwich Hospitals Charity**

The N&N Hospitals Charity is the primary charity associated with the Trust and its Hospitals. The past year 2024/25 has been another year of real achievement in which the Charity has supported enhanced care, helping to make the Trust even better for patients.



We are continuing to grow and develop our Charity – doing more to support all the Trust's Hospitals and facilities. The Charity accounts for 2024/25 are yet to be formally audited but we expect them to show total income in the region of £2.7m.

**More Grants awarded by the Charity:** We are actively using our funds to make a real difference for patients and staff and during 2024/25 we have spent another £2 million on charitable activities. We also carry forward commitments of a further £1.5 million in approved grants – supporting more projects and better care for patients into the future.

#### **More support for our midwives**

With the support of a gift left in the will of Anne Love (resident of North Norfolk), the N&N Hospitals Charity Committee has approved a grant of £98k to provide a base for our Walsingham Team of community midwives at Cromer Hospital.

***“This is brilliant! It will help our midwives to offer better and more flexible services to our North Norfolk patients and their families”.***

Pam Sizer – Community Midwifery Matron

## Major grants

In addition to hundreds of smaller grants, in recent years the Charity has been able to make significant contributions to major projects and initiatives. This has continued during 2024/25.

A grant of £1.6 million has funded additional scanners and imaging equipment at the Trust's new Community Diagnostic Centre which opened in March 2025, on the Norwich Research Park. The Centre provides facilities for investigation and monitoring of patients across all clinical specialities but the Charity's contribution may be particularly relevant for cardiology and cancer patients. A grant of £2 million has funded equipment throughout the new Norfolk and Norwich Orthopaedic Centre (NANOC) which opened in October 2024. The NANOC builds on the long history of expertise in orthopaedic surgery in Norwich and the Charity's grant is facilitating even greater access to specialist services for local patients.

### Our donors

The Charity is supported by hundreds of individuals, families, community groups and businesses. Fundraisers have walked, run, abseiled, boxed, knitted and baked to support our aim of better care in our local hospitals, and we are incredibly grateful to everyone who has worked hard to support us in 2024/25. Every penny counts, so whether a donation is big or small, we are grateful for each and every one.

In October 2024, the Charity Committee confirmed a grant of £100k to fund the services of our Complementary Therapies Team for the next two years and to extend their therapies to more patients requiring cancer and palliative care across the Hospital.

*"This is an amazing development for our patients. Offering a holistic approach to the emotional and psychological needs of patients, as well as the physical, has been proven to be beneficial for wellbeing. **We are extremely grateful to the N&N Hospitals Charity for funding this service.**"*

Daniela Ayre, Matron, Lead Nurse, Specialist Palliative Care Team

### Supporting our Norfolk patients and clinicians:

In October 2024, the Charity Committee was pleased to award a grant of £60,000 to support maintenance of the Norfolk Arthritis Register (NOAR) for the next 3 years.

NOAR is the largest inception cohort of patients with rheumatoid arthritis globally and has been recruiting patients from across Norfolk continuously since 1990. It is a major regional, national, and international research resource.

*"This is tremendous news - transformative for us. I am absolutely delighted. It is a great example of the Charity's funds supporting innovative and impactful research within the local community."*

Professor Alex MacGregor – Director, Norwich Epidemiology Centre (UEA) & Honorary Consultant Rheumatologist (NNUH)

### Supporting care in rural & coastal North Norfolk:

*"In the last 5 years the N&N Hospitals Charity has awarded grants totalling more than £3m to support the care of patients at Cromer & District Hospital."*

***Our thanks go to everyone who fundraises for our Charity, and to those who leave gifts in wills, to enable these grants to be made. Their generosity is humbling and much appreciated.*** John Paul Garside – Charity Director

Almost half of our grants are made possible thanks to gifts in wills and we have been notified of 15 new legacy gifts this year. To everyone who remembers us in their will, and to their families, thank you.

**Fundraising £3m to purchase another two surgical robots:**

*“With the support of the Hospital’s Charity we are able to provide really specialist surgery to our patients, many of whom have advanced cancer. Our robotic systems are some of the busiest in the NHS and have assisted our surgeons to treat nearly 5,000 patients with really precise surgery, reducing complications and length of hospital stay. **With more robots we can do even more for our patients and we are very grateful to all the donors and supporters of our Hospital Charity.**”*

James Hernon – Consultant General & Colorectal Surgeon

**Some key facts & figures:**

The Charity provides hundreds of grants each year:

- sponsoring training courses for staff,
- purchasing additional items of equipment,
- supporting clinical research and
- funding enhancements to the patient environment and services.

Over 10 years to 2024 the Charity has raised £22 million in funds and spent £24 million in charitable expenditure

Many grants are small but our largest was £2 million for equipment in the new orthopaedic centre which opened in October 2024.

More than half the grants support staff to provide improved patient care, for example through advanced training and education.

We actively limit spending on administration and overheads. Our fundraising costs are extremely low and on average are less than 10p for every £1 spent on charitable expenditure – a ratio of 9:1.

**Next Steps and Looking Ahead**

The Charity provides support to departments and services across the Trust and all its sites.

We have a number of ongoing and planned fundraising appeals and campaigns, to assist the Trust with further enhancements and to support better care.

- **Surgical Robots:** in 2021 the Charity awarded a grant of £1 million to support programme of robot assisted surgery at NNUH. This has been put to really impressive use by our surgical teams and we are now raising £3 million to purchase two more robot surgical support systems;
- **Parental accommodation:** the Charity has raised £375,000 to start a project to create additional accommodation for parents of children and babies in our Jenny Lind Children’s Hospital including our Neonatal Intensive Care Unit (NICU). We will continue to raise funds for this project in 2025/26, to enhance the facilities for our specialist Children’s Hospital

### Supporting research for patient benefit:

The Corporate Trustee has set a target to award research-related funding of £0.5 million per annum, on a sustained basis by 2027. We have established a funding programme to achieve this target two years ahead of schedule, with £3m of research funding over the next 5 years.

During 2024/25 the Charity Committee approved a grant of £150k to establish a Clinical Seedcorn Fund Programme, with match funding from our partners in Quadram Institute Bioscience, to explore clinical research projects in:

- The role of the gut microbiome in pregnancy - Dr Antonietta Heyhoe and Prof Jonathan Lartey
- Characterising the microbiome in relation to cholestatic liver disease - Dr Naiara Beraza and Dr Simon Rushbrook
- Vitamin B12 and folate sufficiency in very pre-term babies at the time of discharge home - Prof Martin Warren and Dr Isabel Iglesias-Platas
- Bloodstream infection diagnosis using metagenomics - Dr Matthew Gilmour and Dr Ngozi Elumogo
- Establishment of an Oral Biorepository – Dr Jennifer Ahn-Jarvis and Prof John Phillips
- Use of organ-on-chip technology to address resistance to fungal infection in women - Dr Emily Jones and Dr Paul Simpson
- Decreasing risk of urinary tract infections in Type 2 diabetes mellitus patients – Prof Alison Mather and Dr Jason Cheung

We are very excited by these prospects for Norwich researchers to achieve real benefit for patients with the support of our Charity funding.

### Can you help?

We are very grateful to all our supporters and fundraisers. If you would like more information, or to donate to support our work, please visit [www.nnhospitalscharity.org.uk](http://www.nnhospitalscharity.org.uk).

[If you would like to talk directly to a member of the Charity team, please email us at charity@nnuh.nhs.uk or phone 01603 287107.](mailto:charity@nnuh.nhs.uk)

To find out more about the Charity, or to sign-up for our quarterly Newsletter, please visit [www.nnhospitalscharity.org.uk](http://www.nnhospitalscharity.org.uk) or keep up to date with us on Twitter, Facebook, Instagram or LinkedIn @NNHospCharity



A group of our robot-assisted surgeons.



**Norfolk & Norwich  
Hospitals Charity**

## Sustainability: Delivery and Taskforce on Climate-related Financial Disclosures

### Greening with PRIDE

Our updated [Green Plan: Green with Pride](#), was adopted by our Board on 11 September 2024. It outlines our proposed aims, plans and their targeted outcomes across the “triple bottom line” – social, environment and economic. It pushes a focus on considering the local and global impacts of these three elements, driving change towards the best interests of public health.

The plan is broken down into the key focus areas for ease of responsibility and accountability across our departments and management. It covers aspects such as waste, resources, energy, travel and transport, digitalisation, biodiversity, and staff engagement and training. These areas align with the NHS England and NHS Improvement’s ambitions and expectations for decarbonisation and create a holistic view around sustainability. The plan focuses on the following elements:

**People Focussed leadership:** further develop communications and engagement to ensure appropriate profile is given to this plan to engender and support empowerment and transformation.

**Sustainable Models of Care:** embed sustainability into our divisional operations, adapting the way we work to be more informed and responsible consumers.

**Making our Infrastructure Count:** support reducing the need to travel, encourage green forms of transport and look to provide supporting infrastructure.

**Reducing Travel and Transport emissions:** support reducing the need to travel, encourage green forms of transport and look to provide supporting infrastructure.

**Sustainable Procurement:** support procurement processes to limit the production of consumables where possible and ensure their responsible use and disposal.

**Making it Happen:** work towards having the right funding and resources in place to support the Green Plan.

### Our Story so far:

**Green Champions:** During 2024 we reached our target of having 500 NNUH Green Champions. As of 31 March 2025, NNUH had 530 Green Champions.

**Divisional representation and Green Groups:** During 2024 NNUH worked with divisional governance to achieve representation on Sustainability Committee across the clinical divisions. This included endorsement of the Green Plan plus nominated colleagues or groups that have responsibility for sustainability. NNUH also welcomed a new Green Group in Pharmacy who won the special award for sustainability alongside Radiology at the 2024 Staff Awards.

**Toolkit and dashboard:** The Green Plan’s aims around creating a Sustainability Toolkit and Dashboard were also achieved this year.

**Manifold decommissioning:** NHS England funded the decommissioning of our Nitrous Oxide manifold. Nitrous Oxide is almost 300 times more potent as a Greenhouse Gas than Carbon Dioxide and there has been much discussion over preceding years as to the impact decommissioning the manifold may have. That being said NNUH has quantified the benefit of this scheme to be 360 tonnes CO<sub>2</sub>e per annum.

**Centre for Sustainable Healthcare competition inc. midwifery:** NNUH's Women and Children's Division won a national Green Midwifery Competition with a project focussed on better care for patients with Hyperemesis Gravidarum. NNUH, funded by the Hospital's Charity, has launched a Green Team competition of its own in partnership with the Centre for Sustainable Healthcare.

**Walking aids:** This year also saw the introduction of NNUH's walking aid recycling scheme with Norse and the Prison Service. In 2 months, 230 items were refurbished, saving just over 3 tonnes CO<sub>2</sub>e.

**Food and Drink and food digester:** NNUH has set up a new Food and Drink for Healthcare Steering Committee to deliver the National Standards for Healthcare Food and Drink specifically the delivery of high-quality, healthy and sustainable food and minimised waste. A new food digester has also been delivered to adhere to new food waste regulations.

**LED funding:** The Trust was also successful in securing funding for LEDs at Cromer through the NHS Energy Efficiency Fund. This work has already been completed.

**Offensive waste:** The Trust has successfully introduced Offensive Waste across its Estate. It is believed that once the appropriate segregation of clinical waste is achieved across the organisation that 390 tonnes CO<sub>2</sub>e will be saved per annum.

**Policies and procedures:** NNUH worked with the Acute Collaborative across the Norfolk and Waveney Integrated Care System to develop a sustainability section in the updated Procedural Document Development Policy which applies to the three acute Trusts in our area.

### **Plan for next year**

New statutory guidance was released on 4 February 2025 which has been considered by Sustainability Committee and reported to Board on 2 April 2025. A few minor amendments to the actions identified in the Plan were agreed in line with this guidance and as part of the annual update which will be communicated with regional NHS teams by 31 July 2025 as required.

### **Task Force on Climate-related Financial Disclosures (TCFD)**

NHS England's NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of the sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in the sustainability reporting requirements on a phased basis up to the 2025-26 financial year.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars for 2024/25. These disclosures are provided below.

### **Governance**

The Board receives quarterly updates via its Finance, Investments and Performance Committee (FIPC) and six-monthly reports directly. Reports monitor progress against goals and targets for addressing climate related issues. Both consider how climate related issues impact broader organisational plans and performance monitoring.

A member of the Executive Team is assigned as Senior Responsible Officer and has formed a Sustainability Committee whose purpose is defined in its Terms of Reference to:

- Create and oversee the programme of work to deliver the NNUH Green Plan
- Support the embedding of sustainability into the day-to-day operations and decision-making of the Trust
- Provide a forum that encourages Trust wide/Board to ward engagement for sustainability across the Trust
- Oversee and manage accurate reporting of the Trust's net zero emissions targets set by NHS England and the Norfolk and Waveney Integrated Care System (ICS)

Other areas of escalation are taken via Hospital Management Board as appropriate/required.

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, we recognise that we must take a more proactive action on driving sustainability, decarbonisation and social value across our organisation and supply chain through working with our Partners.

### **Risk management**

Sustainability Committee identifies and assesses climate-related risks and escalates within the organisation as appropriate. The main identified risk is associated with financial penalties for using fossil fuels meaning the Trust is open to volatile utility pricing: IF the Trust continues to use fossil fuels and grid electricity (at least in the short to medium term) THEN the Trust will continue to see increasing fines with respect to carbon emissions and volatile utility prices RESULTING IN funding having to be diverted from other areas of spend.

The Trust is mitigating this risk by exploring the decarbonisation of heat and its supporting infrastructure.

Risks are escalated by Sustainability Committee to Hospital Management Board, FIPC and the Board as part of reporting alongside other Trust risks as appropriate.

### **Metrics and targets**

Table 1 shows the KPIs NNUH uses to monitor overall progress as instructed by NHS England. The metric around fossil fuel consumption is related to our key risk specifically. The [Green Plan](#) also has an action delivery performance table appended to it.

**Table 1 – NHS England metrics**

<b>Focus area</b>	<b>Metric</b>	<b>Data</b>
<b>Workforce</b>	Named board-level lead for green plan	Linda Martin
<b>Medicines</b>	N2O volume and emissions	Data not received
	Entonox volume and emissions	Data not received
<b>Travel and transport</b>	% of owned/leased fleet that is ULEV or ZEV	None in corporate fleet.
	Total fleet emissions	Not monitored
	Only ZEVs in its salary sacrifice scheme?	No
	Does the organisation operate sustainable travel-related schemes for staff?	Yes
<b>Estates and facilities</b>	Emissions from fossil-fuel-led heating sources	Data not yet available
	Number of oil-led heating systems	None
	% of gross internal area covered by LED lighting	41.8% on Mainsite (Feb) 100% at main offsites
	% of sites with a heat decarbonisation plan	Mainsite only
<b>Supply chain and procurement</b>	Inclusion of CRPs and Net Zero Commitment requirements in all relevant procurements	Yes
	Inclusion of requirements for a minimum 10% social value in procurements, including KPIs	Yes, excluding KPIs
<b>Food and nutrition</b>	Weight of food waste: spoilage, production, unserved and plate waste	Planned
<b>Adaptation</b>	Number of overheating occurrences triggering a risk assessment (in line with “heatwave” plan)	Data not received
	Number of flood occurrences triggering a risk assessment	Data not received

### **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 1 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.
- Our 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 2024/25.

## Approval of the Performance Report

I confirm my approval of the Performance Report:

A handwritten signature in black ink, appearing to be 'LD', written in a cursive style.

**Professor Lesley Dwyer**  
Chief Executive

**Date: 23 June 2025**

# Accountability Report



# Directors' Report

## **Board of Directors**

The Board of Directors is a unitary board, with all Executive and Non-Executive Directors having joint responsibility for every decision of the Board and share the same liabilities. This does not impact upon the responsibilities of the Chief Executive as Accountable Officer to Parliament, for ensuring that the Trust operates consistently within the national policy and public service values.

The composition of our Board of Directors is set out in our Constitution and comprises of six Executive Directors and has a majority of independent Non-Executive Directors which may be up to eight including the Chair.

In addition to the Board of Directors, as an NHS Foundation Trust we have a Council of Governors, who represent the interest of our patients and the community we serve.

We use the 'Code of governance for NHS Provider trusts' to provide a corporate framework and ensure that our Board of Directors lead and direct the Trust with effective decision making, management of risk and delivering the right outcomes.

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 can 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 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 Chair cannot achieve such resolution.

## **Who is on the Board of Directors?**

### **Chair and Chief Executive**

#### **Chair, Tom Spink**

Tom was appointed as Non-Executive Director in June 2020. Tom was requested to take on the position of Interim Chair from May 2022 and was then appointed to the position of substantive Chair from 22 March 2023.

By background, Tom was 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 then Group Procurement Director. Tom was previously a non-executive director at the East of England Ambulance Service NHS Trust.

As Chair of the Trust, Tom is Chair 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. Tom is also Charitable Funds Committee and Committees in Common.

### **Chief Executive, Professor Lesley Dwyer**

Lesley was appointed as Chief Executive of the Trust in March 2024. With extensive experience in healthcare leadership, she brings a wealth of knowledge and a proven track record of improving healthcare services across various organizations.

Lesley joined us from the Central Adelaide Local Health Network, where she served as Chief Executive. It is the largest health authority in South Australia, employing more than 18,000 staff. During her five-year tenure, Lesley demonstrated exceptional leadership and operational oversight. Lesley was also Chief Executive of Medway NHS Foundation Trust in Kent between 2015 and 2018, where she helped lift the organisation out of quality Special Measures and into a well led "Good" rating from the Care Quality Commission.

At NNUH, Professor Dwyer leads the executive team responsible for the overall leadership of the hospitals. Her vision and commitment to excellence continue to drive positive changes and enhancements in patient care, staff engagement, and operational efficiency. Lesley is chairperson for the Financial Recovery Board on behalf of the Integrated Care Board and is an important member of the Quadram Institute Partners and Norwich Research Park collaborations.

## **Executive Directors**

### **Chief Operating Officer**

Chris Cobb was appointed as Chief Operating Officer (COO) 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**

Dr Bernard Brett was appointed as Interim Medical Director in September 2023 and as substantive Medical Director in October 2024. Bernard is responsible for providing professional strategic medical advice to the Board and leadership on clinical quality and safety and clinical research. He provides professional leadership for all doctors in the Trust. Bernard is a gastroenterologist and an experienced Medical Manager, he held the position of Chair of the East of England Clinical Senate for almost ten years until June 2024 and previously held a variety of posts including Deputy Medical Director at the NNUH from 2019 to 2023, Board member for Norfolk and Waveney CCG, Medical Director, Responsible Officer, Appraisal Lead and Divisional Director at the James Paget University Hospital.

### **Chief Nurse**

Rachael Cocker was appointed as Interim Chief Nurse in March 2024 and as Chief Nurse in September 2024. Rachael is responsible for professional leadership of nurses, midwives, AHPs, Pharmacists and Healthcare Scientists, as well as all Health Care Support Workers across the Trust. The Chief Nurse is responsible for providing professional clinical advice to the Board. Rachael has worked at NNUH for over 30 years, having qualified as a registered general nurse and registered midwife. Throughout her career she has held various nursing leadership roles, gaining experience across all areas of healthcare delivery within the organisation. Rachael is a member of the Board's Quality & Safety Committee and Research & Education Assurance Committee.

### **Interim Chief Finance Officer**

Liz Sanford was appointed as Interim Chief Finance Officer in March 2024 and stepped down when Marcus Thorman was appointed in March 2025. Liz is a chartered accountant (CPFA) who began working for the NHS in 2015 with NHS Improvement, where she was a member of the East of England finance team. Following a secondment to The Queen Elizabeth Hospital, King's Lynn, as Deputy Director of Finance in 2019, she joined the Trust in September 2020 to take up the post of Director of Finance – Operations. Liz is a member of the Finance, Investments & Performance Committee and audit committee.

### **Interim Chief Finance Officer**

Marcus Thorman was appointed as Interim Chief Finance Officer in March 2025. Having started in the NHS on the graduate scheme, Marcus has subsequently been a CFO in several trusts including a district general hospital, a specialist Trust, a teaching hospital and most recently within the group model at Manchester University NHS Foundation Trust. Marcus is a member of the Finance, Investment and Performance Committee and the Audit Committee

### **Non-Executive Directors**

**Julian Foster** was appointed as Non-Executive Director in June 2019 and reappointed in June 2022. Julian is a chartered accountant and corporate treasurer. He worked in investment banking until moving to the social housing sector and has held executive finance and development director roles in growing housing association groups in the Eastern region over 20 years. He currently undertakes several voluntary roles including being trustee and treasurer of Vision Norfolk and trustee of Emmaus Norfolk & Waveney. Julian is Chair of the Trust's Audit Committee and is a member of the Finance, Investments & Performance Committee, Charitable Funds Committee, Nominations & Remuneration Committee and Committees in Common. Julian is the Nominated Non-Executive for Emergency Preparedness, Digital and Cyber Security and Theatre Productivity.

**Professor Philip Baker** was appointed as a Non- Executive Director in February 2025. Phil is the Pro-Vice-Chancellor (PVC) for the Faculty of Medicine and Health Sciences at the University of East Anglia (UEA). Prof Baker joined UEA in November 2024 from the University of Leicester where he was the Pro-Vice-Chancellor, Research and Enterprise. Phil is a member of the Audit Committee, Quality and Safety Committee and Research and Education Committee.

**Professor Charles ffrench-Constant** was appointed as Non-Executive Director in September 2021. Charles is Pro-Vice-Chancellor for Medicine and Health Sciences at University of East Anglia (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. Charles was a member of the Trust's People & Culture Committee, Research and Education Committee and Nominations and Remunerations Committee. Charles was our Nominated Non-Executive Director for Education. Charles stepped down in February 2025 when Philip Baker was appointed.

**Dr Pamela Chrispin** was appointed as Non-Executive Director from January 2020 and reappointed in January 2023. 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 Chair of the Trust's Quality & Safety Committee and a member of the Audit Committee, Research and Education Committee and Nominations & Remuneration Committee. Pam is Nominated Non-Executive Director for Safeguarding, Maternity and Children & Young People. Pam stepped down on 30 April 2025.

**Sandra Dinneen** was appointed as Non-Executive Director in January 2020 and reappointed in January 2023. Sandra is an experienced Chief Executive with roles spanning the public, private and not for profit sector. She has a background in economic growth and regeneration and has led and advised on a number of successful development projects. Sandra has a keen interest in organisational and skills development and cultural change and continues to deliver leadership development programmes and executive coaching. Sandra is Chair of the People & Culture Committee and a member of the Trust's Audit 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 and reappointed in January 2023. 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 the former Norfolk Health Authority and a lay member at the former 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. Jo is the nominated Non-Executive for Patient Engagement & Complaints and Equality, Diversity and Inclusion.

**Dr Ujjal Sarkar** was appointed as Non-Executive Director in September 2022. Ujjal is a Lead GP partner at one of the largest GP partnerships in the country. Ujjal has been a GP for more than 17 years with extensive board experience in Clinical Commissioning Groups, GP Federations, hospitals and as a Medical Director in NHS 111. He also works as a Team leader for the General Medical Council Fitness to Practice Directorate. He has a track record of service improvement, innovation and improving patient experience. Ujjal is Chair of the Research and Education Committee and a member of the People and Culture Committee, Quality and Safety Committee and the Nominations and Remuneration Committee. Ujjal is the Trust's Non-Executive Staff Wellbeing Guardian.

**Mrs Nikki Gray** was appointed as Non-Executive Director in January 2024. Nikki qualified as a chartered accountant before pursuing a career across the financial services and energy sectors. Nikki has been a Governor at City College Norwich since 2018, where she currently sits on the Business Committee with previous roles on both the Curriculum & Standards Committee and the Audit Committee.

Nikki is Chair of the Trust's Finance, Investments and Performance Committee and is a member of the Charitable Funds Committee and Nomination and Remunerations Committee.

### **Changes during the Year**

In addition to those detailed above there were a number of changes to the membership of the Board during the year:

- Paul Jones served as Chief People Officer from August 2019 (having held the interim position since May 2019) until 31 December 2024
- Charles French-Constant stepped down as a Non-Executive Director, representing the University of East Anglia, in February 2025.
- Philip Baker took up the post of Non-Executive Director, representing the University of East Anglia in February 2025
- Liz Sanford served as Interim Chief Finance Officer from March 2024 until 23 March 2025
- Marcus Thorman was appointed Interim Chief Finance Officer 24 March 2025
- Pamela Chrispin stepped down as a Non-Executive Director on 30 April 2025.

### **Division of responsibilities**

There is a clear division of responsibilities between the Chair and Chief Executive. The Chair 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 Chair 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 Chair, 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](http://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 Chair has not declared any significant commitments that are considered material to his capacity to carry out his role. The Board considers that the Chair and the Non-Executive Directors satisfy the independence criteria set out in the Code of Governance.

As required by the Code of Governance, the Board has considered Professor Baker and previously Professor French-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, the UEA's representatives' independence as a Non-Executive Director. The Board noted that whilst Professor French-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 both Professor Baker and Professor French-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 appointments to the Board 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, People & Culture and Research and Education. 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.

During 2024/25 Period, the Board disestablished the Major Projects Assurance Committee due to Major Projects ending and therefore any regular reports needed were combined into the Finance, investment and Performance Committee work programme.

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 Chair, Chief Executive, Director of Strategy and major projects (until November 2024) and a second Non-Executive Director.

**Audit Committee:**

In accordance with the Code of Governance, the Audit Committee membership consists only of Non-Executive Directors. The Committee is chaired by Julian Foster with Sandra Dinneen and Pamela Chrispin 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 option to extend appointment was exercised in October 2023 by mutual agreement. 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 2024/25 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 2024/25 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 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 Code of governance for NHS Provider trusts is based on the principles of the UK Corporate Governance Code. The Code of Governance 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 the current Non-executive Directors (NEDs), including the Chair, to be independent. The composition of the Board is such that the majority of its members are independent Non-Executive Directors.
- All substantive 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 2024/25.
- The Chair of the Trust is Chair 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 Chair 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.
- Facilities to attend meetings remotely via the Teams teleconference digital platform 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 assurance committees, with regular 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. Facilities to attend meetings by video/teleconference are in place 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 French-Constant and Professor Baker 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 Chair, 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 Chair 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 Chair 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 reporting schedule includes regular reports from its assurance committees in the domains of Quality & Safety, Finance, Investments & Performance, People & Culture, Research & Education 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 processes around major projects, estates management and our response to the Staff Survey.

During 2024/25 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:
  - Ms Dinneen declared her role as Director of Hathor Consulting LTD and as Chair of Bullen Developments Ltd
  - Professor French-Constant has declared his role as Pro-Vice-Chancellor Faculty of Medicine & Health Sciences at the University of East Anglia.
  - Professor Baker has declared his role as Pro-Vice Chancellor of faculty of medical and health sciences, Vice chair trustee of The Bridge in Leicester and the Independent chair of Health innovation in the East Midlands
  - Mr Foster declared his position as Trustee of Vision Norfolk and as a Non-Executive for Norfolk and Suffolk Foundation Trust
  - Dr Sarkar declared his role as a medical landlord with In-Health diagnostic provider.
  - Dr Brett declared an interest as Director and Shareholder of Eastern Gastroenterology Group Limited and as Director of Norfolk Gastroenterology and Endoscopy Services Ltd

These Board members have accordingly taken no part any 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.

NHS Improvement had previously issued guidance which encouraged ‘*all providers to carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework every three to five years*’.

The Board received the CQC Well-led Assessment report in August 2024 and entered the process of forming the Group in September 2024 prior to the externally facilitated review of leadership being undertaken.

The Group Board and the individual Care Organisations will look to commission the appropriate externally facilitated review as per guidance and in line with the NHS England Insightful Provider Board guidance published in December 2024 to remain compliant with this requirement.

Performance evaluation of individual Executive Board members has been undertaken by the Chief Executive, in accordance with Trust policy and with input from the Non-Executive Directors. Appraisal of Non-Executive Directors has been conducted in accordance with national guidance, by the Chair and that of the Chair was coordinated by the Senior Independent Director.

**vi) *Compliance Statement***

The Trust has applied the principles of the Code of governance for NHS Provider trusts 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. In relation to the more detailed provisions of the Code of Governance, the Trust is compliant with the provisions, with the following exceptions:

**A.1.3** The Trust has identified the Medical Director as the Executive Lead regarding Health Inequalities and the Hospital Management Board has established a Health Inequalities Group which has been meeting monthly since the beginning of 2025 and has a programme of work to monitor and demonstrate improvement to reduce health inequalities. Health Inequalities is a current Quality Priority for the Trust.

**C.2.6** The Trust’s Constitution makes provision for identification of a Deputy or Vice Chair in circumstances of non-availability or illness of the substantive Chair. The Nominations and Remunerations Committee has agreed to review the position during 2025/2026 to establish if this role should be identified on a standing basis.

**B.2.17** The Board has approved a Schedule of Matters Reserved for its decision. Detail of the role and responsibilities of the Council of Governors and the 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 rather than the Board’s Schedule of Matters Reserved.

**C.4.7** The Trust was subject to a CQC assessment against the Well-Led Framework during 2023-24, the formal outcome of that assessment was published in August 2024. The Board will be required to commission a future externally facilitated development review to remain compliant with this requirement.

**Appendix B3.3** On its website the Trust issues copies of papers for public meetings of the Board of Directors, including agendas and minutes. Details and relevant links are provided to governors, ensuring compliance with the provision of the Code. However, papers for any meetings of the Board that are held in private (eg for reasons of personal confidentiality, commercial confidence or for other reason) are not circulated.

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.

Code reference	Summary of requirement	Disclosure
A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	See Environment and Sustainability Section, Statements of Chair and Chief Executive and Overview of Performance Section
A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	See Staff Survey Section, Staff Support Section and reporting on the Boards People Promise and Strategic Commitment to our NNUH Team.
A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	See Annual Report Sections on Strategic Commitment to our Partners, approach to System Working in Statements of Chair and Chief Executive, Overview of Performance (ICS Strategy Involvement).
B2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent.	In Directors Report in Annual Report
B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	In Directors Report in Annual Report

<p><b>B 2.17</b></p>	<p>There should be a schedule of matters specifically reserved for its decision. This schedule 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.</p> <p>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 the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.</p>	<p>A Board-approved Schedule of Matters Reserved is in place.</p> <p>See Board of Directors and Council of Governors sections for details on respective roles and decisions.</p> <p>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.</p>
<p><b>C 2.5</b></p>	<p>If an external consultancy is engaged [to assist in Non-Executive appointment], it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.</p>	<p>Statement in Council of Governors Section</p>
<p><b>C 2.8</b></p>	<p>The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors.</p> <p>The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.</p>	<p>As detailed in Annual Report sections on Council of Governors</p>
<p><b>C 4.2</b></p>	<p>The board of directors should include in the annual report a description of each director's skills, expertise and experience.</p>	<p>Included in Directors Report</p>
<p><b>C 4.7</b></p>	<p>All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.</p>	<p>The Trust was subject to a CQC assessment against the Well-Led Framework during 2023-24, the formal outcome of that assessment was published in August 2024. The Board will be required to commission a future externally facilitated development review to remain compliant with this requirement.</p>

<p><b>C 4.13</b></p>	<p>The annual report should describe the work of the nominations committee(s), including:</p> <ul style="list-style-type: none"> <li>• the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline</li> <li>• how the board has been evaluated, the nature and extent of an external evaluator’s contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition</li> <li>• policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives</li> <li>• the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust’s workforce and communities served</li> <li>• the gender balance of senior management and their direct reports.</li> </ul>	<p>See section in Annual Report regarding:</p> <ul style="list-style-type: none"> <li>• work of the Nominations &amp; Remuneration Committee</li> <li>• Directors Section Board Performance</li> <li>• Diversity and Inclusion</li> <li>• Staff Numbers and Costs</li> <li>• Gender Pay Gap Reporting.</li> </ul>
<p><b>C 5.15</b></p>	<p>Foundation trust 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. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.</p>	<p>See Council of Governors and Foundation Trust Membership sections</p>

<b>D 2.4</b>	<p>The annual report should include:</p> <ul style="list-style-type: none"> <li>• the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans</li> <li>• where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit</li> <li>• an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.</li> </ul>	See Audit Committee Section of Annual Report
<b>D 2.6</b>	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, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	See Annual Report Statements
<b>D 2.7</b>	The board of directors should carry out a robust assessment of the trust's emerging and principal risks.	See Overview of Performance, Directors Report and Annual Governance Statement
<b>D 2.8</b>	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	See Directors Report and Annual Governance Statement
<b>D 2.9</b>	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern.	See Going Concern Statement in Annual report

<b>Section E, 2.3</b>	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	See Remuneration Report
Appendix B, para 2.3 (not in Schedule A)	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
Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	See Council of Governors section
Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has 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, eg 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
Additional requirement of Foundation Trust Annual Reporting Manual (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 (and deciding whether to propose a vote on the foundation trust's or directors' performance).	Not applicable as Governors have not exercised this power.

### **Main Activities of the Audit Committee during the Year Ended 31 March 2025**

The Audit Committee met on 5 occasions during the year ended 31 March 2025. 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 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 2023/2024 were reviewed by the Auditors and presented to the Committee in June 2024. In accordance with the established annual cycle, financial performance for 2024/25 is subject to external audit review during March and June 2025, for review of the Accounts by the Committee in June 2025.

### **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 Tom Spink, as Chair of the Trust. The other members of the Committee are Julian Foster, Pam Chrispin, Joanna Hannam, Sandra Dinneen, Charles French-Constant, Ujjal Sarkar, Nikki Gray and the Chief Executive. The Secretary to the Committee is the Board Secretary. The last Meeting was held prior to the UEA nominated NED change over therefore Phil Baker did not attend 24/25 scheduled meetings.

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 2024/2025 the Committee met on seven 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 undertaking this review the Committee considered the outcome of the Board annual self-evaluation and made no recommendation to change the size or composition of the Board. The Committee has considered potential succession planning and uses recruitment as an opportunity to promote diversity on the Board.

In the case of Executive Director vacancies, the Committee is responsible for identifying suitable candidates to fill vacancies as they arise and overseeing processes for recruitment. The Committee has undertaken these responsibilities with regard to the executive vacancies that arose during 2024/2025

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 2024/25, following consideration of national NHS pay-award guidance, the Committee reviewed and approved revision to remuneration for the Very Senior Managers, as reported in the Remuneration Report. The Committee also agreed the terms of secondments and substantive positions for executive directors.

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.

#### **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. The Membership is completed by an Associate Non-Executive Director and a Patient Safety Representative. The Committee met on 11 occasions during 2024/25.

Matters considered by the Committee during 2024/25 have included the operation of the Trust's clinical governance systems and processes, including our procedures for learning from incidents and examining mortality rates through a mortality focused meeting of the committee.

#### **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 three Non-Executive Directors, Chief Executive, Chief Operating Officer, Chief Finance Officer, Chief People Officer/ Director of workforce, Chief Digital Officer, Director of Transformation and Clinical Executive (Medical Director or Chief Nurse). The Committee met on 10 occasions during 2024/25.

This year the Committee has received regular reports on the Trust's operational position and performance, in the context of very high levels of demand for the services of the Trust. Reports to the Committee have been particularly focussed on management of the emergency care pathway, including waiting times for ambulance staff to transfer patients to ED, use of escalation spaces in the Hospital and initiatives to encourage discharge if patients before lunch.

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 management of the Trust's Estate, cost improvement plans, and detailed financial and operational planning.

#### **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, organisational development and culture. The Membership of the Committee includes three Non-Executive Directors,

Chief Executive, Chief People Officer/ Director of Workforce, Chief Operating Officer, Chief Nurse, Medical Director and the Chiefs of Division.

Matters considered by the People and Culture Committee during 2024/25 have included: Freedom to Speak-Up; Staff Survey results and actions; Corporate Risk Register; Internal Audit Reports; and recruitment & retention. The Committee has encouraged a systematic approach to addressing issues raised through the Staff Survey and will continue to promote development and implementation of the Trust's Workforce Strategy.

### **Major Projects Assurance Committee**

The role of the Major Projects Assurance Committee is to provide scrutiny and challenge with regard to delivery of certain major projects as selected by the Board, in order to obtain assurance and make appropriate reports or recommendations. The membership of the Committee includes at least three Non-Executive Directors, Chief Executive, Chief Operating Officer, Chief Finance Officer, Director of Strategy & Major Projects, Clinical Executive (Medical Director or Chief Nurse), Chief Digital Officer and Director of Transformation.

Due to the major projects coming to an end in 2024-2025 the committee was therefore disestablished with lessons learned reports and the digital projects reports being provided to the Finance, Investment and Performance Committee.

### **Research and Education Assurance Committee**

The role of the Research and Education Committee of the Board is to provide additional capacity for Non-Executive led scrutiny and assurance to the Board that the Trust has appropriate measures and strategies in place related to Research and Education. The membership of the Committee includes at least three Non-Executives, Chief Executive, Medical Director, Chief Nurse, Director of Workforce and Chief Digital Officer.

The committee met on 3 occasions during 2024/25 and are in the process of creating IPR metrics and developing the research strategy as well as the education 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, including 3 Extraordinary Trust Board (ETB) meetings.

Attendance at meetings of the Board and its Committees is shown on the following pages.

## Board of Directors Meetings

Members ✓ attended X apologies * recorded deputy	3 Apr 2024	1 May 2024	5 Jun 2024	19 Jun 2024 ETB	3 Jul 2024	11 Sep 2024	2 Oct 2024	6 Nov 2024	26 Nov 2024 ETB	4 Dec 2024	17 Jan 2025 ETB	5 Feb 2025	5 Mar 2025
Dr Bernard Brett Medical Director	✓	✓	x	x	✓	x	✓	✓	✓	✓	x	✓	✓
Prof Phil Baker Non – Executive Director													✓
Dr Pamela Chrispin Non – Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓
Mr Chris Cobb Chief Operating Officer	x *	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓
Ms R Cocker Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ms Sandra Dinneen Non – Executive Director	✓	✓	x	✓	x	✓	✓	✓	x	✓	x	✓	✓
Prof Lesley Dwyer Chief Executive	✓	✓	✓	✓	x	✓	✓	x	✓	✓	✓	✓	✓
Ms S Gooch Director of Workforce											✓	✓	✓
Mr Julian Foster Non – Executive Director	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prof Charles ffrench-Constant Non – Executive Director	x	✓	✓	x	✓	✓	✓	✓	x	x	✓		
Mrs N Gray Non – Executive Director	✓	✓	x	✓	x	✓	✓	✓	x	x	✓	✓	✓
Mrs Joanna Hannam Non – Executive Director	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Paul Jones Chief People Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	x			
Ms L Sanford Interim Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Ujjal Sarkar Non – Executive Director	✓	✓	✓	x	x	✓	✓	x	x	✓	x	✓	✓
Mr Tom Spink Trust Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

### Attendance at meetings of the Audit Committee

The Audit Committee routinely meets quarterly and met on 5 occasions during the year:

<b>Members</b> ✓ attended X apologies	<b>19 June 2024</b>	<b>05 November 2024</b>	<b>26 November 2024</b>	<b>11 December 2024</b>	<b>26 February 2025</b>
Mr Julian Foster (Chair) Non – Executive Director	✓	✓	✓	✓	✓
Ms Sandra Dinneen Non – Executive Director	✓	x	x	✓	✓
Dr Pam Chrispin Non – Executive Director	✓	✓	✓	x	✓

### Nominations & Remuneration Committee

The Nominations and Remuneration Committee meets routinely twice a year and otherwise as required. The Committee met on 7 occasions during 2024/25

<b>Members</b> ✓ attended X apologies * recorded deputy	<b>05 Jun 2024</b>	<b>03 Jul 2024</b>	<b>11 Sep 2024</b>	<b>02 Oct 2024</b>	<b>28 Oct 2024</b>	<b>04 Dec 2024</b>	<b>05 Mar 2025</b>
Professor Lesley Dwyer Chief Executive	✓	x*	✓	✓	✓	✓	✓
Dr Pamela Chrispin Non – Executive Director	✓	✓	✓	✓	✓	✓	✓
Ms Sandra Dinneen Non – Executive Director	x	x	✓	✓	✓	✓	✓
Professor Charles ffrench-Constant Non – Executive Director	✓	✓	✓	✓	✓	x	
Mr Julian Foster Non – Executive Director	✓	✓	✓	✓	x	✓	✓
Mrs Nikki Gray Non – Executive Director	x	x	✓	✓	x	x	✓
Mrs Joanna Hannam Non – Executive Director	✓	✓	✓	✓	✓	✓	✓
Dr Ujjal Sarkar Non – Executive Director	x	x	x	✓	✓	✓	✓
Mr Tom Spink Trust Chair	✓	✓	✓	✓	✓	✓	✓

### Quality and Safety Committee – meeting and attendance

The Quality and Safety Committee met on 11 occasions during 2024/25:

\*\*Additional meeting

<b>Members</b> ✓ attended X apologies * recorded deputy	<b>23 Apr 2024</b>	<b>28 May 2024</b>	<b>25 Jun 2024</b>	<b>30 Jul 2024</b>	<b>24 Sep 2024</b>	<b>29 Oct 2024</b>	<b>26 Nov 2024</b>	<b>22 Jan 2025 **</b>	<b>28 Jan 2025</b>	<b>25 Feb 2025</b>	<b>25 Mar 2025</b>
Dr Pamela Chrispin (Chair) Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Bernard Brett Medical Director	✓	✓	X	✓	✓	✓*	✓*	✓	✓	✓	✓
Ms Rachael Cocker Chief Nurse	✓	✓	✓	✓	✓	✓*	✓	✓	✓	✓	✓
Prof Lesley Dwyer Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
Ms Claire Fernandez Associate Non-Executive Director	✓	✓	X	X	✓	✓	✓	X	✓	✓	✓
Mrs Joanna Hannam Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ms Rosemary Moore Patient Safety Representative			X	✓	✓	✓	✓	✓	✓	✓	X
Dr Ujjal Sarkar Non-Executive Director	✓	✓	X	✓	✓	X	✓	X	✓	X	✓

## Finance, Investments and Performance Committee – meeting and attendance

The Finance, Investments and Performance Committee met on 10 occasions during the year as follows:

<b>Members</b> ✓ attended X apologies * recorded deputy	24 Apr 2024	29 May 2024	25 Jun 2024	31 Jul 2024	25 Sep 2024	30 Oct 2023	27 Nov 2024	29 Jan 2025	26 Feb 2025	26 Mar 2025
Ms Nikki Gray (Chair) Non-Executive Director	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
Alex Berry Director of Transformation	✓	✓	✓	✓	✓	✓	✓	X	✓	✓
Mr Chris Cobb Chief Operating Officer	✓	X	✓	✓*	✓	✓	✓	✓	✓	✓
Ms Rachael Cocker Chief Nurse	✓	✓	✓	X	✓	✓*	✓	✓	✓	✓
Prof Lesley Dwyer Chief Executive	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Mr Julian Foster Non-Executive Director	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
Ms Sarah Gooch Director of Workforce								✓	✓	X
Mr Simon Hackwell Director of Strategy	✓	✓	X	✓	X	✓	✓			
Mr Paul Jones Chief People Officer	✓*	✓	✓	✓*	✓	✓*	✓			
Mrs L Martin Interim Director of Estates and Facilities								✓	✓	✓
Ms Liz Sanford Chief Finance Officer	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
Ed Prosser-Snelling Chief Digital Information Officer	✓	✓	✓	✓*	X	✓	✓	✓	✓	X
Mr Tom Spink Trust Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

### People and Culture Committee – meeting and attendance

The People and Culture Committee met 5 times during 2024/25. Attendance was as follows:

<b>Members</b> ✓ attended X apologies	<b>24 Jun 2024</b>	<b>23 Jul 2024</b>	<b>25 Nov 2024</b>	<b>27 Jan 2025</b>	<b>24 Mar 2025</b>
Ms Sandra Dinneen (Chair) Non-Executive Director	✓	✓	✓	✓	✓
Dr Bernard Brett Medical Director	✓	✓	✓	✓	✓
Mr Chris Cobb Chief Operating Officer	X	X	X	X	X
Ms Rachael Cocker Chief Nurse	X	X	X	X	X
Prof Lesley Dwyer Chief Executive	X	✓	✓	✓	X
Prof Charles ffrench-Constant Non-Executive Director	✓	✓	✓	X	
Ms Sarah Gooch Director of Workforce				✓	✓
Mrs Joanna Hannam Non-Executive Director	✓	✓	✓	✓	✓
Mr Paul Jones Chief People Officer	✓	✓	✓		
Dr Ujjal Sarker Non-Executive Director	X	X	X	X	X

### Major Projects Assurance Committee

The Trust began 2024/25 with a Major Projects Assurance Committee, meeting routinely once a month and otherwise as required. The Committee met on 5 occasions in 2024/25 before the Board amalgamated it into the Finance, Investments & Performance Committee in October 2024.

### Register of Attendance at Major Projects Assurance Committee Meetings 2024/25

Members ✓ attended X apologies	24 Apr 2024	29 May 2024	25 Jun 2024	31 Jul 2024	25 Sep 2024
Mr Tom Spink Trust Chair	✓	✓	✓	✓	✓
Mrs Alex Berry Director of Transformation	✓	✓	✓	✓	✓
Mr Chris Cobb Chief Operating Officer	✓	✓	✓	X	✓
Ms Rachael Cocker Interim Chief Nurse	✓	✓	✓	X	✓
Prof Lesley Dwyer Chief Executive	✓	✓	✓	X	✓
Mr Julian Foster Non-Executive Director	✓	X	✓	✓	✓
Mrs Nikki Gray (Chair) Non-Executive Director	✓	✓	✓	✓	✓
Mr Simon Hackwell Director of Strategy & Major Projects	✓	X	X	✓	X
Mr Ed Prosser-Snelling Chief Digital Information Officer	✓	X	✓	X	✓
Ms Liz Sanford Interim Chief Finance Officer	✓	X	✓	✓	✓

## Research and Education Committee

During 2024/25 the Board established a Research and Education Committee which meets quarterly and otherwise as required. The Committee met on 3 occasions during 2024/25

### Register of Attendance at Research and Education Committee Meetings 2024/25

Members ✓ attended X apologies * recorded deputy	25 Sep 2024	27 Nov 2024	26 Mar 2025
Dr Ujjal Sarker (Chair) Non-Executive Director	✓	✓	✓
Dr Bernard Brett Medical Director	✓	✓	✓
Ms Rachael Cocker Chief Nurse	✓	✓	X
Dr Pam Chrispin Non-Executive Director	✓	✓	✓
Prof Lesley Dwyer Chief Executive	✓	✓	✓
Prof Charles French-Constant Non-Executive Director	X	X	
Mr Paul Jones Chief People Officer	✓	✓	
Mr Ed Prosser-Snelling Chief Digital Officer	X	✓	X*
Mr Jon Lartey Associate Medical Director of Research	✓	✓	✓
Dr Arun Shankar Director of Medical Education	X	X	✓
Prof Kris Bowles	✓	X	X
Mrs Lucy Weavers Deputy Chief Nurse	X	✓	✓
Dr Lucy Arora Associate Director of Education	X	X	✓
Mrs Sarah Pask Associate Director of OD & Learning	✓	✓	✓
Mr Tom Spink Trust Chair	X	✓	✓

## Council of Governors

The Council of Governors is chaired by Tom Spink who, as Chair 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 reported to 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
- Been consulted on plans for a group Model with the James Paget University Hospital and the Queen Elizabeth Hospital.

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 (UK Engage) 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 2025 the Governors were:

### Public Governors

- Elaine Bailey North Norfolk
- Chris Baxter Rest of England
- Erica Betts Breckland
- Peter Bush Norwich
- Annie Cook Norwich
- Carol Edwards North Norfolk
- Daniel Epurescu Broadland
- Bruce Fleming South Norfolk
- Ines Grote Great Yarmouth and Waveney
- Chris Hind South Norfolk
- Kevin May Broadland
- David McNeil Breckland
- Derek Moncur Norwich
- Adele Swallow Broadland

### **Staff Governors**

- Shahnaz Asghar Contractors and Volunteers
- Cherry Cubelo Nursing and Midwifery
- Catherine Hainey Nursing and Midwifery
- Gemma Lynch Admin and Clerical
- Richard Wharton Medical and Dental
- Michelle Frost Clinical Support

### **Partner Governors**

- Alison Thomas Norfolk County Council
- Vacancy University of East Anglia
- Vacancy Norfolk and Waveney Integrated Care Board

### **Changes during the year:**

The following Governors left the Council of Governors in 2024/25:

- Greg Bowker Breckland
- Bibin Baby Nursing and Midwifery
- Brian Cushion Broadland
- Jackie Hammond Broadland
- Nina Duddlestone Breckland
- Tim How King's Lynn and West Norfolk
- Lynda Turner Breckland

A copy of the Register of Interests declared by the Governors can be found on our website at [www.nnuh.nhs.uk](http://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 Trust's clinical strategy and the management of services
- Major developments on the hospital sites, such as plans for the N&N Orthopaedic Centre and the Community Diagnostic Centre
- The results of patient and staff surveys
- The Trust's Digital Strategy
- The Trust's Workforce Strategy
- The Trust's financial position and performance against national operational standards.

Non-Executive Directors attend formal Council meetings on a rotational basis, to enable discussion particularly concerning the Board Assurance Committees with which they are associated.

In addition to formal meetings, there is a regular cycle of informal Q&A sessions for governors with the Chair, 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.

### Attendance at formal meetings of the Council of Governors

The Council of Governors held five meetings in 2024/25. Attendance at Council meetings was as set out below:

	<b>Members</b> ✓ attended X apologies	<b>25 Apr 2024</b>	<b>25 Jul 2024</b>	<b>24 Oct 2024</b>	<b>23 Jan 2025</b>	<b>30 Jan 2025 Extraordinary in private</b>	<b>25 Mar 2025 Extraordinary in private</b>
1	Mrs Shahnaz Asghar	✓	✓	✓	✓	✓	x
2	Mr Bibin Baby	x	✓	x			
3	Mrs Elaine Bailey	✓	✓	✓	✓	✓	✓
4	Mr Chris Baxter <sup>1</sup>				✓	✓	✓
5	Mr Greg Bowker	✓	✓	✓			
6	Mrs Erica Betts	x	✓	✓	✓	✓	✓
7	Mr Peter Bush	x	x	x	x	✓	x
8	Ms Annie Cook	✓	x	✓	✓	✓	✓
9	Ms Cherry Cubelo <sup>2</sup>				✓	✓	x
10	Mr Brian Cushion	✓	x	x			
11	Mrs Nina Duddleston	✓	✓	✓			
12	Mrs Carol Edwards	x	✓	✓	x	x	x
13	Dr Daniel Epurescu	x	✓	✓	✓	✓	x
14	Dr Bruce Fleming	✓	✓	✓	✓	✓	✓
15	Ms Michelle Frost <sup>3</sup>				✓	x	✓
16	Mrs Ines Grote	✓	✓	✓	✓	✓	✓
17	Ms Catherine Hainey	x	✓	✓	x	✓	✓
18	Mrs Jackie Hammond	✓	✓	✓			
19	Mr Chris Hind	✓	✓	✓	x	x	✓
20	Mr Tim How	x	x	✓			
21	Mrs Gemma Lynch	✓	✓	✓	✓	✓	x
22	Mr Kevin May <sup>4</sup>				✓	✓	✓
23	Mr David McNeil <sup>5</sup>				✓	✓	✓
24	Mr Derek Moncur	✓	✓	✓	✓	x	x
25	Ms Adele Swallow <sup>6</sup>				✓	✓	✓
26	Cllr Alison Thomas	✓	x	✓	✓	x	x
28	Mr Richard Wharton	✓	x	✓	✓	x	x

<sup>1</sup> Mr Chris Baxter elected December 2024

<sup>2</sup> Ms Cherry Cubelo elected December 2024

<sup>3</sup> Ms Michelle Frost elected December 2024

<sup>4</sup> Mr Kevin May elected December 2024

<sup>5</sup> Mr David McNeil elected December 2024

<sup>6</sup> Adele Swallow elected December 2024

## **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 NHSE in exceptional circumstances when communication through the Chair or Board Secretary is not appropriate. Governor Elaine Bailey was selected by Council members to act as Lead Governor from December 2024.

## **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 2025, Membership of the Committee is:

- Tom Spink - Chair
- Elaine Bailey
- Carol Edwards
- Ines Grote
- Chris Hind on one occasion to be quorate.

Members of the Council's Appointments & Remuneration Committee are particularly involved in the process for making non-executive appointments to the Board and Members of the Committee sit on the Interview Panel for NED appointments, with other governors deputising as required.

## **Governor development**

An induction event was held for new governors on 14 January 2025, to discuss the role and responsibilities of governors. The role of governors has been highlighted in the Trust's Pulse magazine to raise awareness about the governors and how they may be contacted by Members.

## **Governor expenses**

The Governor role is unpaid and £1325.59 in travel expenses has been claimed by five governors during 2024/25.

## **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. 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 nominated from local government and our partner University (the University of East Anglia).

We have a Membership Strategy which was developed with input from members and governors and describes our recruitment and involvement of governors and members. We conduct an annual campaign across social media and other communications channels in order to recruit new members and this is supplemented by a face-to-face recruitment.

The size of our public membership over the last few years is detailed below:

Year	Public members
2022/23	15,440
2023/24	14,853
2024/25	14,539

Our staff membership stands at 10,000, making a total of 24,539 members in total.

### **Engagement with 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, staff representative groups, surveys and meetings. More detail is set out in the Staff Matters section of this Annual Report.

Public members receive our quarterly in-house magazine, The Pulse. This publication is used to publicise events such as lectures, the Annual General Meeting and participation in the Patient Choice Staff Award.

The Governors have been involved in a number of events during 2023/25 which included engagement with members (staff and public):

- AGM with all day exhibition event for staff and public on 2 October 2024
- A tour of the new Norfolk & Norwich Orthopaedic Centre on 5 September and the official opening on 27 September 2024
- Staff Awards ceremony with two governors presenting awards on 21 November 2024
- A Cathedral Carols by Candlelight event on 21 December 2024
- A tour of Priscilla Bacon Lodge Hospice on 23 January 2025.

Members can contact the Membership Office by e-mail at [membership@nnuh.nhs.uk](mailto:membership@nnuh.nhs.uk)

## 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 2024/25 financial year or previous year.

### **Expenditure on consultancy**

The 2024/25, the expenditure on consultancy was £1,583k (2023/24: £1,868k).

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

During 2024/25 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 £942.4m of the total income of £1,083m (2022-23 £868.2m of the total income of £982.6m).

### **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 March 2025 can be found at the back of this annual report. The statement of the responsibility of the accounting officer is on page 119.

### **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 35 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.

# Staff Report

We are now heading into year four of Our People and Culture Strategy – caring with PRIDE. This is our plan for delivering our commitment to Team NNUH: Together, we will support each other to be the best that we can be, to be valued and proud of our hospital for all.

Our People and Culture Strategy was developed with and for more than 11,000 people who work and volunteer at the Trust. The Strategy provides clarity on how we uphold our PRIDE values in our own behaviours, how we, as a Trust, embrace the NHS People Promise by putting people's health and wellbeing first and ensuring we all have the skills and confidence to design and deliver the best patient care.

Our greatest strength is the dedicated people who work and volunteer at the Trust, so we're focused on a long-term investment in the skills, experience and wellbeing of everyone in Team NNUH.

It's imperative that we have a culture of inclusion, support and respect at the heart of everything we do. Making NNUH a hospital for all people and a great place to work and learn is about how we invest in, support and value each other every day. This is supported by the Trust's Diversity, Inclusion and Belonging Strategy.



## Education Strategy

A new five-year Multi-professional Education, Learning and Development strategy was published, which sets out six strategic ambitions – these were written following extensive research, consultation and collaboration to ensure that our education and development activities support us in delivering against our corporate and wider regional and national objectives.

These are underpinned by a delivery roadmap detailing the steps we will take to realise our vision for education, learning and development.

## Education, Learning & Development Strategy

Our Plan for the next five years



Welcome to our 5 year Education, Learning & Development Strategy

Our People Promise plan was launched in July 2024 to address the areas where colleagues have said they'd like to see improvements.



## NUH People Promise - (2024/25) - our staff survey priority actions to improve your experience at work

Your concerns:	Progress we've made:	What we'll do next:	What changes you will see:
<p><b>1. You told us that staff shortages is one of your biggest concerns, causing you to feel overworked and under pressure.</b></p> <p>Owner: Paul Jones, Chief People Officer</p>	<ul style="list-style-type: none"> <li>✓ Better support to reduce the number of people leaving in their first 12 months</li> <li>✓ Helped colleagues to stay by offering more flexible working patterns and flexible pension options</li> <li>✓ Implemented Stay Conversations</li> <li>✓ Helped colleagues to maximise pension flexibilities, including retire-and-return and retire flexibly whilst continuing to work</li> <li>✓ Seen a reduction in the number of staff leaving</li> <li>✓ Fast-track route in place to move from bank to permanent roles</li> <li>✓ Achieved a significant reduction in our vacancies</li> </ul>	<ul style="list-style-type: none"> <li>• A further reduction of vacancies across the Trust</li> <li>• Apply the learning from 'Stay Conversations'</li> <li>• Further improve our recruitment processes</li> </ul>	<ul style="list-style-type: none"> <li>• A reduction in vacancies to 6% and 5% for key clinical positions</li> <li>• 10% reduction in the number of staff leaving voluntarily with their first year</li> <li>• Implement new internal recruitment process, e.g.                             <ul style="list-style-type: none"> <li>◦ Streamline process for essential roles</li> <li>◦ Establish generic job descriptions</li> <li>◦ Review of time to hire metric</li> </ul> </li> </ul>
<p><b>2. You told us that the lack of staff facilities and parking options made your life more difficult and extended your working day</b></p> <p>Owner: Simon Hackwell, Director of Strategy and Major Projects</p>	<ul style="list-style-type: none"> <li>✓ 600 additional staff car parking spaces</li> <li>✓ A new "holiday swap" facility for carpark permit holders to share their permit with a colleague during holidays</li> <li>✓ Provided a new NNUH Thickthorn Shuttle Service with 200 additional parking spaces</li> <li>✓ Better support during periods of hot weather, including improved hydration, and cooler facilities</li> <li>✓ Additional outside benches</li> <li>✓ 2 new bookable glass PODs for colleague meetings</li> <li>✓ Refurbishment of the POD coffee shop</li> <li>✓ Refurbishment of the Benjamin Gooch</li> <li>✓ Introduced Single Sign-on to work across applications without needing multiple logins</li> </ul>	<ul style="list-style-type: none"> <li>• Issue additional car parking spaces following self-assessment</li> <li>• Completion of a new Infant feeding room</li> <li>• Review hot desking arrangements to improve space utilisation</li> <li>• Progress heat mitigation measures further</li> </ul>	<ul style="list-style-type: none"> <li>• New permits issued to eligible staff</li> <li>• Continue with the self-assessment programme ensuring that allocation of permits is fair and transparent</li> <li>• Infant feeding room opened with launch event</li> <li>• Space utilisation survey completed and transformation team looking at how we better utilise our real-estate</li> <li>• Temporary AC where budget and infrastructure permit.</li> <li>• Extra cold-water fountains &amp; PAT testing for fans</li> <li>• Accelerating Minor Works requests for blinds, curtains, and solar film</li> <li>• Progression of plans for architectural shading on southern elevation</li> </ul>
<p><b>3. You told us operational pressures, adversely affected the quality of care you want to deliver, and your wellbeing is compromised due to pressure of work</b></p> <p>Owners: Chris Cobb &amp; Rachael Cocker, Chief Operating Officer &amp; Interim Chief Nurse</p>	<ul style="list-style-type: none"> <li>✓ Implemented a process to better support you where moves are unavoidable</li> <li>✓ Reduced the number of "in shift" moves</li> <li>✓ Ongoing programme of "Support and Restore" days, Schwartz Rounds, and cost of living help</li> <li>✓ A "Caring for You" Expo delivered to support personal and financial wellbeing</li> <li>✓ A Wellbeing Hub with a drop-in service to access support and advocacy services</li> <li>✓ Menopause Training delivered and promotion of support services for colleagues affected</li> </ul>	<ul style="list-style-type: none"> <li>• Commit to de-escalation plans to avoid corridor care and reduce additional patients in bays</li> <li>• Help managers within divisions understand avenues to appropriate wellbeing support / occupational health advice to meet staff needs</li> <li>• Explore introduction of the 'Start well/ End well' programme</li> <li>• Increase staff awareness of how to access wellbeing support offerings</li> <li>• Enable protected time to better support you</li> </ul>	<ul style="list-style-type: none"> <li>• De-escalation plans are implemented and communicated</li> <li>• Education for managers on use of occupational health and wellbeing services</li> <li>• All divisions educated on Start Well / End Well programme. 4 pilot areas to trial programme.</li> <li>• Monitor usage of wellbeing support offerings via WHWB and EAP quarterly reports</li> <li>• Develop an agreed protocol for protected time from your manager</li> </ul>
<p><b>4. You told us that poor behaviours are still too common and lead to poor experience at work</b></p> <p>Owners: Bernard Brett &amp; Paul Jones, Interim Medical Director &amp; Chief People Officer</p>	<ul style="list-style-type: none"> <li>✓ Developed a Cultural Change Programme</li> <li>✓ Expanded the support available to you under our "No Excuse for Abuse" approach and provided manager training</li> <li>✓ Rolled out a new Civility and Respect Code to provide better guidance and support for calling out poor behaviours</li> <li>✓ A new Diversity, Inclusion and Belonging Strategy launched, to support a more inclusive culture for our staff and patients</li> <li>✓ New Speak Up Policy launched, making clear the routes available for you to raise concerns and have these positively resolved</li> </ul>	<ul style="list-style-type: none"> <li>• Develop a culture where the right behaviours and conduct are adopted, being clear about what is and isn't acceptable</li> <li>• Ensure unacceptable behaviours are addressed</li> <li>• Ensure patients and visitors display appropriate behaviours</li> </ul>	<ul style="list-style-type: none"> <li>• Publish a code of acceptable behaviours</li> <li>• Deliver 3 'call it out' training sessions for each Division</li> <li>• Introduce a Trust protocol to better support our colleagues experiencing sexual harassment</li> <li>• Supporting staff through prosecutions for serious assaults</li> </ul>
<p><b>5. You told us that you didn't always feel valued, empowered, or supported and leadership skills need to improve</b></p> <p>Owner: Paul Jones, Chief People Officer</p>	<ul style="list-style-type: none"> <li>✓ Over 300 Leaders achieved their "Licence to Lead" in the last year to support managers in delivering good people management</li> <li>✓ Established "Living our Values" boards to recognise staff achievements through our PRIDE and annual award winner</li> <li>✓ Created and published a Staff Recognition Framework highlighting the range of options to thank individuals and teams for their work</li> </ul>	<ul style="list-style-type: none"> <li>• Provide clear expectations of our managers and leaders</li> <li>• Support and educate managers to deliver good people management</li> <li>• Enable Leaders to listen and value feedback by spending time in the work environment</li> </ul>	<ul style="list-style-type: none"> <li>• Publish and promote NHS 'expectations of managers' framework</li> <li>• A further 300 Managers to complete the Licence to Lead programme</li> <li>• Leaders educated to undertake routine 'Gemba' walks and work with their teams to improve the work environment, together</li> </ul>

Here are some of the achievements against our People Promise priority actions to date:

1. Staff Shortages
2. Staff Facilities
3. Working Care Environment
4. Poor Behaviours
5. Leadership



### Staff Shortages

- Learning from Stay Conversations is ongoing
  - Labour turnover reduced from 9.2% December 2023 to 6.9% December 2024
- Generic job descriptions for common roles are being completed
- Human Resources continues to recruit to all requested recruitment activity
- Development of automatic robotic processes is ongoing
- Part of ICS collaborative recruitment project on benchmarking and sharing recruitment best practice
- Time to hire is 34 days, versus the target of 38 days.
- A Right to Work specialist is now in post, working directly with colleagues and line managers.

### Staff Facilities

- Infant feeding room opened August 2024
  - Booking process launched in December 2024 following feedback from users
    - 37 slots were booked in February 2025
- Car Parking – 3,850 permit holders have now completed their car parking self-assessment
  - Currently 90% of those assessed have retained their car parking permits
  - Waiting list has reduced from over 2,000 to 908
  - Over 1,900 audits of the self- assessments have taken place, with 72 colleagues' responses under review
  - Only the partial permit holders, those on the waiting list and SERCO colleagues are left to be assessed
    - Since starting the project 426 new car parking permits have been issued for the surface car park and
- Rouen Road space survey commenced in November 2024

## **Working Care Environment**

- Start Well End well trials commenced in Critical Care expanding to the Emergency Department and Post Anesthetic Care Unit.
- Redesign of the wellbeing pages on the intranet is underway to help colleagues and line managers to understand the services available
- Protected Time Protocol in draft and will be shared with staff groups for feedback
- A Schwartz Round took place in January 2025.

## **Poor Behaviours**

- Sexual safety working group formed
- Sexual Safety Policy in consultation, awaiting feedback.
  - October 2024 updates to the Workers Protection Act, introducing a legal duty for employers to proactively take reasonable steps to prevent sexual harassment
- Call it out training continues
- Grand Round focusing on tackling inappropriate behaviors took place in February 2025 and continues.

## **Leadership**

- Gap Analysis of the NHS Expectations of a Line Manager has been undertaken
- Performance Improvement Policy, previously called Capability Policy, has been updated, with new template letters and policy launched in February 2025
- Attendance training updated, with training available for line managers. Prior to Christmas 2024:
  - 245 existing line managers attended training on updates and
  - 18 new managers attended the full training
- HR Matters newsletter process now embedded, with a newsletter emailed to line managers which links to the Trust's intranet, communicating all HR updates.
- As of February 2025, 222 Managers have fully completed their Licence to Lead, so far, this financial year.

## Staff numbers and costs

Our staff numbers have risen from 9,244 to 9,580 as we have filled vacancies and responded to the demands on our services. We also have staff registered with our Staff Bank, temporary workers and nearly 550 volunteers across the Trust.

Average number of employees (WTE basis)			2024/25	2023/24
	Permanent	Other	Total	Total
Medical and dental	825	598	1,424	1,346
Ambulance staff	-	-	-	-
Administration and estates	1,305	61	1,365	1,662
Healthcare assistants and other support staff	2,313	395	2,708	2,323
Nursing, midwifery and health visiting staff	2,532	233	2,765	2,677
Nursing, midwifery and health visiting learners	139	0	139	104
Scientific, therapeutic and technical staff	852	31	883	840
Healthcare science staff	278	18	296	292
Social care staff	-	-	-	-
Other	-	-	-	-
<b>Total average numbers</b>	<b>8,244</b>	<b>1,336</b>	<b>9,580</b>	<b>9,244</b>
<b>Of which:</b>				
Number of employees (WTE) engaged on capital projects	43	14	57	36

	2024/25			2023/24		
	Total	Permanent Staff	Other	Total	Permanent Staff	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	460,435	396,224	64,211	419,625	357,217	62,408
Social security costs	47,545	40,914	6,631	43,600	37,116	6,484
Apprenticeship levy	2,288	1,969	319	2,126	1,810	316
Pension Cost - defined contribution plans - employers contribution to NHS Pensions	53,666	46,182	7,484	47,950	40,819	7,131
Pension Cost - Employers contribution paid by NHSE on providers behalf	35,017	30,134	4,883	20,917	17,806	3,111
Pension Cost - Other	115	-	115	140	-	140
Termination Benefits	1,715	1,715	-	21	21	-
Temporary Staff - Agency / Contract Staff	11,862	-	11,862	19,198	-	19,198
<b>Total Gross Staff Costs</b>	<b>612,643</b>	<b>517,138</b>	<b>95,505</b>	<b>553,577</b>	<b>454,788</b>	<b>98,788</b>

## Breakdown of male and female staff as at 31 March 2025

	Male Headcount	Female Headcount
<b>Executive Director/ Non-Executive Director</b>	7	8
<b>Other senior managers</b>	1	2
<b>Employees</b>	<b>2,375</b>	<b>7,748</b>

## 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;
- the proportions of male and female employees in each pay quartile.

### 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 Trust'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 Trust 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 ([Norfolk and Norwich University Hospitals NHS Foundation Trust » Gender Pay Gap Report](#)) or
- the Cabinet Office website ([Gender pay gap reports for Norfolk and Norwich University Hospitals NHS Foundation Trust - Gender pay gap service](#))

## Sickness Absence

Figures Converted by DH to Best Estimates of Required Data Items			
Months	Average FTE for 2024	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE
12	8,694	89,555	10.3

### Staff Turnover

For the 12 months to 31 March 2025, the staff turnover rate was 8.2%. This has steadily reduced over the last 12 months from 9.5% at 31 March 2024.

## NHS Staff Survey 2024

The annual National NHS Staff Survey has operated since 2003 and enables the Trust to monitor the experiences of our colleagues 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, then feel supported to provide high quality care for our patients.

The results of the Staff Survey 2024 were published in March 2024. Our response rate to the Staff Survey 2024 has remained the same as 2023 at 47% - with 4,508 respondents, compared with 4,378 in 2023. This is slightly lower than the Acute Trust average of 49%.

The results showed a marginal improvement on those from 2023 in four of the seven People Promise themes as well as the two additional questions on staff engagement and morale. We scored marginally above average for all acute trusts for “We Work Flexibly” at 6.25% (average 6.24%).

The overall results were made available to all staff in a story on the intranet and each team was able to view its results on the Business Intelligence system. A pack was issued to managers to help them explain and take action on the results within each department. Poorly performing teams were offered additional help in staff support and development.

We discussed the results with staff representatives, such as the Staff Council, Staff Networks and the Joint Staff Consultative Committee. Actions are being taken forward through our People Promise plan, in line with the National People Plan.

The People Promise sets out what staff can expect from their leaders and from each other, highlighting the things that would most improve their working experiences.

The [NHS Staff Survey](#) tracks our progress towards staff engagement, staff morale and the seven elements of the People Promise:

Indicators (‘People Promise’ elements and themes)	2024/25		2023/24		2022/23	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	6.9	7.2	6.9	7.2	6.7	7.2
We are recognised and rewarded	5.5	5.9	5.5	5.9	5.2	5.7
We each have a voice that counts	6.2	6.6	6.3	6.7	6.1	6.6
We are safe and healthy	5.7	6.0	5.7	6.0	5.3	5.9
We are always learning	5.4	5.6	5.3	5.6	5.0	5.4
We work flexibly	6.2	6.2	6.1	6.2	5.7	6.0
We are a team	6.4	6.7	6.4	6.7	6.2	6.6
Staff engagement	6.3	6.8	6.3	6.9	6.1	6.8
Morale	5.5	5.9	5.5	5.9	5.1	5.2

## 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)

The Staff Council was formed in 2022 and has representatives across a wide range of staff groups and roles. The group acts as a forum to hold the Trust to account in the delivery of our People Promise action plans, suggest ideas to improve staff experience and provide feedback on our proposals and help us shape initiatives. We have a number of Staff Networks, which meet frequently to make a positive difference to colleagues and our Trust. These are:

- NNUH Together
- LGBT+
- Disabilities and Long Term Health Conditions
- Women's Network.

## Other communication mechanisms

Staff engagement is supported by a comprehensive internal communications programme which includes a sophisticated intranet, called the Beat, which includes daily news, blogs from senior leaders, information, policies, guidelines, discussion forums, an event calendar and departmental information. On the Beat, we published a fortnightly update from the Hospital Management Board about performance, finance and workforce issues which keeps staff up to date on a range of issues affecting our hospitals.

There is a weekly round-up of news and information emailed to all staff, a quarterly magazine called The Pulse, plus a regular programme of events and awareness days. The CEO also runs a monthly open meeting in the lecture theatre, open to all staff, which covers current issues and strategy. 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.

## Diversity and Inclusion

Equality, Diversity and Inclusion (EDI) is a critical component to making improvements to our organisational culture. In line with the commitment to embedding the NHS People Promise and in response to our Caring with Pride Corporate strategy we launched a Diversity, Inclusion and Belonging strategy in October 2023, which consisted of a five-year plan towards embedding our ethos of '*Our Hospital for All*'. We have since been working on completing the first-year actions within the strategy plan.

Actions which have been completed include:

- Providing an infant feeding room for our staff,
- Launched a civility and respect policy,
- Published our first ethnicity pay gap report,
- Improved facilities and rebrand of our spiritual healthcare service (previously known as the Chaplaincy)
- Delivered ‘call it out’ training to support and educate staff on microaggressions and how to be an active bystander
- Improved the support to access reasonable adjustments via the Access to Work government scheme.

The two Equality Standards – Workforce Race Equality Standard (WRES) and Disability Equality Standard (WDES), Gender and Ethnicity Pay Gap Reports, and the Equality Delivery System (EDS2) report – along with engaging with our Staff Networks and Equality and Diversity Group (EDGe) are also part of our efforts for positive change, engagement and inclusivity which support our commitment to make the Trust “*Our Hospital for All.*”

### **Equality and Diversity Policy and Equality Impact Assessments**

Our Equality, Diversity and Inclusion (EDI) policy describes our approach to these issues. 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 (EIA) Form(s) and guide. The EIA is a way of investigating whether any of our 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 we need 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**

The Trust established an Equality and Diversity Group (EDGe) to reflect patient/service user and workforce related matters in 2019. The group involved the senior management team as well as our Staff Network chairs/representatives as they worked together to identify gaps, improvements and ensuring we meet our EDI requirements. Since the launch of our Diversity, Inclusion and Belonging Strategy in October 2023, we have recently decided to revisit the Terms of Reference for this group and consider a different approach. The “new” group will be known as the Diversity, Inclusion and Belonging Steering Group and will launch in April 2025. The group will involve a more concise but influential membership. The group will report to relevant governance groups including the Workforce and Education Sub Board and Hospital Management Board where appropriate. The main purpose of the group will be to monitor progress against the strategy.

In addition to the above group, there is a Health Inequalities Group which meets on a monthly basis to focus on the CORE20PLUS5 objectives and any other business relating to

health inequalities identified from a patient/service user lens.

### **Workforce Race Equality Standards (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 this year is required to be published by the 31 August 2025. Key indicators taken from the WRES 2024 report are:

- **WRES Indicator 1 – 18.1%** of our overall workforce are from a Black, Asian or ethnic minority background. The overall Trust total workforce increased by 5%, of which the Black and Minority Ethnic workforce increased by 3%, with Black and Minority Ethnic representation showing year-on-year improvement within senior non-clinical roles.
- **WRES Indicator 2** – white candidates are **1.53x** more likely to be appointed from shortlisting compared to Black and Minority Ethnic candidates. There is an improvement compared to 2023 reporting where it was **1.68x** more likely for white candidates to be appointed from shortlisting than Black and Minority Ethnic candidates.
- **WRES staff survey indicator 5 – 32.3%** of Black and Minority Ethnic staff and **26.9%** of white staff have reported to the Trust that they have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This has improved compared to 2023 reporting where **36.6%** of Black and Minority Ethnic and **33.5%** of white staff experienced such behaviours from patients or service users. This seems to indicate some beneficial impact from the “No Excuse for Abuse” campaign, run with Norfolk Constabulary, which outlines the custodial sentences which can apply and the “Withdrawal of Treatment Protocol”, for patients who persistently abuse staff providing them with care.
- **WRES staff survey indicator 7 – 49.2%** of Black and Minority Ethnic staff and **54.3%** of white staff have reported that they believe the Trust provides equal opportunities for career progression or promotion. This has improved significantly for our Black and Minority Ethnic colleagues compared to 2023 reporting (meeting the 10% improvement target that we had set out in our WRES action plan for 2025). However, it has remained relatively static for our white staff members. The Trust is now above the benchmark median for Acute Trusts which is **47.0%**.

### **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 this year is required to be published by the 31 August 2025.

Key indicators taken from the WDES 2024 report are:

- **WDES Indicator 1 – 4.87%** of our staff have disclosed they have a disability, which is a 2% increase on the previous year but 28% of staff have disclosed a disability via the national staff survey.
- **WDES Staff Survey Indicator 4a – 33.5%** of disabled staff and **25.6%** of non-disabled staff reported that they had experienced harassment, bullying or abuse from patients / service users in the past 12 months. This has improved compared to 2023 reporting which reported **38.9%** of disabled staff and **31.8%** of non-disabled staff experienced such behaviour from patients/service users.
- **WDES Indicator 4b – 28.6%** of disabled staff and **19.3%** of non-disabled staff reported they had experienced harassment, bullying or abuse from other colleagues which is a decrease for both groups compared to last year (31.8% and 21.9% respectively)
- **WDES Indicator 5 – 47.7%** of disabled staff and **55.3%** of non-disabled staff said that they believed that the Trust provides equal opportunities for career progression or promotion.
- **WDES Indicator 9 –** our staff engagement score has increased for both our disabled and non-disabled staff. Our engagement score is now **6.0** for disabled staff and **6.5** for non-disabled staff (5.8 and 6.2 respectively)

### Trade Union Facility Time

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 2023 – 31 March 2024, the Trust reported 14 trade union representatives providing 13.39 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%	2
51 – 99%	8
100%	1

The total spend on paying employees who were relevant union officials for facility time during the relevant period was £76,034.34 which represented 0.01% of the Trust's total pay bill. The total hours on paid TU facility time totalled 3,441 which represented 13.34% of total paid facility time.

### Local Counter Fraud Service (LCFS)

The Trust 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 regular updates and training sessions provided to staff through the intranet, with guidance or advice issued by NHS Counter Fraud Authority. This process is detailed in our Anti-Fraud and Bribery Policy.

### Exit packages

- Reporting of compensation schemes - exit packages 2024/25
- Exit package shown by cost band (including any special payment element)

The following table is subject to audit

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	5	22	27
£10,000 - £25,000	12	1	13
£25,001 - 50,000	9	2	11
£50,001 - £100,000	3	1	4
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	29	26	55
Total Resource cost £	£727,804	£231,881	£959,685

- Reporting of compensation schemes - exit packages 2023/24
- Exit package shown by cost band (including any special payment element)

The following table is subject to audit

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	-	13	13
£10,000 - £25,000	1	-	1
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	1	13	14
Total Resource cost £	£21,333	£30,468	£51,801

## Exit packages: other (non-compulsory) departure payments

The following table is subject to audit

	2024/25		2023/24	
	Payments agreed		Payments agreed	
	Number	£000	Number	£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	26	216	13	30
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
<b>Total</b>	<b>26</b>	<b>216</b>	<b>13</b>	<b>30</b>
Of which: Non-contractual payments requiring HM Treasury approval made to individuals where the payment value was more than 12 months' of their annual salary.	0	0	0	0

## Off-payroll payments

**Table 1: Highly-paid off-payroll worker engagements as at 31 March 2025 earning £245 per day or greater**

Number of existing engagements as of 31 March 2025	
Of which: 1	
Number that have existed for less than one year at time of reporting	1
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number 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.

**Table 2: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater**

Number of off-payroll workers engaged during the year ended 31 March 2025	
Of which:	
Not subject to off-payroll legislation *	0
Subject to off-payroll legislation and determined as in-scope of IR35 *	1
Subject to off-payroll legislation and determined as out-of-scope of IR35 *	1
Number of engagements reassessed for compliance or assurance purposes during the year	1
Of which: number of engagements that saw a change to IR35 status following review	0

\* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

**Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025**

**Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025**

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.	0

In any cases where individuals are included within the first row of this table the trust should set out:

- Details of the exceptional circumstances that led to each of these engagements.
- Details of the length of time each of these exceptional engagements lasted.

### Consultancy expenditure

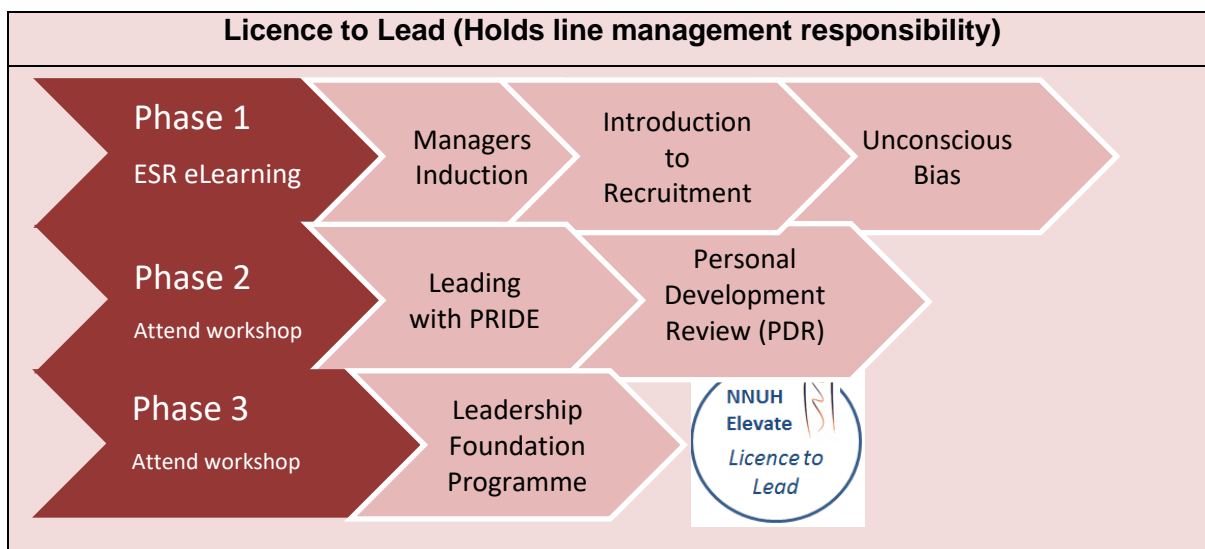
£1,583k was spent on consultancy expenditure in 2024/25 (2023/24: £1,868k).

### Staff Development

#### 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.



Providing line managers with the skills and confidence to lead effectively plays a critical part in day-to-day staff experience and developing the culture of the Trust. Our Licence to Lead is a modular programme. There has been excellent engagement with over 2,500 managers having commenced the programme. Of these, 698 have completed their licence in full with a further 1,164 having completed at least 60% of the learning (data as at February 2025).

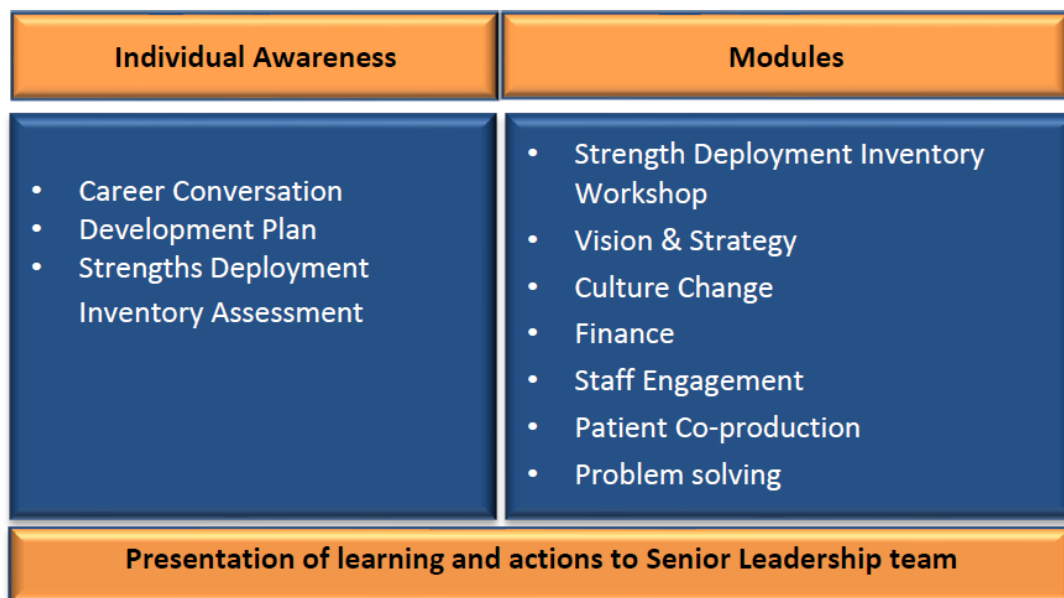
### Connected Leaders

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

This programme was 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.

#### Programme Overview



The programme has been offered to the organisations across the Norfolk and Waveney Integrated Care System (ICS) and a large range of departments have attended since its launch.

The evaluation feedback has recognised the participants improved set of leadership skills. They have acknowledged the benefits to improved team and collaborative working. The teams have also progressed some key projects to improve their service areas from the development of new or updated strategies, improved systems and processes for staff and patients, staff working relationships and departmental cultures.

### 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 and Minority Ethnic colleagues by providing an accelerated leadership pathway within the Trust.

## **Apprenticeships**

During the financial year of 2024/25, we have seen 165 colleagues commence on an apprenticeship; 113 are existing colleagues and 52 are new apprentices, with 23 aged between 16–18 years. The total number is lower than in 2023/2024 (196).

We continued to offer a diverse number of apprenticeships standard with 28 delivered between clinical and non-clinical subjects; this included the new additions of the Project Management Degree Apprenticeship, AI Data Specialist Level 7, Diagnostic Radiographer Degree Apprenticeship.

Moving into 2025/2026 the team will continue to advertise and promote opportunities and highlight career pathways through the apprenticeship route to students and individuals seeking employment.

In 2024/2025, as the largest NHS Trust in the region, the Trust has supported other health and social care organisations by working with the Norfolk County Council to share excess Apprenticeship Levy Funds. We have committed £335,000 (out of an agreed £350,000) to train staff at Norfolk Community Health and Care NHS Trust, GP Surgeries, and Pharmacies with the training being paid for monthly for up to two and a half years. This has allowed us to support our system partners to build the wider health and care workforce within the ICS and prevent funds from expiring from the Trust's Apprenticeship Levy budget.

## **Work Experience**

In 2024, we continued to offer ad-hoc work experience placements across the Trust in a variety of settings including Physiotherapy, Cardiology, Neurophysiology, and Phlebotomy. In total we received a total of 216 applications from a variety of students for ad-hoc placements during 2024/2025. Applications for ad-hoc work experience are accepted in windows throughout the year and anyone aged 14+ who are new to the NHS are welcome to apply.

We hosted our annual Year 10 work experience weeks during June and July 2024 where we were able to offer 20 students a place from the 110 applications received from students.

Due to the popularity of our Year 10 work experience programme and following feedback from students, school contacts and colleagues we have redesigned our Year 10 work experience and have planned three separate 'Career Insight' programmes'. The first programme was hosted in February 2025 and was open to both Year 10 and 11 students. The 3-day programme provides students with an insight into a variety of health careers including Allied Health, Nursing, Support and Corporate Services. The next programme will be in July 2025 and will be open for Year 10 students with the final programme of the year being during October 2024 for both Year 10 and 11 students.

We have also worked with departments including Pathology, Radiotherapy, Pharmacy and Finance to host career specific work experience for students throughout the year with plans in place to support other departments across the Trust to host career specific programmes.

## **Career Engagement**

During 2024/2025 we have attended a total of 23 Careers Fairs across 18 schools, colleges, sixth forms and Job Centres engaging with approximately 1,780 individuals interested in a career within Health.

We work with Trust colleagues who join us at these events as Health Ambassadors to promote their areas of specialities and to talk to students and members of the public about pathways into health careers. Currently we work with 28 colleagues across a variety of departments and specialities as Health Ambassadors.

## **T-Levels**

T-Levels are delivered over two years following GCSEs and are equivalent to three A Levels. Students must undertake an industry placement of 315 hours during their course to acquire on the job training and skills.

The Trust has hosted a total of ten Health T-Level placements during 2024/2025, with four students now working in Health Care Support Worker roles since the Trust first established placements in 2023.

We are currently working with local providers to organise and establish placements for T-Level Health students for 2025/2026.

## **Functional Skills**

We have continued to offer free L2 Functional Skills sessions in Maths and English in association with City College Norwich as a way of supporting colleagues in continuing their development.

In 2024/25 we ran three cohorts with applications open to any Trust colleague (including bank), sessions run for a 12-week period and are online only. We also continued to encourage colleagues to apply through Norfolk County Council when applications for City College were not available or when L1 or classroom sessions are requested– applications must be completed online and directly with the council as we are not involved in the running of these programmes. Completion of Functional Skills allows colleagues to apply for higher apprenticeships (this is essential requirement for most) and apply for higher banded jobs within the Trust.

## **Work Matters**

Work Matters, previously Project Search, is a work focused internship 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 Trust and has now been running for 16 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 Trust or within the wider community by the end of the programme. Since commencing in 2009, over 150 students have accessed the programme.

Following the recruitment for the 2024/2025 programme, eight students started in September 2024 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 and their families to gain an understanding of the employment opportunities within health and social care. We continue to work with NHS Employers and the Careers Transition Partnership to support individuals with work shadowing and 1-1 career support.

During 2024/2025 we have contacted 23 individuals who have registered their interest and have hosted two candidates on work shadowing placements within Project and Operational Management areas.

### **Workplace Health & Wellbeing (Occupational Health)**

Workplace Health & Wellbeing (WHWB) has continued to see a significant increase in demand for occupational health services linked to the ongoing pressures on NHS staff with elective recovery programmes, impact of industrial action as well as a difficult winter season resulting in the hospital being in escalation over several weeks.

## **Core Occupational Health Services**

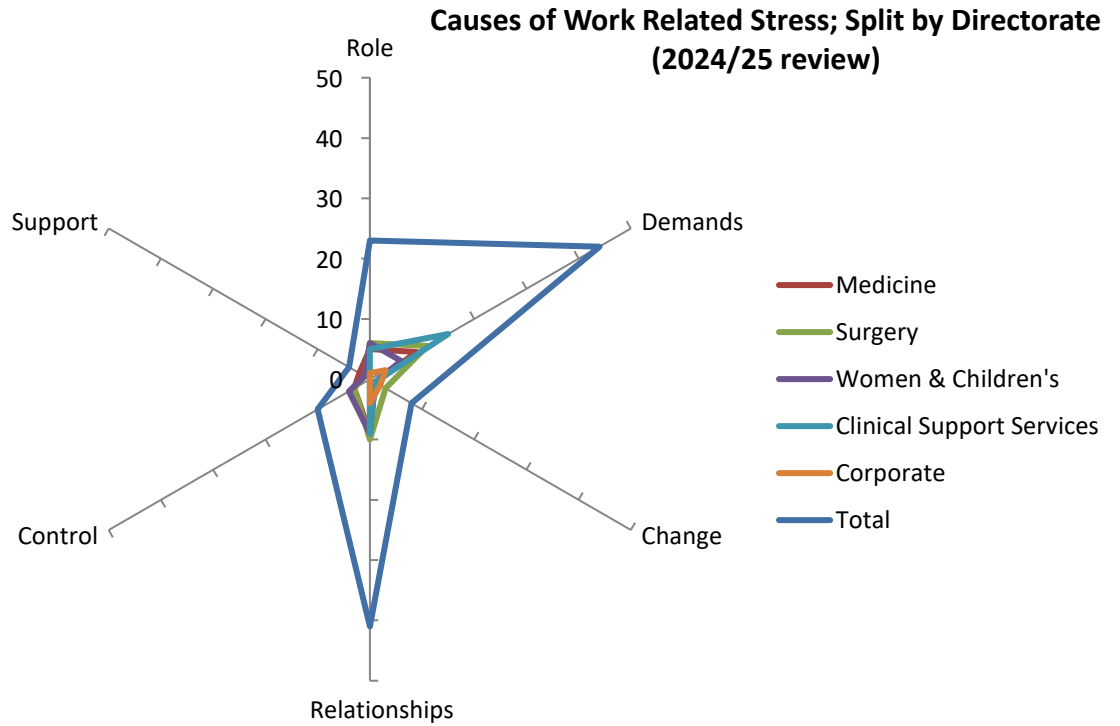
### **Service Delivery**

Core occupational health services have continued over the course of this year. We have undertaken absence referrals, immunisation services, to provide essential protection to colleagues working in clinical environments and exposed to blood and body fluids.

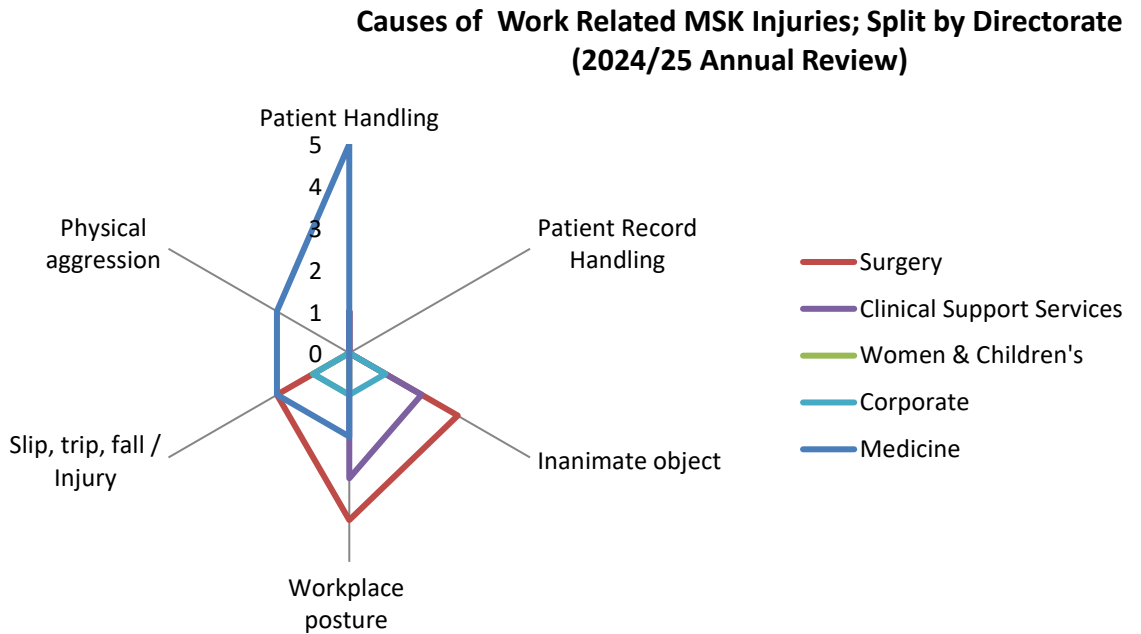
### **Occupational Health Referrals**

The emerging themes over this last year facing colleagues have been reported as:

- Psychological Referrals: Work-related stress consistently emerged as a leading cause. Issues identified include workload pressure, interpersonal conflicts, and lack of managerial support.
- Burnout / Moral Injury - staff on the wards report exhaustion, anxiety and feeling overwhelmed. This can be linked to the ratio of staffing in relation to number of patients (when in escalation). Clinical staff continue to report not being able to deliver safe care due to unsafe staffing levels and inadequate resources which impacts their wellbeing. The additional patients in a bay or corridor have been a frequent citation as well as an increase in hours worked responding to waiting list initiatives. For administration staff, repeated cancellation and rescheduling of appointments (industrial action response) has caused significant distress.



- Musculoskeletal (MSK) Cases: A decline was observed, with work-related MSK cases reducing from 14% in Q1 to no cases reported in Q3 with an increase to 10% in Quarter 4.



- The impact of underlying health issues on the ability to perform their role.

### **Increased recruitment support**

Occupational health services in the NHS are a vital stage of the recruitment process of staff. WHWB have supported the Trust in the recruitment of new service provision (e.g. Orthopaedic centre) as well as the continued onboarding of healthcare assistants.

Having additional dedicated administration and clinical resource to respond to this request has demonstrated the ability to respond to tight timelines and work in partnership with the Trust to ensure OH clearances and immunisation scheduled have been undertaken accordingly.

### **Immunisation Services for staff**

An increase in immunisation events have occurred in this last year, driven by efforts to boost measles compliance and the introduction of the Pertussis vaccine for priority Group 2 staff in line with updated UK Health Security Agency (UKHSA) recommendations.

### **Measles Response**

In January 2024, NHS England released guidance notification for the risk assessment and infection prevention and control measures for measles in healthcare staff considering the concerns regarding the rising cases of measles in the country. WHWB worked with the Trust to form a task and finish group to consider the presenting risks and mitigate these with a series of actions.

After a year of work actions have included:

- Reviewed occupational health system data to establish staff immunity to measles commencing with the high-risk entry point areas. Confirmation of over 80% immunity
- Created a detailed contract trace matrix so all staff are clear on any exclusion requirements depending on level of exposure, PPE worn and immunity history
- Created a risk assessment tool to assess vulnerable staff and who should not be allocated a patient with suspected or confirmed case of measles
- Provide guidance on the PPE required when caring for patients with suspected or confirmed cases of measles
- Worked with the ICB on developing a pathway of clinical care if an immunosuppressed or pregnant colleague is exposed to a confirmed case and requires immunoglobulin treatment.

### **Pertussis Vaccination – Extending Healthcare Vaccination to Group 2**

In June 2024, UKHSA released updated guidance outlining an enhanced approach to pertussis immunisation in healthcare workers. This required health care settings to expand eligibility criteria: Healthcare workers in neonatal units, paediatric departments, maternity wards, and those with frequent exposure to infants are now considered high priority for vaccination.

The Trust has proactively incorporated these changes into its staff immunisation strategy. Targeted communication campaigns, and integration of immunisation tracking within the occupational health system have been introduced to optimize vaccine uptake and compliance. The vaccination rollout began in October and continues into 2025.

This initiative aligns with national immunisation goals to reduce pertussis transmission in healthcare settings.

Future audits will assess the effectiveness of these measures and inform ongoing measure to increase uptake.

### **Autumn Booster Campaign**

#### **Covid & Influenza Vaccination programmes**

Once again, the WHWB team mobilised a temporary team to provide a seasonal vaccination programme which included both COVID and Influenza boosters. A programme of co-delivery was designed but also allowed colleagues to have these undertaken separately if that was their preference.

The team used a dedicated software system to allow online booking and were provided with a clinical space to create a dedicated vaccine hub. For financial resourcing constraints, our programme ran for a two month period.

Despite lower uptake than in previous years, the Trust achieved one of the highest vaccination rates among acute Trusts in the region and nationally. Due to high levels of flu circulation, flu vaccines remain available on request until end February 2025, while the COVID booster program concluded on January 31 2025.

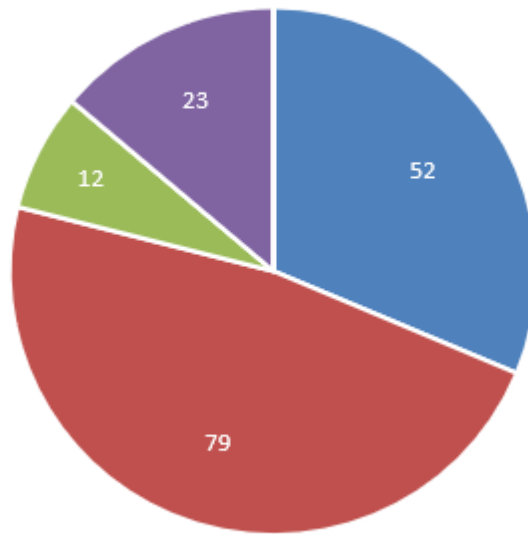
Our success within this programme, was undoubtedly as a result of strong medical and nursing leadership together with the support of a dedicated software programme and prominent communications plan.

#### **Exposure incidents**

Our blood exposure support line continues and all colleagues who have such incidents are assessed and supported with any necessary treatment.

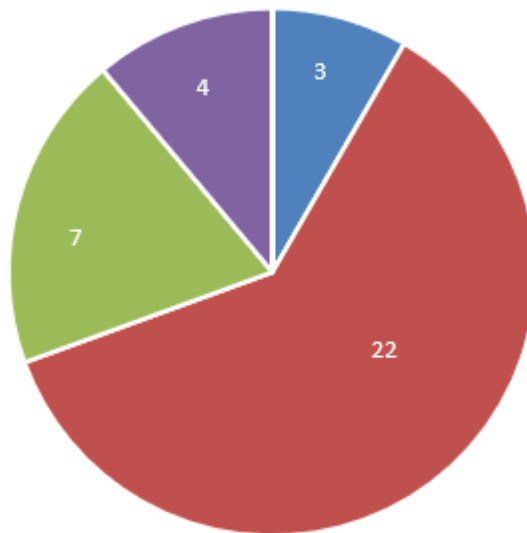
Blood exposure incidents, including needlestick injuries, remained consistent at approximately 50 cases per quarter.

**Sharps Incidents by Directory  
2024/25 Annual Review**



■ Medicine ■ Surgery ■ Women and Children's ■ Clinical Support Services ■ Corporate

**Blood Exposures by Directory  
2024/25 Annual Review**



■ Medicine ■ Surgery ■ Women and Children's ■ Clinical Support Services ■ Corporate

Improved staff training and enforcement of PPE use are required to reduce these numbers.

Many exposure incidents could have been prevented through appropriate PPE usage. Increased compliance monitoring has been recommended to clinical areas through Health & Safety Committee as well as the Workforce and Education Sub Board.

### Contact tracing

Since the removal of mandatory mask wearing (post pandemic), the rate of infectious disease contact tracing for staff has increased. Primarily this is down to the staff not considering the need to wear PPE when faced with patients displaying respiratory symptoms.

Contact tracing cases increased from 20 in Q1 to 36 in Q2 before stabilizing at 16 cases in Q3 & Q4. The rise in Q2 was due to an increase in prevalence of pertussis and covid nationally.

This is a risk to staff and patient protection. This area of PPE compliance has been raised at both Health & Safety Committee and the Workforce and Education Sub Board, with summaries provided to Hospital Management Board for action by the clinical areas.

### Health Surveillance

Health surveillance process have started to resume. WHWB are working with the Health & Safety team to identify the areas of most risk and commencing the health surveillance programmes in these areas.

### Wellbeing

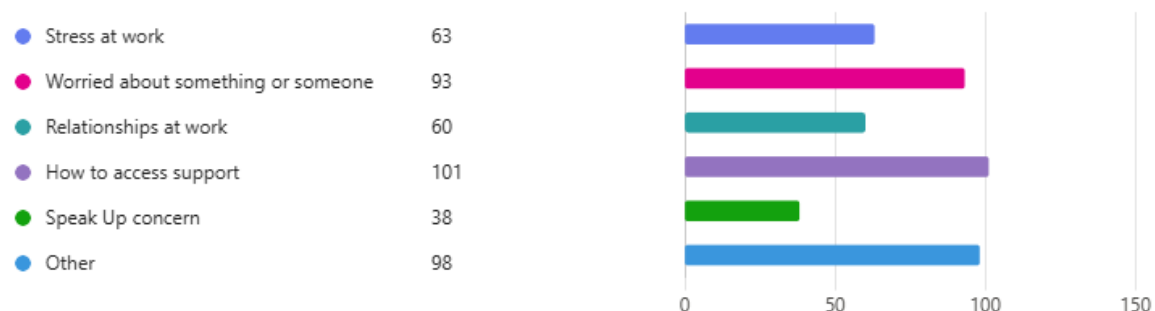
The Wellbeing team has made significant strides in providing comprehensive support and training programs to enhance staff wellbeing. The team remains committed to fostering a positive and supportive work environment for colleagues. This highlights key achievements and initiatives implemented throughout the year.

### Staff Health & Wellbeing Hub

Following the success of the weekly drop-in support sessions made available by the Health & Wellbeing team and the Trust's Freedom to Speak Up Guardian over the past year, we have successfully managed to extend this service on each weekday.

The hub facility in the East atrium is now offered Monday – Friday from 10am to 3pm and is staffed by colleagues from Workplace Health and Wellbeing, Chaplaincy / Spiritual Healthcare, Professional Advocates and Freedom to Speak Up. This service has been valuable for staff to talk through concerns.

Reason for visit



## Training Programs

- **Medical Teams:** Continued support for the PGME I-lead program and "Introduction to Wellbeing & Self-care strategies" for Resident Doctors and SAS groups
- **Staff Induction:** 60-minute introductory session for healthcare assistants and preceptor groups, with other groups included as requested
- **Menopause:** Quarterly training sessions, expanded to staff in February 2025 due to demand.
- **Sleep:** Well-received sleep training program delivered by HWB Mental Health practitioner
- **Migraine:** Re-established training program in collaboration with Headache Specialist nurse practitioner
- **Wellbeing Training:** Monthly workshops in partnership with NHS Talking Therapies, covering various topics and a new "Wellbeing & Mental Health Training – guidance for leaders and champions" starting in March 2025.

## Wellbeing Programme

- **Start Well End Well:** Introduced in alignment with the People Promise action plan, supporting colleague's well-being throughout their employment journey. This program addresses onboarding experiences, ongoing staff support, and exit strategies. Trial implementation in Critical Care, expanding to the Emergency Department and Post Anaesthetic Care Unit.
- **Schwartz Rounds:** The Schwartz Round programme has been very difficult to get off the ground in this year due to challenges of securing a panel, colleagues being released time to attend and raising awareness amongst colleagues. However, when they have taken place, the feedback is extremely positive. This area of work will be a focus for the forthcoming year as the evidence to support burnout is widely published.

## Physical Activity and Other Groups:

- Extended provision of Running club, Walking group, Yoga, Pilates, and Dance groups.
- Promotion of Library "Book of the Month" and "Knit & Natter" craft social group.

## Communication:

- Increased promotion of activities and provisions through broader communication channels.
- Successful Wellbeing & Benefits Expo in October 2024, planned to be repeated twice yearly.

## Targeted Support:

- **Culture/Civility:** Presentations to Paediatric consultants and Cromer hospital, including "Resilience, Civility and Wellbeing" sessions
- **Team Support:** Provided walkabouts, drop-in sessions, and reflective discussions for teams facing challenges

- **Monthly Support Groups:** Continued peer support groups for Long Term Conditions, Menopause, Line Managers, Neurodiversity, Men's Cave, and A&C Late Lunch.

#### **Individual Support:**

- One-to-one support with a new booking system for easier access
- Facilitation of staff support hub with drop-in support and signposting.

#### **Employee Assistance Programme (EAP)**

For many years, the Trust has provided a 24/7 EAP to support the mental wellbeing of staff. Providing this level of support is recommended by NHS England. The Trust commenced working with Vivup who provided their exclusive NHS offer for EAP services (which includes telephone counselling / guided self-help) in January 2023. This has enabled a dedicated staff benefits platform to be created which includes aspects such as wellbeing advice, EAP services as well as other benefits such as discounted rates with various stores and their Home and Electronics benefit platform as part of their Lifestyle savings platform.

#### **Menopause Helpline**

In July 2024, with the support of the N&N Hospital Charity, the Trust launched a dedicated Menopause Helpline. This service provides 24/7 access to specialist menopause experts, offering confidential advice and support tailored to the unique needs of colleagues experiencing menopause-related challenges. The helpline has been well received, with a strong initial uptake indicating a clear demand for this resource.

Key features of the Menopause Helpline include:

- Expert advice on managing symptoms such as hot flashes, fatigue, and mood changes
- Guidance on workplace adjustments to support those experiencing menopause
- Referral pathways for further clinical intervention if required.

Additionally, efforts are being made to increase awareness of menopause-related issues through targeted training sessions and workshops for line managers and colleagues. Feedback gathered over the coming months will inform further improvements to this service.

#### **Support to the Trust through contribution at meetings:**

Regular attendance and contribution through verbal and written reports are provided at the following meetings:

- Health & Safety Committee
- Workforce and Education Sub Board
- Infection, Prevention & Control Committee
- Joint Staff Consultative Committee
- Staff Networks and Staff Council
- ICS Wellbeing Leads
- Complex Care Board
- Staff Survey Prioritisation Group

## **Policy Review / Development**

WHWB have responded to changes in national (UK Health Security Agency) guidance and reviewed its clinical policies in relation to Exposure Prone Procedures – in particular the monitoring of staff with a blood borne virus' and the requirements to identify those who may reactivate with Hepatitis B virus. In addition, the team have reviewed the following policies for the Trust:

- Management of glove usage
- Management Varicella Zoster Infection for Healthcare Workers
- Management of Hepatitis C in Healthcare workers
- Control of gastrointestinal infections in healthcare workers.

## **Faculty of Occupational Medicine SEQOHS (Safe effective, Quality OH Service) Accreditation**

In May 2024, we undertook our annual SEQOHS accreditation assessment review following the full five-year assessment which was completed in May 2022. We were delighted with the extremely positive report received and the ongoing award of accreditation for the services delivered. The summary of the report stated:

*"Thank you for providing detailed information to support the annual review process. Strong satisfactory evidence has been provided to demonstrate continued compliance with the SEQOHS standards. The actions taken in outcome to client feedback and the reported adverse event are appropriate and demonstrate openness and transparency. The auditing and clinical governance evidence provided is excellent and of a very high standard and confirms an ongoing systematic approach and commitment to client care. I have absolutely no hesitation in recommending that service accreditation be renewed for a further year. Many congratulations.*

*I would like to congratulate your service for its continued commitment to maintaining SEQOHS standards."*

## **WHWB External Customers**

As far as external business is concerned, we have maintained our success with our current customers during this last year and will achieve the highest level of income to date.

As part of income to the Trust, the Associate Director - Workplace Health, Safety and Wellbeing, continues to have the additional position of Chair of the NHS Health at Work Network (since 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 creating responses to Government consultations, supporting services on the measles and pertussis guidance changes, collaborating with the Health & Safety Executive on subject areas such as Nitrous Oxide in maternity services. In addition, she has been the NHS representative in the SEQOHS accreditation standards review programme as well as overseeing a 'Good practice' programme of work to support Network members in clinical practice.

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 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 and provides manual handling training and guidance on patient manual handling activities.

### Personnel Changes:

- In August 2024, the department acknowledged the departure of the previous Lead Health & Safety Adviser, who advanced to a promoted position in a neighbouring organisation. A new Lead Health & Safety Adviser was appointed and commenced in post in January 2025. This vacancy period did impact the proactive work undertaken by the team
- The department also records the retirement of the previous Manual Handling Trainer in November 2024 and welcomed a new trainer to the role in December 2024.

### Key Operational Activities:

- **Comprehensive Inspections:** Regular inspections were conducted reviewing 13 critical areas, adhering to the NHS Staff Council Health & Safety Standards.
  - Instances of immediate risk to health, safety, and welfare identified during these inspections were addressed through immediate verbal communication with relevant department leads.
  - Formal inspection reports were provided to area management for the development and implementation of mitigation and control measures.
  - A centralised observation register is maintained to identify trends, common themes, and track the completion of corrective actions.
- **Waste**

**Dangerous Goods Management:** The department continued to provide support to the External Dangerous Goods Safety Advisor, offering guidance to department leads on the implementation of control measures. The safe segregation and management of all waste classes were prioritised to ensure the safety of staff, patients, the public, and the environment.

**Sharps Smart:** The H&S team have supported the Soft FM contractor in implementing the recyclable sharps bins across the Trust. This included the duty of care visit to the supplier.

**Tiger Waste:** The team are supporting the facilities team with the roll out of the offensive / non-infectious 'Tiger waste' stream roll out.

- **Control of Substances Hazardous to Health (COSHH):** Ongoing support was provided for the management of the electronic COSHH system, ensuring the completion and review of assessments. Operational activities included collaborating with clinical teams to ensure the safe storage of chemicals and the provision of appropriate Personal Protective Equipment (PPE) at the point of use.
- **Personal Protective Equipment / Respiratory Protective Equipment (RPE) Fit Testing:** To maintain business continuity in response to potential pandemics or high-consequence infectious diseases, the department ensured Face Fit Testing met the requirements outlined in the Department of Health and Social Care's FFP3 Resilience in the Acute Setting. Fit testing is managed by divisional fit testers.

Support is being given to implement PPE requirements for High consequence infectious diseases, with training starting in April 2025. [NHS England » Addendum on high consequence infectious disease \(HCID\) personal protective equipment \(PPE\)](#)

- **Nitrous Oxide (Entonox) Exposure Management.**  
**Risk Assessment and Mitigation:** In recognition of the potential risks associated with nitrous oxide (Entonox) exposure, particularly within maternity services, a focused initiative was undertaken to ensure compliance with relevant health and safety regulations.

**Environmental and Personal Monitoring:** Collaborative efforts with the facilities management team were implemented to conduct comprehensive air quality monitoring. This included both environmental monitoring, to assess ambient nitrous oxide levels within designated areas, and personal monitoring, to evaluate individual exposure levels.

**Regulatory Compliance:** All monitoring and control measures were conducted in strict adherence to the Health and Safety Executive (HSE) guidelines and established workplace exposure limits (WELs).

**Monitoring Results:** The findings from both environmental and personal monitoring demonstrated that nitrous oxide exposure levels remained consistently below the designated WELs, confirming the effectiveness of existing control measures and ensuring the safety of personnel. Ongoing assurance monitoring will take place over this next year.

- **Building Safety:** The Health and Safety team has supported the Trust in reviewing health and safety concerns with new builds, including the new Norfolk and Norwich Orthopaedic Centre (NANOC) building, and the Community Diagnostic Centre. In addition, support provided for the new proposed layout and design plans for the plaza reconfiguration
- **Health and Safety Committee Reporting:** Progress updates on mandatory areas were provided via the Health and Safety Quarterly Report to the Health and Safety Committee. Existing health and safety documentation including policies and risk

assessments are continually reviewed and improved to meet the needs of the Trust and this remit also encapsulates that ensuring any new potential hazards are observed and assessed to ensure controls are implemented to mitigate the likelihood of harm occurring.

## 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 Trust. The training covers topics such as health and safety, manual handling, prevention and management of aggression, chemicals and waste.

Classroom-based training for Prevention and Management of Aggression which includes a physical breakaway element training continues with the main objective to ensure that colleagues requiring the induction session are priority for training. This training is required for colleagues working in mandatory areas of the hospital e.g., Emergency Department. There remains a backlog of colleagues who are new to the Trust requiring this training since the pandemic when training could not be delivered. Contingencies such as eLearning is in place for colleagues that require a refresher session so the focus can be on those who have not previously received the training.

Manual Handling Induction and Refresher training continues to be completed. With new staff appointed, the training is currently being evaluated to ensure relevant to all staff that are required to receive. In addition, a site wide manual handling equipment audit has commenced in January 2025 to ensure awareness of all equipment and Lifting Operations and Lifting Equipment Regulations (LOLER) testing is meeting regulations.

## Incidents

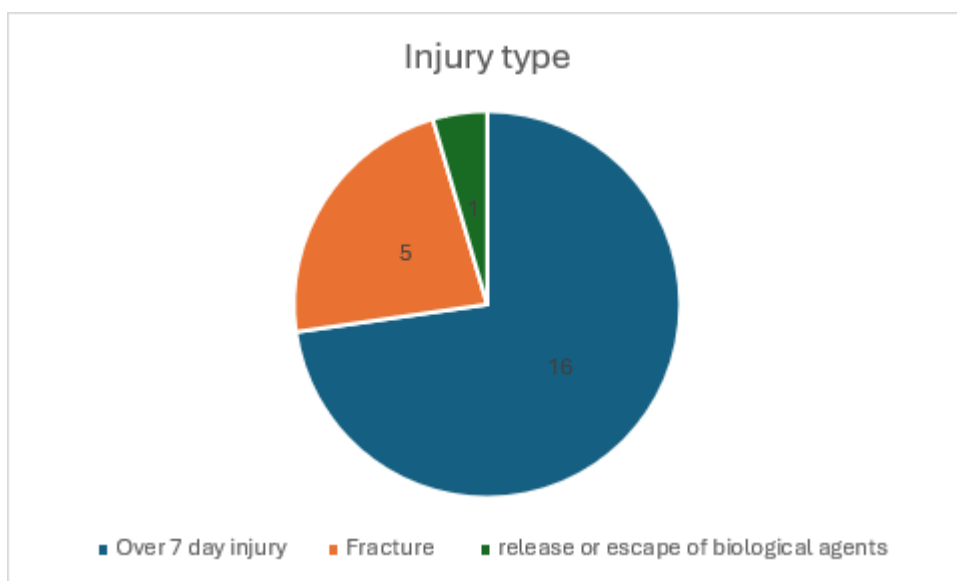
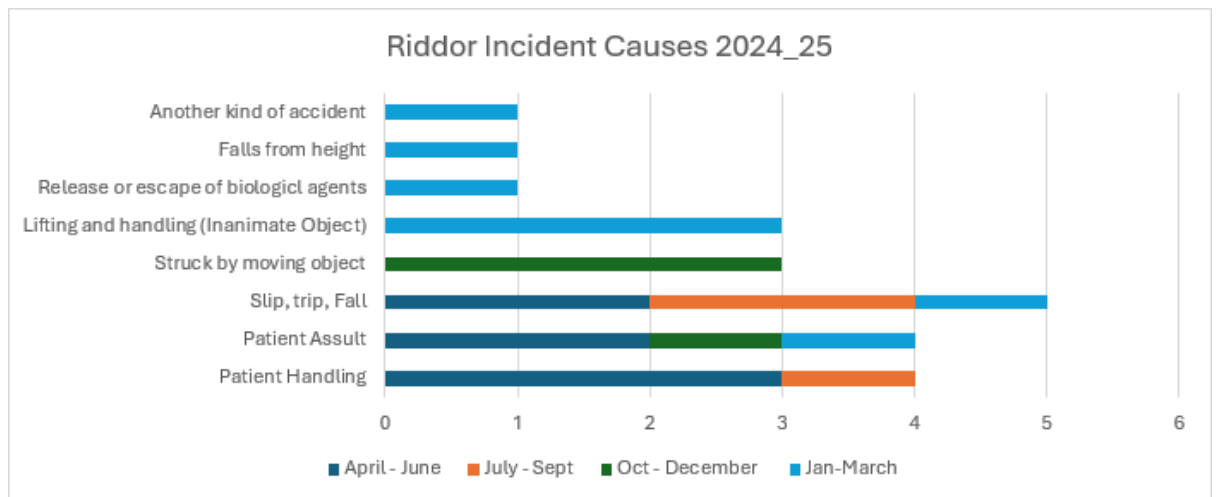
There are five highest categories of health and safety related incidents that are reported most frequently for staff. These are:

- Violence (including assault, abuse or harassment)
- Needlestick injury
- Accidents and Injuries (not slips, trips and falls)
- Slips, trips and falls
- Moving and Handling

	Accidents and Injuries (NOT slips, trips, falls)	Electricity, temperature extremes	Exposure to harmful agent - radiation / biological / substance	Moving and Handling	Needlestick / Sharps Incident	Slips, Trips and Falls	Violence (including assault, abuse or harassment)	Total
Public , contractors, visitors	9	1	3	0	2	23	16	54
Staff (Including Agency Staff)	126	25	74	89	222	89	340	965
<b>Total</b>	<b>135</b>	<b>26</b>	<b>77</b>	<b>89</b>	<b>224</b>	<b>112</b>	<b>356</b>	<b>1019</b>

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

During the period April 2024 to March 2025 the Health and Safety team reported a total of 22 incidents to the Health and Safety Executive as they met the schedule of RIDDOR. 21 of these related to Trust colleagues, the other single case related to a worker of a contracted organisation;



This is an increase in reporting compared to 2023/2024 which had a total of 16 incidents being reported for the period. The number of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) incidents is reflected as an incidence rate against the national average. The Trust's overall incidence rate is 200 per 100,000 employees based on a staffing level of 11,000. The national incidence rate for healthcare in 2023/2024 was 292.

# NHS England's

## NHS Oversight Framework

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

NHS organisations are allocated to one of four 'segments', from those with no specific support needs (segment 1) to those with a requirement for mandated intensive support (segment 4). By default, all NHS organisations are allocated to Segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

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

Providers are categorised from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. Through 2024/25, 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 also in Segment 3.

There are currently no additional regulatory Undertakings attached to the Trust's Provider Licence.

This segmentation information is the Trust's position as at 23 January 2025. The latest 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/>

## **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 NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require the 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 [name] NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

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

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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

Signed:

A handwritten signature in black ink, appearing to be 'LD', written in a cursive style.

**Professor Lesley Dwyer, Chief Executive**

**Date: 23 June 2025**

## Annual Governance Statement for the year ended 31 March 2025

### Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 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 Trust Accountable 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 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 Norfolk and Norwich University Hospitals NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

### Capacity to handle risk

The Trust takes a holistic approach to risk management which incorporates clinical and non-clinical risk by ensuring that risks are identified, managed appropriately in line with statutory, mandatory and best practice requirements.

To support this approach, the organisation has a risk management strategy implemented in 2023 and spanning to 2027, which was approved by the Audit Committee and ratified by the Board of Directors.

Whilst the Board of Directors have overall joint responsibility for risk. Oversight and management of the strategy and supporting policies and processes is delegated to the Chief Nurse's executive portfolio. The Chief Nurse is supported by the Head of Risk Management as the subject matter expert. Staff are made aware of their responsibilities to identify and manage risk through a variety of communications methods depending on their level of seniority and role within the organisation.

All staff are required to complete Level 1 mandatory training through corporate induction at the commencement of their employment. This is the foundation to ensure that all employees understand what a risk is and can undertake a risk assessment, in particular the ability to identify, correct any immediate risks to patient's safety and escalate appropriately to senior colleagues to formalise the risk assessment and implement mitigating measures. During this process, staff are also signposted on where to find the strategy, policies, procedures and how to access the risk management system.

Level 2 – 4 training builds on risk management knowledge to support leaders right through to the Board of Directors, including risk appetite, culture and maturity supported by assurances required. 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 Sub-Board, which reports to the Hospital Management Board, the Quality & Safety Committee through to the Board of Directors.

Following a review of falls, nutrition and hydration incidents which have caused harm to patients, in 2024 the Trust has substantively employed a specialist practitioner to lead on preventative falls management and a specialist practitioner to lead on improving nutrition and hydration. These colleagues share learning and provide training to all levels of staff and are responsible for implementing service and quality improvements across the organisation.

At the beginning of 2025, a Learning from Insight and Outcomes Group was established. The purpose of this group is to identify and commission improvement and transformation work to those areas of improvement not aligned to existing work streams to ensure efficient use of available resources to improve quality, safety, patient and staff experience and reduce risk to support achievement of the Trust's strategic objectives.

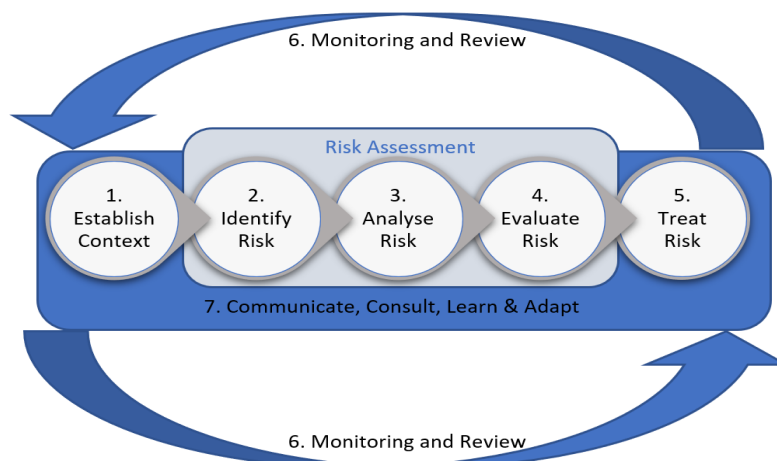
### The risk and control framework

The risk policy has a clear definition of what is deemed as a 'risk'. The Trust uses a systematic approach to risk management, which is supported by a well-designed structure and process which is applied consistently across the organisation.

It is recognised that it is not possible to eliminate all risks or for an organisation to be risk adverse, therefore the Trust has general principles where it will seek to eliminate, and controls risks which have the potential to:

- Harm its staff, patients, visitors and other stakeholders
- Have a high potential for incidents to occur
- Negatively impact on the Trust's operations
- Result in loss of public confidence in the Trust and/or its partner agencies
- Have severe financial consequences which would prevent the Trust from carrying out its functions.

The systematic approach includes the identification and assessment of risks, a process for escalating risks to the Trust Risk Register and management of risk. All risks with a residual score of 15 or greater need to have an executive senior risk owner. Risks should be aligned to the relevant executive and escalated to them and the Head of Risk as soon as practicably possible. The overall risk management process is shown concisely below and is detailed in the risk management policy.



Check and challenge of risk is carried out at speciality level and through peer review by the Risk Oversight Committee. This 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.

The Head of Risk Management is a core member of the Hospital Management Board and attends sub board committees to provide reports and recommendations related to risk and share lessons learned.

In accordance with the NHS Provider licence, section 4 (governance) the Trust does have a board and committee structure as described in figure 1.

The sub board committees listed in figure 1, each receive extracts of the Corporate Risk Register of all risks aligned with the responsibilities detailed in their terms of reference. Each committee chaired by a Non-Executive and with Executive Directors members will review these risks and assess the level of assurance regarding the mitigations in place to minimise the risk.

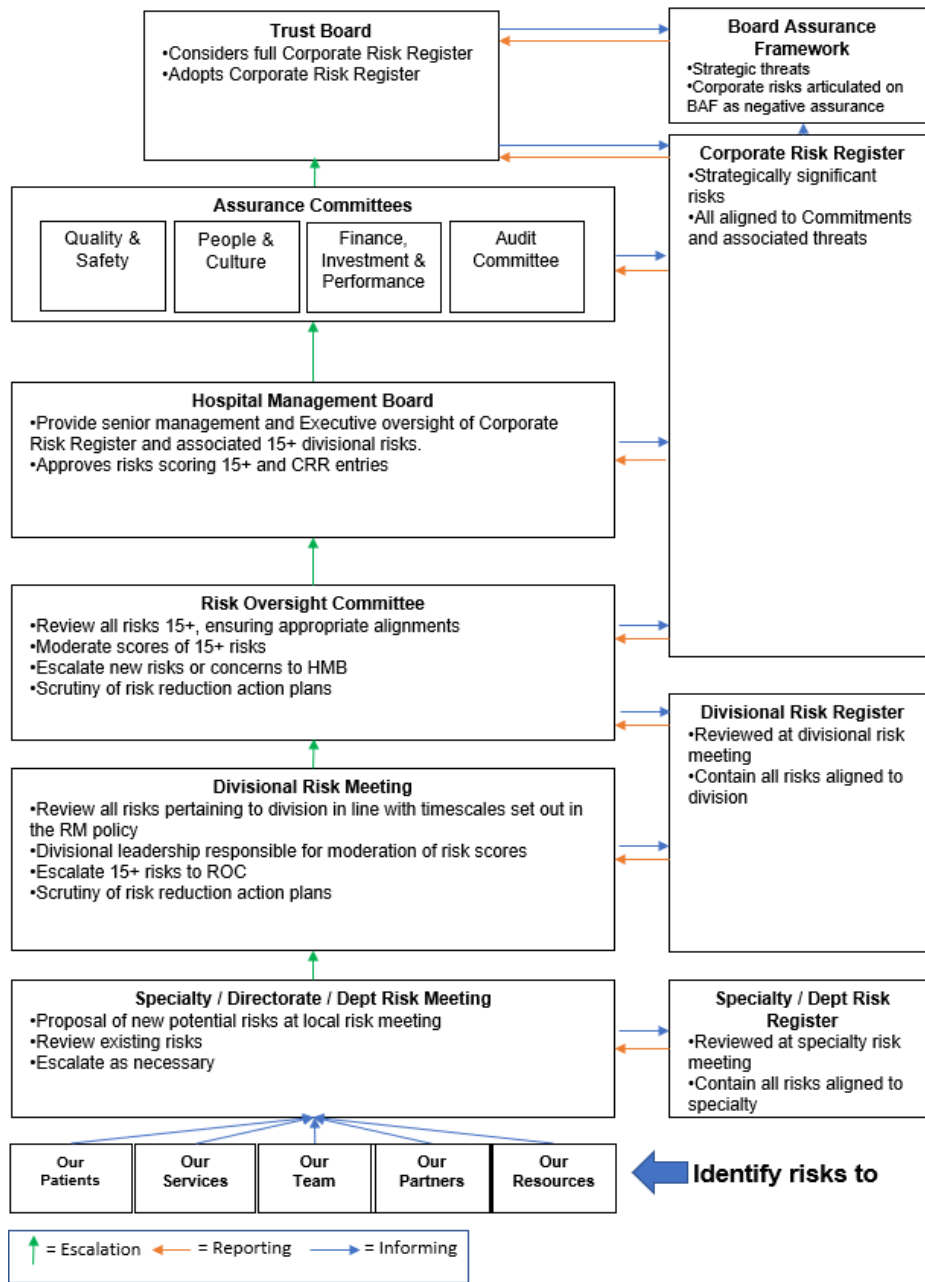
Each Executive Director has a portfolio of responsibility delegated from the Chief Executive on behalf of the Board of Directors.

Figure 1 overleaf details how risk information flows and can be escalated from wards and departments through to the Board of Directors.

The Senior Information Risk Owner (SIRO) responsible for data security is delegated by the Board of Directors to the Chief Digital Information Officer, who in turn is supported by the Head of Information Governance and Cyber Security and is the named Data Protection Officer for the organisation. Information Governance and data security are included throughout the risk management strategy and policy.

There are additional policies and procedure in place through the information governance framework to provide additional levels of risk management specifically detailing data security.

Figure 1 – Risk Reporting and Escalation Framework



### Significant and Strategic Risks

The top risks faced by the organisation during the last year have been related to:

- the significant challenges to achieve the financial plan for the Trust and the requirement to break even at the end of the financial year
- elective performance capacity and activity
- increased Urgent and Emergency demand, which impacted on patient experience due to the use of escalation beds.

A series of mitigation activities have been put in place led by Executive Directors which has resulted in a reduction of these risks; however, they remain priorities for the organisation going forward into the next financial year.

## Clinical Audit

Clinical audit at local and national levels are important and form part of the Trust's risk and control framework. Clinical audits are completed by multidisciplinary staff groups and supported by the Clinical Audit & Effectiveness Manager and team. Audits provide assurance against clinical practice or identify areas for additional learning and improvement. The annual Clinical Audit Plan is subject to review by the Audit Committee and Quality & Safety Committee with routine progress and escalation reports to the Quality and Safety Committee through to the Board of Directors.

## Incident reporting

Incident reporting processes are well established within the organisation, staff are aware of the incident reporting system used and are openly encouraged to report incidents and near misses. The system sends notifications to managers to investigate reported incidents and allows staff to receive feedback from investigators. The Trust is now in the second year of implementation of the Patient Safety Incident Response Framework (PSIRF), supported by a Patient Safety Incident Response Plan (PSIRP) and has undertaken a review of the Patient Safety Incident priorities at the beginning of 2025 to ensure that governance and risk processes remain aligned with the Quality Strategy for the Norfolk and Waveney Region.







## Care Quality Commission (CQC)

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

The latest inspection report from the CQC was published in August 2024, it detailed the well led review of leadership teams and unannounced visits in clinical areas within the hospital.

The overall quality rating remains the same as 'requires improvement'. Table 1 shows the individual ratings for each of the key lines of enquiry.

**Table 1. Care Quality Commission Ratings**

Ratings		
<b>Overall trust quality rating</b>	<b>Requires Improvement</b>	
Are service safe?	Requires Improvement	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive?	Requires Improvement	
Are services well-led?	Requires Improvement	

The report did highlight that the Trust has a new substantive Chief Executive, who was appointed since the inspection and the CQC were assured that the Chief Executive has a grip on the risks and concerns identified in the report and had already taken steps to drive significant and sustainable improvements in quality and performance.

In addition, the CQC stated the Trust risk registers clearly defined actions required to address and/or mitigate the risk as well as arrangements for review and appropriate oversight, as well as a named risk owner. The CQC report also noted that all leaders spoken with were able to identify the top risks that were being managed through the corporate risk register. The governance structure in place provided assurance of oversight and performance against safety measures.

## **Staffing**

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 NHS guidance on Managing Conflicts of Interest.

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 annual National NHS Staff Survey enables us to monitor the experiences of our colleagues 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 from the 2024 survey were a very marginal improvement on those for 2023 in four of the seven People Promise themes, as well as the two additional questions on staff engagement and morale. The feedback is used as part of our People Promise programme and other initiatives to improve staff experience.

The Trust recognises the crucial role played by its staff in delivering services to our patients. Staff are actively encouraged to participate in decision making and service improvement throughout all levels of the organisation. The Staff Council with representation from all professional groups continues to provide staff with an important voice and contribute to addressing key issues which concern staff. The Trust also has long standing partnership arrangements with unions through our Joint Staff Consultative Committee (JSCC) and Local Negotiations Committee. Members of the Staff Council and JSCC are also invited to join topic specific workshops on strategic and cultural developments.

The Director of Workforce has continued to Chair the Workforce and Education Sub Board which monitors activities and risks related to the workforce, safe staffing (nursing, midwifery and medical & dental), health and wellbeing and education of our staff. The Director of Workforce attends the People and Culture Committee chaired by the Senior Independent Non-Executive Director to report and escalate items as per their terms of reference.

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.

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

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

The Trust's operational Plan for 2024/25 was approved by the Board of Directors following national guidance. Assurance regarding 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.

During 2024 Divisional Performance Committee meetings took place led by Executive Directors to check and challenge and ensure that resources were used economically, efficiently and effectively across clinical services. This is triangulated through clinical audit data and a Performance Assurance Framework which includes quality, safety, and effectiveness elements.

The Trust continues to use Getting It Right First Time (GIRFT) and model health data to benchmark itself against other organisations. In 2024 the Trust was one of the pilot sites to participate in the Further Faster GIRFT programme, which has since been rolled out to all Trusts.

Progress against cost improvement programmes continues to be monitored through a Programme Management Office process reporting through to the Hospital Management Board and onwards to the Finance, Investments and Performance Committee.

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. 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.

The Trust has not had an external Use of Resources review since December 2019, with a report published in April 2020, where the Trust was rated overall as 'requires improvement', reflecting the Trust's financial deficit and inability to consistently achieve the constitutional operational standards. The Trust has completed a use of resources self-assessment in 2024 and remains as required improvement.

As part of their annual audit, our external auditors are required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if in their opinion the Trust has not. Please see the Independent Auditor's Report included within the Annual Accounts for their opinion on the use of resources and a description of the work performed. The external audit review identified that whilst there is a robust governance process in relation to CIP, there continues to be challenges for the Trust in relation to CIP identification and delivery. The Trust requires significant engagement from budget holders and clinicians across the Trust to drive the efficiency and productivity programmes needed to support longer term financial sustainability.

Our external audit has "raised a significant weakness in relation to the arrangements that the Trust has had in place during the year linked to improving economy, efficiency and effectiveness. The arrangements in place during the year to March 2025 were insufficient to ensure a fully worked up plan to address the gap that was in place as of 1 April 2024 and we consider there to be a significant risk of financial loss if the Trust is unable to deliver the savings and efficiency gains required."

In response to this the Trust has increased the level of senior management and clinical engagement to ensure stakeholder accountability for delivery of a realistic efficiency plan for 2025/26. Assurance will be provided to the Board on delivery progress.

The Trust was placed into the NHS England Investigation and Intervention process during 2024 to address the financial position both the organisation and system faced. This support has assisted the organisation to deliver against agreed 2024/25 plans.

### **Information Governance**

The Trust has developed and implemented a series of policies, procedures and processes in line with legislation relating to the General Data Protection Regulations for the United Kingdom and best practice issued by the Information Commissioner's Office.

In line with this guidance, the Trust has experienced colleagues who have responsibility and accountability for the organisation to support the information governance framework throughout the Trust. This includes the designated Senior Information Risk Owner (Chief Digital Information Officer), the named Data Protection Officer (Head of Information Governance and Cyber Security) and the Caldicott Guardian.

The management of information governance, including incident reporting and risk management, is formally reported at the Caldicott and Information Governance Assurance Group. The Digital Transformation Committee and Electronic Patient Record Project Board oversees development and implementation of digital systems which include assessments following information governance principles.

Items for escalation are reported to the Hospital Management Board, and the appropriate board assurance committees and through to the Board of Directors of which the Chief Digital Information Officer attends.

The Data Security and Protection Toolkit (DSPT) is an NHS Digital online self-assessment tool that mandates all organisations that use NHS data to self-assess and assure their performance against standards. The toolkit was submitted in June 2024 with 23 of the 24 standards recorded as 'Met'.

The Cyber Assessment Framework independent review has been undertaken using the NHS England DSP Toolkit Independent Assessment Guide and Independent Assessment Framework 2024/25. The overall risk rating across all five objectives for Norfolk & Norwich University Hospitals NHS Trust has been rated as: Very High. The audit findings highlight several areas for improvement across the Trust's information and data security policies and procedures. An action plan has been agreed with management that addresses each of the sixteen actions.

Implementation of relevant DSPT improvement actions are tracked through the Caldicott and Information Governance Assurance Group and escalated as appropriate to Hospital Management Board and Audit Committee.

Incident Management/Data Breaches: 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 the proportionate satisfaction of its legal and NHS obligations.

During 2024/25, the Trust reported three potential data breaches to the Information Commissioners Office through the Data Security and Protection Toolkit and two of those incidents were also reported to the Department of Health and Social Care/NHS England.

## **Data Quality and governance**

The Trust has a Data Quality Manager and team, which are closely affiliated with the Access, Commissioning, Clinical Coding and Income teams.

These teams maintain and support the organisation, including providing training to staff, to adhere to a series of policies, procedures and processes for how patient demographics, referrals, elective waiting list information and hospital attendances are recorded on the Patient Administration System (PAS).

Through the support of the Business Informatics team and the use of PowerBI software, teams review reports on an agreed series of performance metrics for the steps within a patient's pathway, which will highlight potential issues which require corrective action to safeguard against inaccurate data recording.

The Chief Operating Officer, supported by the Deputy Chief Operating Officer for planned care, oversees the performance of elective waiting times on behalf of the organisation in accordance with the NHS standards for planned care. There is a series of processes in place supported by PowerBI reporting. The Deputy Chief Operating Officer meets regularly with the operational leads for the clinical services to review their elective performance and address any issues identified relating to the quality of the data.

To provide additional governance, the Trust contacts all patients who have waited over 12-weeks through their preferred communication route to identify if patients still require an appointment or if their priority has changed requiring us to bring their treatment forward. This process will also identify any potential data inaccuracies that have not been addressed through other processes in place.

We monitor patients on our longest waiting lists through our Clinical Harm Review Group. The objective of this Group is to review patients who have been waiting a long time for care and to take appropriate action to mitigate any potential harm.

## **Review of effectiveness**

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and other Board assurance committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors has met as scheduled and routinely reviews internal control arrangements throughout the year with detailed discussions, checking and challenging information presented to provide assurance.

Statistical Process Control charts supported by narrative are provided to Board assurance committees and as an integrated performance report to the Board of Directors allowing analysis of national, regional and local priorities, safety and effectiveness and patients and their families experience.

The Head of Internal audit opinion for 2024/25 has acknowledged that the organisation has an adequate and effective framework for risk management, governance and internal control.

Of the nine internal audit assignments resulting in formal opinions during 2024/25, seven were positive (reasonable or substantial assurance) with two partial assurance reports regarding Data Quality and Consultant Job Planning. In each case mitigating actions are agreed and followed up to completion, with monitoring by the Audit Committee.

Based on the work undertaken in 2024/25 the Internal Auditors confirmed that they had not identified any significant governance weaknesses, within 2024/25 reviews.

Substantial assurance has been provided for the NHS England Checklist for Grip and Control, and Divisional Governance for this reporting period. Reasonable assurance for Staff Mental Health & Wellbeing, Business Continuity Planning, Staff Retention and Recruitment and Service Management Process as part of best practice for Information & Technology.

Further enhancements are required for Data Quality and Consultant job planning, as only partial assurance was provided for these internal audits. Management actions are in place to address the areas highlighted, which are monitored through Hospital Management Board and the Audit Committee.

### **Conclusion**

Following guidance in the national Foundation Trust Annual Reporting Manual, no significant internal control issues have been identified. The Trust's Internal Auditors have confirmed that no specific issues were identified as part of Internal Audit work undertaken during the year that should be identified as significant control issues.

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".*



Signed.....

Chief Executive

Date: 23 June 2025

## 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 Directors' Nominations and Remuneration Committee. The Nominations and Remuneration Committee determined that Trust staff on the VSM pay scale should receive a consolidated pay award of 5%. The Medical Director in addition to their managerial duties also maintains a clinical practice and solely received the Medical and Dental pay award of 6% from 1<sup>st</sup> April 2024. The Medical Director is also entitled under the consultant contract for Clinical Impact Awards (CIA), formerly Clinical Excellence Awards (CEA), in 2024/25.

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

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

Senior managers are employed on contracts of service and are substantive employees of the Trust. Their contracts are open-ended employment contracts which can be terminated by either party with six months' notice. 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 2024/25.



Signed by Chair of Remuneration Committee on 23 June 2025    Interim Chairman – Mark Friend

## Senior Managers' remuneration policy

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

Remuneration component	Applicable to	Jurisdiction	Relevance to Trust's long- and short-term objectives	Amount payable
Basic salary	All senior managers	Nominations and Remuneration Committee	Recommendations in respect of basic salary are made to the Nominations and Remuneration Committee by the Chief Executive (for executive directors) and the Chairman (for the Chief Executive) on the basis of assessment of performance at annual appraisal, and specifically achievement of agreed personal objectives that reflect the long- and short-term objectives of the Trust	Any increases are agreed with reference to 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 Impact Award (formerly 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.  The Scheme ended on 1 <sup>st</sup> April 2024. Existing awards granted prior to 1 <sup>st</sup> April 2018 remain in place.	Awards are determined by the Local Awards Committee in accordance with an agreed scheme that recognises clinical excellence across five domains. Analysis of the scheme demonstrates a linkage to the Trust's strategic objectives including the leadership and delivery of clinical services, teaching, training and research.	Level nine award is the maximum that can be awarded locally.

### Accompanying notes:

- (1) With the exception of the end of the Local Clinical Impact Awards (formerly Clinical Excellence Awards) scheme, there have been no additions or changes to the components of the remuneration package during 2024/25
- (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
<b>Executive Directors:</b>				
L Dwyer, Chief Executive	04/03/2024	Ongoing	n/a	6 Months
CM Cobb, Chief Operating Officer	17/04/2019	Ongoing	n/a	6 Months
B Brett, Medical Director (Appointed 10 October 2024, Interim Medical Director from 14 September 2023)	14/09/2023	Ongoing	n/a	6 Months
R Cocker, Chief Nurse (Appointed 4 September 2024, Interim Chief Nurse from 29 February 2024)	29/02/2024	Ongoing	n/a	6 Months
PD Jones, Chief People Officer	10/06/2019	31/12/2024	n/a	6 Months
E Sanford, Interim Chief Finance Officer	11/03/2024	23/03/2025	n/a	6 Months
M Thorman, Interim Chief Finance Officer	24/03/2025	Ongoing	n/a	6 Months
<b>Non-Executive Directors:</b>				
TI Spink, Chairman	22/03/2023	21/03/2026	12 Months	3 Months
JA Foster, Non-Executive Director	01/06/2019	31/10/2025	7 Months	3 Months
P Chrispin, Non-Executive Director	01/01/2020	31/04/2025	1 Month	3 Months
S Dinneen, Non-Executive Director	01/01/2020	31/12/2025	9 Months	3 Months
JM Hannam, Non-Executive Director	01/01/2020	31/12/2025	9 Months	3 Months
U Sarkar, Non-Executive Director	05/09/2022	04/09/2025	18 Months	3 Months
N Gray, Non-Executive Director	02/01/2024	31/12/2026	33 Months	3 Months
C ffrench-Constant, Non-Executive Director	01/09/2021	31/01/2025	n/a	3 Months
P Baker, Non-Executive Director	03/03/2025	03/03/2028	36 Months	3 Months

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

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

#### Nominations and Remuneration Committee

The Nominations and Remuneration Committee consists of the Chairman of the Trust, at least three other non-executive directors and the Chief Executive. During 2024/25 the membership comprised the Chairman of the Trust (Chair of the Committee) and all of the other non-executive directors and the Chief Executive.

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

The Committee met seven times during 2024/25, on 5 June, 3 July, 11 September, 2 October, 28 October, 4 December, and 5 March 2025. 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 seven executive directors in office during the year (filling six roles) and nine non-executive directors, including the Chairman (filling eight roles). In aggregate the directors received reimbursement of expenses of £2,275 claimed by four directors. In 2023/24, 19 directors had been in office, being eleven executive directors (filling six roles) and eight non-executive directors. In aggregate they received reimbursement of expenses of £1,626 claimed by five directors.

No significant awards were made to past directors during the 12 months ended 31 March 2025.

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 2024/25 there were 25 governors (16 public governors, six staff governors and three partner governors) and five governors claimed aggregate expenses of £1,326. In 2023/24 there were 25 governors (16 public governors, six staff governors and three partner governors) and four governors claimed aggregate expenses of £448.

Remuneration – Audited

Name and title		12 months ended 31st March 2025					12 months ended 31st March 2024				
		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
TI Spink, Chairman	TI Spink	50 – 55	100	0	0	55 – 60	50 – 55	0	0	0	50 – 55
S Higginson, Chief Executive (Until 13 August 2023)	S Higginson	0	0	0	0	0	100 – 105	0	0	0	100 – 105
N Hulme, Interim Chief Executive (Secondment from ESNEFT between 14 August 2023 - 3 March 2024)	N Hulme	0	0	0	0	0	130 – 135	1,500	0	0	130 – 135
L Dwyer, Chief Executive (Appointed 19 February 2024 (CEO from 4th March 2024))	L Dwyer	260 – 265	0	0	0	260 – 265	30 – 35	0	0	5 – 7.5	40 – 45
CM Cobb, Chief Operating Officer	CM Cobb	190 – 195	0	0	0	190 – 195	180 – 185	0	0	0	180 – 185
ERE Denton, Medical Director (Until 14 September 2023)	ERE Denton	0	0	0	0	0	100 – 105	0	15 – 20	0	115 – 120
B Brett, Medical Director (Appointed 10 October 2024, Interim Medical Director from 14 September 2023)	B Brett	230 – 235	0	30 – 35	507.5 – 510	770 – 775	125 – 130	0	15 – 20	10 – 12.5	155 – 160

Name and title		12 months ended 31st March 2025					12 months ended 31st March 2024				
		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
NVC Fontaine, Chief Nurse (Until 29 February 2024)	NVC Fontaine	0	0	0	0	0	145 – 150	0	0	0	145 – 150
R Cocker, Chief Nurse (Appointed 4 September 2024, Interim Chief Nurse from 29 February 2024)	R Cocker	165 – 170	0	0	517.5 – 520	685 – 690	10 – 15	0	0	0 – 2.5	10 – 15
PD Jones, Chief People Officer (Until 31 December 2024) *	PD Jones	210 – 215	0	0	22.5 – 25	235 – 240	155 – 160	0	0	35 – 37.5	190 – 195
R Clarke, Chief Finance Officer (Until 11 March 2024)	R Clarke	0	0	0	0	0	170 – 175	0	0	157.5 – 160	330 – 335
E Sanford, Interim Chief Finance Officer (Appointed 11 March 2024 until 23 March 2025)	E Sanford	180 – 185	0	0	55 – 57.5	235 – 240	10 – 15	0	0	0 – 2.5	10 – 15
M Thorman, Interim Chief Finance Officer (Appointed 24 March 2025) **	M Thorman	5 – 10	0	0	0	5 – 10	0	0	0	0	0

\* Paul Jones received payment in lieu of notice of £82k based on a contractual six months' salary plus a further £8k for accrued annual leave entitlement. These are included in the figure above. In addition, Paul Jones received a £33k redundancy payment. This is not included in the salary figure above.

\*\* Due to the appointment date of Marcus Thorman the Greenbury Submission Window had already closed resulting in the Pension Related Benefits for 24/25 not being supplied. Therefore £nil has been detailed. This will have an immaterial impact on the table above.

Name and title		12 months ended 31st March 2025					12 months ended 31st March 2024				
		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 (UEA NED Post until 31 January 2025)	C ffrench-Constant	10 – 15	0	0	0	10 – 15	10 – 15	0	0	0	10 – 15
P Baker, Non-Executive Director (UEA NED Post Appointed 3 March 2025)	P Baker	0 – 5	0	0	0	0 – 5	0	0	0	0	0
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
N Gray, Non-Executive Director (Appointed 2 January 2024)	N Gray	10 – 15	0	0	0	10 – 15	0 – 5	0	0	0	0 – 5
JM Hannam, Non-Executive Director	JM Hannam	10 – 15	0	0	0	10 – 15	10 – 15	0	0	0	10 – 15
U Sarkar, Non-Executive Director	U Sarkar	10 – 15	0	0	0	10 – 15	10 – 15	0	0	0	10 – 15

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.

No additional benefits will become receivable by directors in the event that they retire early.

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 2024/25 was £260k-£265k (2023/24: £180k-£185k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

### **Pay ratio information table**

<b>2024/25</b>	<b>25th percentile</b>	<b>Median</b>	<b>75th percentile</b>
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	31,890	42,003	52,651
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	31,890	42,003	52,651
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff): mid-point of band of highest paid director (£)	8.23	6.25	4.99

<b>2023/24</b>	<b>25th percentile</b>	<b>Median</b>	<b>75th percentile</b>
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	27,930	36,075	49,740
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	26,806	35,620	48,892
'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 (£)	6.53	5.06	3.67

There has been a significant increase in the ratios comparing the quartiles of staff against the highest paid director. This is the result of the prior year's highest paid director leaving the Trust during 2023/24, meaning that the comparison was made against the next highest paid director for that year.

**Percentage change in remuneration of highest paid director**

<b>2024/25</b>	<b>% Change from previous financial year in salary and allowances</b>	<b>% Change from previous financial year in performance pay and bonuses</b>
Highest paid director (midpoint of band)	27.40	100.00
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)	1.78	-30.12
<b>2023/24</b>	<b>% change from previous financial year in salary and allowances</b>	<b>% change from previous financial year in performance pay and bonuses</b>
Highest paid director (midpoint of band)	-16.09	-100.00
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)	0.40	17.52

	<b>2024/25</b>	<b>2023/24</b>
Band of highest paid director's total remuneration (£'000)	260 – 265	180 – 185
Midpoint of band	262,500	182,500
25 <sup>th</sup> percentile (£)	31,890	27,930
Median total (£)	42,003	36,075
75 <sup>th</sup> percentile (£)	52,651	49,740
Remuneration ratio	6.25	5.06

## Employee Remuneration Range

	2024/25	2023/24
Band of highest paid employee (£'000)	380 – 385	180 – 185
Band of lowest paid employee (£'000)	10 – 15	10 – 15

In 2024/25, six (2023/24: nil) employees received remuneration in excess of the highest paid director. Remuneration ranged from £12.5k to £382.5k (2023/24: £10.0k to £182.5k). 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 1.78%.

The highest paid director's remuneration was 6.25 times (2023/24: 5.06 times) the median remuneration of the workforce which was £42,003 (2023/24: £36,075).

## Total Pension Entitlement

2024/25 Name and title	Real increase in pension at age 60  (bands of £2,500) £'000	Real increase in pension lump sum at age 60  (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2025  (bands of £5,000) £'000	Lump sum at age 60 related to accrued pensions at 31 March 2025  (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2024  £'000	Real increase in Cash Equivalent Transfer Value  £'000	Cash Equivalent Transfer Value at 31 March 2025  £'000
L Dwyer, Chief Executive	0 – 2.5	0	5 – 10	0 – 5	85	0	99
CM Cobb, Chief Operating Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
B Brett, Medical Director	22.5 – 25	60 – 62.5	90 – 95	245 – 250	1,537	578	2,246
R Cocker, Chief Nurse	22.5 – 25	60 – 62.5	65 – 70	175 – 180	930	542	1,555
PD Jones, Chief People Officer	0 – 2.5	0	35 – 40	55 – 60	698	23	795
E Sanford, Chief Finance Officer	2.5 – 5	0	20 – 25	0 – 5	278	39	361
M Thorman, Chief Finance Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A

N/A – Christopher Cobb chose not to be covered by the Pension Arrangements during the reporting year.

N/A – Marcus Thorman due to the appointment date, the Greenbury Submission Window had already closed resulting in the Pension Related Benefits for 24/25 not being supplied. Therefore N/A has been detailed.

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

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2025. HM Treasury published updated guidance on 27 April 2023; this guidance was used in the calculation of 2024/25 CETV figures.

2023/24 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 2024  (bands of £5,000) £'000	Lump sum at age 60 related to accrued pensions at 31 March 2024  (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2023  £'000	Real increase in Cash Equivalent Transfer Value  £'000	Cash Equivalent Transfer Value at 31 March 2024  £'000
S Higginson, Chief Executive	N/A	N/A	N/A	N/A	N/A	N/A	N/A
L Dwyer, Chief Executive	0 – 2.5	0 – 0	0 - 5	0 - 5	0	3	85
CM Cobb, Chief Operating Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ERE Denton, Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
B Brett, Medical Director	0 – 2.5	0 – 2.5	60 – 65	175 – 180	1,355	18	1,537
NVC Fontaine, Chief Nurse	0	30 – 32.5	65 – 70	185 – 190	1,403	108	1,684
R Cocker, Chief Nurse	0 – 2.5	0	40 – 45	110 – 115	820	1	930
PD Jones, Chief People Officer	2.5 - 5	0	30 – 35	55 – 60	538	86	698
R Clarke, Chief Finance Officer	7.5 – 10	15 -17.5	45 – 50	130 – 135	714	140	950
E Sanford, Chief Finance Officer	0 – 2.5	0 - 2.5	15 – 20	0 - 5	217	1	278

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 – Christopher Cobb chose not to be covered by the Pension Arrangements during the reporting year.

N/A – Roy Clarke was only covered by the Pension Arrangements between June 2023 and January 2024.

Nancy Fontaine is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

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

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2024. HM Treasury published updated guidance on 27 April 2023; this guidance was used in the calculation of 2023/24 CETV figures.

## Bonus

The Trust is required by NHSE to disclose any payments that fall within the definition of “Performance Related Bonuses” and it has been determined by the Department of Health and Social Care that Clinical Impact Awards (CIA), formerly Clinical Excellence Awards (CEA), meet this definition. As such they have been disclosed as a “Bonus”. Clinical Impact Awards are given to recognise and reward the exceptional contribution of NHS consultants, over and above that normally expected in a job, to the values and goals of the NHS and to patient care. Clinical Impact Awards are administered at a national level by the Advisory Committee on Clinical Excellence Awards, and at a local level by the Local Awards Committee. These payments were previously classified within Other Remuneration. There have been no new Clinical Impact Awards payable to the directors in 2024/25, however the individual who held the role of medical director during the period was in receipt of existing clinical impact awards as part of their remuneration package.



Signed on behalf of the Board on 23 June 2025

Chief Executive – Lesley Dwyer

### Approval of the Accountability Report

I confirm my approval of the Accountability Report.

A handwritten signature in black ink, appearing to be 'LD' with a flourish.

**Professor Lesley Dwyer**  
**Chief Executive**

**Date: 23 June 2025**

# Accounts

Norfolk and Norwich University Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2025

# 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 Norfolk and Norwich University Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2025 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

### Basis for opinion

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

### Going concern

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

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

Our conclusions based on this work:

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

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

### Fraud and breaches of laws and regulations – ability to detect

#### *Identifying and responding to risks of material misstatement due to fraud*

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

- Enquiring of management, the Audit Committee and internal audit 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, and the Trust's channel for "whistleblowing, 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 financial performance targets delegated to the Trust by NHS England
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

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

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

We also identified a fraud risk related to liabilities and related expenses for purchases of goods or services are not recorded in the correct accounting period in response to incentives to manipulate the results of the Trust and System to meet the expectations or performance targets set by the government or external regulators and the opportunity to manipulate the non pay non depreciation expenditure around the year end.

In determining the audit procedures we took into account the results of our evaluation and testing of the operating effectiveness of some of Trust-wide fraud risk management controls.

We also 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 unusual cash or unusual expenditure combinations.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Selecting a sample of expenditure postings either side of the year end date and vouching to supporting evidence to ensure the expenditure has been recognised in the correct year.
- Selecting a sample of accruals meeting our high risk criteria and vouching to supporting evidence to ensure the completeness, existence and accuracy of accrued expenditure.

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

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

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

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

Firstly, the Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of

compliance with these laws and regulations as part of our procedures on the related financial statement items.

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

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

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

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

### **Other information in the Annual Report**

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

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

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

### ***Remuneration and Staff Reports***

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.

### **Accounting Officer's responsibilities**

As explained more fully in the statement set out on page 121, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity.

### **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](http://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.

#### **Significant weakness – Improving Economy, Efficiency and Effectiveness**

We inspected the financial plan for 2024-25 and this included a breakeven plan with £50.1m of efficiencies, which is significantly higher than the levels previously delivered by the Trust. Whilst there is a robust governance process in relation to CIP, there continues to be challenges for the Trust in relation to CIP identification and delivery.

The Trust requires significant engagement from budget holders and clinicians across the Trust to drive the efficiency and productivity programmes needed to support longer term financial sustainability.

As a result of the work that the Trust still needs to do to drive efficiency internally we have raised a significant weakness in relation to the arrangements that the Trust has had in place during the year linked to improving economy, efficiency and effectiveness. The arrangements in place during the year to March 2025 were insufficient to ensure a fully worked up plan to address the gap was in place as at 1 April 2024 and we consider there to be a significant risk of financial loss if the Trust is unable to deliver the savings and efficiency gains required.

#### **Recommendation:**

The Trust will need to undertake a programme of engagement and buy-in from budget holders and clinicians across the organisation to ensure they are signed up to a realistic delivery plan and that this is in place for the 2025/26 financial planning process well ahead of 1 April 2025.

Assurance will need to be provided to the Board that the plans that are being put in place are delivering and a fully worked up CIP plan should be in place ahead of the start of the next financial year

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

As explained more fully in the statement set out on page 128, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

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

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

### **Statutory reporting matters**

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

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

We have nothing to report in these respects.

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

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

### **DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT**

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Norfolk and Norwich University Hospitals NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.

*Emma Larcombe*

**Emma Larcombe**

**for and on behalf of KPMG LLP**

*Chartered Accountants*

20 Station Road

Cambridge

CB1 2JD

24 June 2025

## Foreword to the accounts

### Norfolk and Norwich University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2025, have been prepared by 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** .....

**Name** Lesley Dwyer  
**Job title** Chief Executive  
**Date** 23 June 2025

## Statement of Comprehensive Income

		2024/25	2023/24
	Note	£000	£000
Operating income from patient care activities	3	942,368	868,214
Other operating income	4	140,804	114,357
Operating expenses	7,9.1	<u>(1,059,319)</u>	<u>(949,537)</u>
<b>Operating surplus from continuing operations</b>		<b><u>23,853</u></b>	<b><u>33,034</u></b>
Finance income	11	6,263	6,752
Finance expenses	12	(43,594)	(64,447)
PDC dividends payable		<u>-</u>	<u>-</u>
<b>Net finance costs</b>		<b><u>(37,331)</u></b>	<b><u>(57,695)</u></b>
Other gains / (losses)	13	<u>315</u>	<u>(73)</u>
<b>(Deficit) for the year</b>		<b><u>(13,163)</u></b>	<b><u>(24,734)</u></b>
<b>Other comprehensive income</b>			
<b>Will not be reclassified to income and expenditure:</b>			
Impairments	8	-	(28,702)
Revaluations		<u>326</u>	<u>5,420</u>
<b>Total comprehensive (expense) for the period</b>		<b><u>(12,837)</u></b>	<b><u>(48,016)</u></b>

## Statement of Financial Position

		31 March 2025	31 March 2024
	Note	£000	£000
<b>Non-current assets</b>			
Property, plant and equipment	14	413,816	388,865
Right of use assets	16	43,683	48,871
Receivables	18	57,554	61,789
<b>Total non-current assets</b>		<b>515,053</b>	<b>499,525</b>
<b>Current assets</b>			
Inventories	17	15,793	16,137
Receivables	18	54,914	38,177
Cash and cash equivalents	19	93,418	104,705
<b>Total current assets</b>		<b>164,125</b>	<b>159,019</b>
<b>Current liabilities</b>			
Trade and other payables	20	(143,146)	(137,574)
Borrowings	22	(26,170)	(26,538)
Provisions	24	(4,024)	(3,341)
Other liabilities	21	(23,419)	(26,735)
<b>Total current liabilities</b>		<b>(196,759)</b>	<b>(194,188)</b>
<b>Total assets less current liabilities</b>		<b>482,419</b>	<b>464,356</b>
<b>Non-current liabilities</b>			
Borrowings	22	(383,203)	(395,066)
Provisions	24	(3,945)	(6,709)
Other liabilities	21	(1,155)	(1,446)
<b>Total non-current liabilities</b>		<b>(388,303)</b>	<b>(403,221)</b>
<b>Total assets employed</b>		<b>94,116</b>	<b>61,135</b>
<b>Financed by</b>			
Public dividend capital		390,850	345,033
Revaluation reserve		26,328	26,365
Income and expenditure reserve		(323,062)	(310,263)
<b>Total taxpayers' equity</b>		<b>94,116</b>	<b>61,135</b>

The notes on pages 161 to 206 form part of these accounts.



Name	Lesley Dwyer
Position	Chief Executive
Date	23 June 2025

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
<b>Taxpayers' and others' equity at 1 April 2024 - brought forward</b>	<b>345,033</b>	<b>26,366</b>	<b>(310,263)</b>	<b>61,136</b>
(Deficit) for the year	-	-	(13,163)	<b>(13,163)</b>
Other transfers between reserves	-	(364)	364	-
Revaluations	-	326	-	<b>326</b>
Public dividend capital received	45,817	-	-	<b>45,817</b>
<b>Taxpayers' and others' equity at 31 March 2025</b>	<b>390,850</b>	<b>26,328</b>	<b>(323,062)</b>	<b>94,116</b>

## Statement of Changes in Taxpayers Equity for the year ended 31 March 2024

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
<b>Taxpayers' and others' equity at 1 April 2023 - brought forward</b>	<b>323,888</b>	<b>52,715</b>	<b>(107,364)</b>	<b>269,239</b>
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	(181,232)	<b>(181,232)</b>
(Deficit) for the year	-	-	(24,734)	<b>(24,734)</b>
Other transfers between reserves	-	(3,067)	3,067	-
Impairments	-	(28,702)	-	<b>(28,702)</b>
Revaluations	-	5,420	-	<b>5,420</b>
Public dividend capital received	21,145	-	-	<b>21,145</b>
<b>Taxpayers' and others' equity at 31 March 2024</b>	<b>345,033</b>	<b>26,366</b>	<b>(310,263)</b>	<b>61,136</b>

## **Information on reserves**

### **Public dividend capital**

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

### **Revaluation reserve**

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

### **Income and expenditure reserve**

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

## Statement of Cash Flows

	2024/25	2023/24
Note	£000	£000
<b>Cash flows from operating activities</b>		
Operating surplus	23,853	33,034
<b>Non-cash income and expense:</b>		
Depreciation and amortisation	7.1 32,855	35,772
Net impairments	8 24,295	61
Income recognised in respect of capital donations	4 (5,899)	(398)
(Increase) / decrease in receivables and other assets	(10,805)	14,398
Decrease / (increase) in inventories	344	(2,012)
(Decrease) / increase in payables and other liabilities	(5,028)	1,934
(Decrease) in provisions	(2,124)	(3,458)
<b>Net cash flows from operating activities</b>	<b>57,491</b>	<b>79,331</b>
<b>Cash flows from investing activities</b>		
Interest received	6,308	6,858
Purchase of PPE and investment property	(60,686)	(39,561)
Sales of PPE and investment property	109	15
Receipt of cash donations to purchase assets	-	73
<b>Net cash flows (used in) investing activities</b>	<b>(54,269)</b>	<b>(32,615)</b>
<b>Cash flows from financing activities</b>		
Public dividend capital received	45,817	21,145
Capital element of lease rental payments	(10,672)	(10,544)
Capital element of PFI, LIFT and other service concession payments	(16,116)	(14,292)
Interest paid on lease liability repayments	(481)	(528)
Interest paid on PFI, LIFT and other service concession obligations	(33,057)	(32,359)
PDC dividend (paid) / refunded	-	1,289
<b>Net cash flows (used in) financing activities</b>	<b>(14,509)</b>	<b>(35,289)</b>
<b>(Decrease) / increase in cash and cash equivalents</b>	<b>(11,287)</b>	<b>11,427</b>
<b>Cash and cash equivalents at 1 April - brought forward</b>	<b>104,705</b>	<b>93,278</b>
<b>Cash and cash equivalents at 31 March</b>	19.1 <b>93,418</b>	<b>104,705</b>

## **Notes to the Accounts**

### **Note 1 Accounting policies and other information**

#### **Note 1.1 Basis of preparation**

NHS England 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 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

#### **Accounting convention**

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

#### **Note 1.2 Going concern**

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

#### **Note 1.3 Interests in other entities**

The NHS Foundation Trust is the corporate trustee to Norfolk and Norwich Hospitals Charity. The Foundation Trust has assessed its relationship to the charity 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 charity and has the ability to affect those returns and other benefits through its power over the fund. The charity'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 charity. Since 2013/14 the Trust has chosen not to consolidate the charity on the basis it is not material.

#### **Joint operations**

The Trust has a 62% 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.

## **Note 1.4 Revenue from contracts with customers**

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

### **Revenue from NHS contracts**

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

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

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

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

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

### **Revenue from research contracts**

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

### **NHS injury cost recovery scheme**

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

### **Note 1.5 Other forms of income**

#### **Grants and donations**

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

#### **Apprenticeship service income**

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

### **Note 1.6 Expenditure on employee benefits**

#### **Short-term employee benefits**

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

#### **Pension costs**

##### *NHS Pension Scheme*

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

### **Note 1.7 Expenditure on other goods and services**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

### **Note 1.8 Discontinued operations**

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

## **Note 1.9 Property, plant and equipment**

### **Recognition**

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

#### *Subsequent expenditure*

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

### **Measurement**

#### *Valuation*

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying 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.

A full valuation of the PFI hospital was performed as at 31 March 2025 by the Trust's externally appointed independent valuer, Montagu Evans, Chartered Surveyors.

The revaluation basis for all of the Trust's land and buildings was DRC as an MEA, 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.

This has been reflected in the 2024/25 accounts.

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

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

#### *Depreciation*

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

#### *Revaluation gains and losses*

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

#### *Impairments*

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

### **De-recognition**

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

### **Donated and grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

## Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) 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. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

### *Initial recognition*

In accordance with HM Treasury's *FReM*, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy - note 1.13).

### *Subsequent measurement*

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income. The Trust annually capitalises an element of the lifecycle replacement prepayment. This is consistent with the operators schedule for replacement. These are treated as additions in the year.

### *Initial application of IFRS 16 liability measurement principles to PFI and LIFT liabilities in 2023/24*

IFRS 16 liability measurement principles were applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

## Useful lives of property, plant and equipment

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

	<b>Min life</b>	<b>Max life</b>
	<b>Years</b>	<b>Years</b>
Land	-	-
Buildings, excluding dwellings	5	82
Dwellings	-	-
Plant & machinery	3	20
Transport equipment	10	12
Information technology	1	10
Furniture & fittings	5	20

### **Note 1.10 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.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

### **Note 1.11 Cash and cash equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

### **Note 1.12 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 the 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, i.e., when receipt or delivery of the goods or services is made.

#### **Classification and measurement**

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and financial liabilities are classified as subsequently measured at amortised cost.

#### **Financial assets and financial liabilities at amortised cost**

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

### **Impairment of financial assets**

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

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.

### **Derecognition**

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

## **Note 1.13 Leases**

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

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

### **The Trust as a lessee**

#### *Recognition and initial measurement*

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

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

#### *Subsequent measurement*

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

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

### **The Trust as a lessor**

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

#### *Finance leases*

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

#### *Operating leases*

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

## Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

## 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 24.2 but is not recognised in the Trust's accounts.

## Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

## Note 1.15 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 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed, 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.

**Note 1.16 Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

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

**Note 1.17 Value added tax**

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

**Note 1.18 Corporation tax**

The Trust does not fall within the scope of Corporation Tax for the year ended 31 March 25, neither did it for the year ended 31 March 24.

**Note 1.19 Climate change levy**

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

**Note 1.20 Foreign exchange**

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

**Note 1.21 Third party assets**

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

**Note 1.22 Losses and special payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

**Note 1.23 Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

**Note 1.24 Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

**Note 1.25 Critical judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

An assessment of the Trust's 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 2025 by the Trust's externally appointed independent valuer, Montagu Evans, Chartered Surveyors.

The revaluation basis for all of the Trust's land and buildings was DRC as an MEA, 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.

This has been reflected in the 2024/25 accounts.

**Note 1.26 Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

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 22, 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 2025 or 31 March 2024, or the amounts charged through the Statement of Comprehensive Income.

The Trust has a legal obligation to pay Octagon Healthcare Limited for the maintenance of the PFI hospital over the contract period to maintain the hospital at a contractually agreed standard. The contract does not require the supplier to provide detailed and costed maintenance plans over the life of the contract, and therefore it is not possible to evidence with any certainty that work undertaken will equate to the value of payments made. The timing of any maintenance work is variable and subject to frequent change, adding to the difficulty to model the value of work undertaken.

Due to these limitations, the Trust has consistently applied an agreed model from the outset of the contract to estimate the size of the lifecycle maintenance prepayment, together with the timing and amount to be capitalised each year. This model suggests that the lifecycle maintenance prepayment will increase until 2030/31, before reducing to nil by the end of 2037/38 as maintenance works are concentrated toward the end of the contract term to ensure the hospital is handed over in the required condition. The balance of the prepayment at 31 March 2025 was £60.5m. If 5% of the expected works were not to be undertaken the prepayment would be overstated by £3m.

## Note 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.

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 3.2. The Trust's main source of income is from within the UK for the provision of healthcare services.

### 2024/25:

	Medicine	Clinical Support	Surgery and Emergency	Women, Children and Sexual Health	Services	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Pay	170,290	99,190	210,806	64,904	57,180	602,370
Non Pay	127,728	41,891	63,686	12,694	113,426	359,425
<b>Total</b>	<b>298,018</b>	<b>141,081</b>	<b>274,492</b>	<b>77,598</b>	<b>170,606</b>	<b>961,795</b>

### 2023/24:

	£'000	£'000	£'000	£'000	£'000	£'000
Pay	154,834	91,057	187,992	59,352	52,205	545,440
Non Pay	122,495	39,505	61,263	12,764	101,249	337,276
<b>Total</b>	<b>277,329</b>	<b>130,562</b>	<b>249,255</b>	<b>72,116</b>	<b>153,454</b>	<b>882,716</b>

### Reconciliation - Pay

	2024/25	2023/24
	£'000	£'000
Employee Expenses - Non-executive directors (note 7.1)	152	158
Employee Expenses - Staff and executive directors (note 7.1)	600,503	545,261
VSS & Redundancy (note 7.1)	1,715	21
<b>Subtotal per accounts</b>	<b>602,370</b>	<b>545,440</b>
Less: Pay on Trust wide reserves	-	-
<b>Total</b>	<b>602,370</b>	<b>545,440</b>

### Reconciliation - Non Pay

	£'000	£'000
Operating Expenses (note 7.1)	1,059,319	949,537
Less: Pay (see above)	(602,370)	(545,440)
Less: Depreciation (note 7.1)	(32,855)	(35,772)
Less: Consortium payments (note 7.1)	(29,665)	(20,689)
Less: Research and development (note 7.1)	(8,658)	(8,584)
Less: Education & training - notional expenditure funded from apprenticeship fund	(2,051)	(1,715)
Less: Impairments (note 7.1)	(24,295)	(61)
Less: Other	-	-
<b>Total</b>	<b>359,425</b>	<b>337,276</b>

### Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

<b>Note 3.1 Income from patient care activities (by nature)</b>	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
<b>Acute services</b>		
Income from commissioners under API contracts - variable element*	217,992	192,980
Income from commissioners under API contracts - fixed element*	594,131	570,894
High cost drugs income from commissioners	74,758	69,039
Other NHS clinical income	11,053	7,915
<b>All services</b>		
Private patient income	3,231	2,876
National pay award central funding***	2,085	446
Additional pension contribution central funding**	35,017	20,917
Other clinical income	4,101	3,147
<b>Total income from activities</b>	<b>942,368</b>	<b>868,214</b>

\*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2024/25 NHS Payment Scheme documentation.

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

\*\*Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

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

### Note 3.2 Income from patient care activities (by source)

	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
<b>Income from patient care activities received from:</b>		
NHS England	161,026	240,003
Integrated care boards	773,998	621,851
Department of Health and Social Care	-	-
Other NHS providers	12	75
NHS other	-	-
Local authorities	336	262
Non-NHS: private patients	3,231	2,876
Non-NHS: overseas patients (chargeable to patient)	584	443
Injury cost recovery scheme	1,677	1,384
Non NHS: other	1,504	1,320
<b>Total income from activities</b>	<b>942,368</b>	<b>868,214</b>
<b>Of which:</b>		
Related to continuing operations	942,368	868,214
Related to discontinued operations	-	-

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

	2024/25	2023/24
	£000	£000
Income recognised this year	584	443
Cash payments received in-year	194	213
Amounts added to provision for impairment of receivables	199	206
Amounts written off in-year	365	219

**Note 4 Other operating income**

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	8,620	-	<b>8,620</b>	7,752	-	<b>7,752</b>
Education and training	37,702	2,051	<b>39,753</b>	33,579	1,715	<b>35,294</b>
Income in respect of employee benefits accounted on a gross basis	15,914	-	<b>15,914</b>	15,140	-	<b>15,140</b>
Receipt of capital grants and donations and peppercorn leases	-	5,899	<b>5,899</b>	-	398	<b>398</b>
Charitable and other contributions to expenditure	-	-	-	-	197	<b>197</b>
Revenue from operating leases	-	359	<b>359</b>	-	304	<b>304</b>
Other income	70,258	-	<b>70,258</b>	55,272	-	<b>55,272</b>
<b>Total other operating income</b>	<b>132,494</b>	<b>8,309</b>	<b>140,803</b>	<b>111,743</b>	<b>2,614</b>	<b>114,357</b>

**Of which:**

Related to continuing operations	140,803	114,357
Related to discontinued operations	-	-

### Note 5.1 Income from activities arising from commissioner requested services

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

	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
Income from services designated as commissioner requested services	935,957	862,634
Income from services not designated as commissioner requested services	6,411	5,580
<b>Total</b>	<b><u>942,368</u></b>	<b><u>868,214</u></b>

### Note 5.2 Profits and losses on disposal of property, plant and equipment

The Trust has not disposed of land and buildings assets used in the provision of commissioner requested services during the year.

## Note 6 Operating leases - Norfolk and Norwich University Hospitals NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where Norfolk and Norwich University Hospitals NHS Foundation Trust is the lessor.

### Note 6.1 Operating lease income

	2024/25	2023/24
	£000	£000
<b>Lease receipts recognised as income in year:</b>		
Minimum lease receipts	87	87
Variable lease receipts / contingent rents	272	217
<b>Total in-year operating lease income</b>	<b>359</b>	<b>304</b>

### Note 6.2 Future lease receipts

	31 March	31 March
	2025	2024
	£000	£000
<b>Future minimum lease receipts due in:</b>		
- not later than one year	87	87
- later than one year and not later than two years	87	87
- later than two years and not later than three years	87	87
- later than three years and not later than four years	87	87
- later than four years and not later than five years	87	87
- later than five years	175	262
<b>Total</b>	<b>610</b>	<b>697</b>

## Note 7.1 Operating expenses

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,638	4,629
Purchase of healthcare from non-NHS and non-DHSC bodies	15,875	18,080
Staff and executive directors costs	600,503	545,261
Remuneration of non-executive directors	152	158
Supplies and services - clinical (excluding drugs costs)	104,223	94,702
Supplies and services - general	10,750	4,704
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	113,097	107,631
Inventories written down	88	53
Consultancy costs	698	307
Establishment	5,057	5,769
Premises	34,120	30,690
Transport (including patient travel)	4,654	4,498
Depreciation on property, plant and equipment	32,855	35,772
Net impairments	24,295	61
Movement in credit loss allowance: contract receivables / contract assets	2,561	2,641
Movement in credit loss allowance: all other receivables and investments	167	257
Change in provisions discount rate(s)	7	(109)
Fees payable to the external auditor		
audit services- statutory audit	233	193
Internal audit costs	136	90
Clinical negligence	19,773	22,190
Legal fees	36	(91)
Insurance	464	450
Research and development	8,658	8,584
Education and training	4,889	4,569
Expenditure on short term leases	229	494
Redundancy	1,715	21
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	34,707	32,857
Hospitality	101	112
Losses, ex gratia & special payments	10	13
Grossing up consortium arrangements	29,665	20,689
Other services, eg external payroll	2,330	1,917
Other	1,633	2,345
<b>Total</b>	<b>1,059,319</b>	<b>949,537</b>
<b>Of which:</b>		
Related to continuing operations	1,059,319	949,537
Related to discontinued operations	-	-

## Note 7.2 Other auditor remuneration

### Other auditor remuneration paid to the external auditor:

No other auditor remuneration was paid for other non-audit services to the Trust.

## Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £5,000k (2023/24: £5,000k).

## Note 8 Impairment of assets

	2024/25	2023/24
	£000	£000
<b>Net impairments charged to operating surplus / deficit resulting from:</b>		
Unforeseen obsolescence	-	61
Changes in market price	24,295	-
<b>Total net impairments charged to operating surplus / deficit</b>	<b>24,295</b>	<b>61</b>
Impairments charged to the revaluation reserve	-	28,702
<b>Total net impairments</b>	<b>24,295</b>	<b>28,763</b>

\*In 2023/24 the Trust impaired the carrying value of equipment due to unforeseen obsolescence relating to a hazard notice received from the Medicines and Healthcare products Regulatory Agency. The equipment was subsequently disposed of.

\*In 2024/25 the Trust impaired the carrying value of the new community diagnostic centre land and building following a revaluation carried out by the Trust's valuer, Montagu Evans.

**Note 9.1 Employee benefits**

	<b>2024/25</b>	<b>2023/24</b>
	<b>Total</b>	<b>Total</b>
	<b>£000</b>	<b>£000</b>
Salaries and wages	460,436	419,625
Social security costs	47,545	43,600
Apprenticeship levy	2,288	2,126
Employer's contributions to NHS pensions	88,683	68,867
Pension cost - other	115	140
Termination benefits	1,715	21
Temporary staff (including agency)	11,862	19,198
<b>Total gross staff costs</b>	<b>612,644</b>	<b>553,577</b>
<b>Of which</b>		
Costs capitalised as part of assets	3,729	2,394

**Note 9.2 Retirements due to ill-health**

During 2024/25 there were nine early retirements from the trust agreed on the grounds of ill-health (ten in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £1,081k (£738k in 2023/24).

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

## Note 10 Pension costs

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

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

### a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

### b) Full actuarial (funding) valuation

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

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

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

**Note 11 Finance income**

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

	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
Interest on bank accounts	6,263	6,752
<b>Total finance income</b>	<b>6,263</b>	<b>6,752</b>

**Note 12.1 Finance expenditure**

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

	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
<b>Interest expense:</b>		
Interest on lease obligations	481	528
<b>Finance costs on PFI, LIFT and other service concession arrangements:</b>		
Main finance costs	33,057	32,359
Remeasurement of the liability resulting from change in index or rate	10,005	31,507
<b>Total interest expense</b>	<b>43,543</b>	<b>64,394</b>
Unwinding of discount on provisions	51	53
<b>Total finance costs</b>	<b>43,594</b>	<b>64,447</b>

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

	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

**Note 13 Other gains / (losses)**

	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
Gains on disposal of assets	458	15
Losses on disposal of assets	(143)	(88)
<b>Total gains / (losses) on disposal of assets</b>	<b>315</b>	<b>(73)</b>

Note 14.1 Property, plant and equipment - 2024/25

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Valuation/gross cost at 1 April 2024 - brought forward</b>	<b>17,014</b>	<b>287,997</b>	<b>43,636</b>	<b>78,340</b>	<b>108</b>	<b>51,179</b>	<b>1,715</b>	<b>479,989</b>
Additions	-	31,791	18,473	16,023	-	3,888	469	<b>70,644</b>
Impairments	(2,001)	(22,622)	-	-	-	-	-	<b>(24,623)</b>
Revaluations	134	(9,688)	-	-	-	-	-	<b>(9,554)</b>
Reclassifications	-	36,690	(36,689)	(7)	-	7	(1)	-
Disposals / derecognition	-	(719)	-	(2,858)	-	(3,629)	(436)	<b>(7,642)</b>
<b>Valuation/gross cost at 31 March 2025</b>	<b>15,147</b>	<b>323,449</b>	<b>25,420</b>	<b>91,498</b>	<b>108</b>	<b>51,445</b>	<b>1,747</b>	<b>508,814</b>
<b>Accumulated depreciation at 1 April 2024 - brought forward</b>	-	<b>5,475</b>	-	<b>44,984</b>	<b>74</b>	<b>39,375</b>	<b>1,215</b>	<b>91,123</b>
Provided during the year	-	10,656	-	5,982	6	4,769	169	<b>21,582</b>
Impairments	-	(328)	-	-	-	-	-	<b>(328)</b>
Revaluations	-	(9,880)	-	-	-	-	-	<b>(9,880)</b>
Reclassifications	-	1	-	(1)	-	-	-	-
Disposals / derecognition	-	(719)	-	(2,733)	-	(3,618)	(429)	<b>(7,499)</b>
<b>Accumulated depreciation at 31 March 2025</b>	-	<b>5,205</b>	-	<b>48,232</b>	<b>80</b>	<b>40,526</b>	<b>955</b>	<b>94,998</b>
<b>Net book value at 31 March 2025</b>	<b>15,147</b>	<b>318,244</b>	<b>25,420</b>	<b>43,266</b>	<b>28</b>	<b>10,919</b>	<b>792</b>	<b>413,816</b>
<b>Net book value at 1 April 2024</b>	<b>17,014</b>	<b>282,522</b>	<b>43,636</b>	<b>33,356</b>	<b>34</b>	<b>11,804</b>	<b>500</b>	<b>388,866</b>

**Note 14.2 Property, plant and equipment - 2023/24**

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Valuation / gross cost at 1 April 2023</b>	<b>12,904</b>	<b>322,182</b>	<b>27,863</b>	<b>86,716</b>	<b>108</b>	<b>49,712</b>	<b>1,734</b>	<b>501,219</b>
Additions	2,547	3,074	23,566	4,417	-	2,162	2	35,768
Impairments	-	(47,080)	(1,148)	(61)	-	-	-	(48,289)
Revaluations	1,563	3,175	-	-	-	-	-	4,738
Reclassifications	-	6,646	(6,645)	(1)	-	-	-	-
Disposals / derecognition	-	-	-	(12,731)	-	(695)	(21)	(13,447)
<b>Valuation/gross cost at 31 March 2024</b>	<b>17,014</b>	<b>287,997</b>	<b>43,636</b>	<b>78,340</b>	<b>108</b>	<b>51,179</b>	<b>1,715</b>	<b>479,989</b>
<b>Accumulated depreciation at 1 April 2023</b>	-	<b>15,489</b>	-	<b>51,845</b>	<b>68</b>	<b>33,446</b>	<b>1,085</b>	<b>101,933</b>
Provided during the year	-	10,194	-	5,782	6	6,624	151	22,757
Reversals of impairments	-	(19,526)	-	-	-	-	-	(19,526)
Revaluations	-	(682)	-	-	-	-	-	(682)
Disposals / derecognition	-	-	-	(12,643)	-	(695)	(21)	(13,359)
<b>Accumulated depreciation at 31 March 2024</b>	-	<b>5,475</b>	-	<b>44,984</b>	<b>74</b>	<b>39,375</b>	<b>1,215</b>	<b>91,123</b>
<b>Net book value at 31 March 2024</b>	<b>17,014</b>	<b>282,522</b>	<b>43,636</b>	<b>33,356</b>	<b>34</b>	<b>11,804</b>	<b>500</b>	<b>388,866</b>
<b>Net book value at 1 April 2023</b>	<b>12,904</b>	<b>306,693</b>	<b>27,863</b>	<b>34,871</b>	<b>40</b>	<b>16,266</b>	<b>649</b>	<b>399,286</b>

**Note 14.3 Property, plant and equipment financing - 31 March 2025**

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	15,147	124,170	25,420	35,436	28	10,863	734	<b>211,798</b>
On-SoFP PFI contracts and other service concession arrangements	-	180,842	-	-	-	-	-	<b>180,842</b>
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-
Owned - donated/granted	-	13,232	-	7,830	-	56	58	<b>21,176</b>
<b>Total net book value at 31 March 2025</b>	<b>15,147</b>	<b>318,244</b>	<b>25,420</b>	<b>43,266</b>	<b>28</b>	<b>10,919</b>	<b>792</b>	<b>413,816</b>

**Note 14.4 Property, plant and equipment financing - 31 March 2024**

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	17,014	85,430	43,636	29,205	34	11,738	434	<b>187,491</b>
On-SoFP PFI contracts and other service concession arrangements	-	183,359	-	-	-	-	-	<b>183,359</b>
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-
Owned - donated/granted	-	13,733	-	4,151	-	66	66	<b>18,016</b>
<b>Total net book value at 31 March 2024</b>	<b>17,014</b>	<b>282,522</b>	<b>43,636</b>	<b>33,356</b>	<b>34</b>	<b>11,804</b>	<b>500</b>	<b>388,866</b>

**Note 15 Donations of property, plant and equipment**

During the year assets to the value of £4,699k (2023/24: £232k) were purchased using charitable support. No conditions were imposed by the donor.

**Note 16 Leases - Norfolk and Norwich University Hospitals NHS Foundation Trust as a lessee**

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

The Trust as a lessee makes use of leased assets for the delivery of patient care including the lease of laboratory equipment, buildings for delivery of community activity, and significant radiotherapy equipment.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.

**Note 16.1 Right of use assets - 2024/25**

	<b>Property (land and buildings)</b>	<b>Plant &amp; machinery</b>	<b>Transport equipment</b>	<b>Information technology</b>	<b>Total</b>	Of which: leased from DHSC group bodies
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
<b>Valuation / gross cost at 1 April 2024 - brought forward</b>	<b>25,891</b>	<b>44,003</b>	<b>204</b>	<b>2,576</b>	<b>72,674</b>	<b>499</b>
Additions	326	3,048	195	-	<b>3,569</b>	236
Remeasurements of the lease liability	1,628	907	-	-	<b>2,535</b>	-
Movements in provisions for restoration / removal costs	(8)	-	-	-	<b>(8)</b>	-
Disposals / derecognition	(1,797)	(6,407)	(65)	-	<b>(8,269)</b>	(169)
<b>Valuation/gross cost at 31 March 2025</b>	<b>26,040</b>	<b>41,551</b>	<b>334</b>	<b>2,576</b>	<b>70,501</b>	<b>566</b>
<b>Accumulated depreciation at 1 April 2024 - brought forward</b>	<b>4,534</b>	<b>18,138</b>	<b>103</b>	<b>1,028</b>	<b>23,803</b>	<b>130</b>
Provided during the year	523	9,842	108	800	<b>11,273</b>	114
Disposals / derecognition	(1,797)	(6,397)	(65)	-	<b>(8,259)</b>	(169)
<b>Accumulated depreciation at 31 March 2025</b>	<b>3,260</b>	<b>21,583</b>	<b>146</b>	<b>1,828</b>	<b>26,817</b>	<b>75</b>
<b>Net book value at 31 March 2025</b>	<b>22,780</b>	<b>19,968</b>	<b>188</b>	<b>748</b>	<b>43,684</b>	<b>491</b>
<b>Net book value at 1 April 2024</b>	<b>21,357</b>	<b>25,865</b>	<b>101</b>	<b>1,548</b>	<b>48,871</b>	<b>369</b>
Net book value of right of use assets leased from other NHS providers						156
Net book value of right of use assets leased from other DHSC group bodies						335

**Note 16.2 Right of use assets - 2023/24**

	<b>Property (land and buildings)</b>	<b>Plant &amp; machinery</b>	<b>Transport equipment</b>	<b>Information technology</b>	<b>Total</b>	Of which: leased from DHSC group bodies
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
<b>Valuation / gross cost at 1 April 2023 - brought forward</b>	<b>23,813</b>	<b>40,457</b>	<b>106</b>	<b>2,576</b>	<b>66,952</b>	<b>417</b>
Additions	554	2,181	112	-	2,847	169
Remeasurements of the lease liability	-	1,605	-	-	1,605	-
Movements in provisions for restoration / removal costs	1,611	-	-	-	1,611	-
Disposals / derecognition	(87)	(240)	(14)	-	(341)	(87)
<b>Valuation/gross cost at 31 March 2024</b>	<b>25,891</b>	<b>44,003</b>	<b>204</b>	<b>2,576</b>	<b>72,674</b>	<b>499</b>
<b>Accumulated depreciation at 1 April 2023 - brought forward</b>	<b>1,853</b>	<b>8,802</b>	<b>43</b>	<b>228</b>	<b>10,926</b>	<b>110</b>
Provided during the year	2,768	9,381	66	800	13,015	107
Disposals / derecognition	(87)	(45)	(6)	-	(138)	(87)
<b>Accumulated depreciation at 31 March 2024</b>	<b>4,534</b>	<b>18,138</b>	<b>103</b>	<b>1,028</b>	<b>23,803</b>	<b>130</b>
<b>Net book value at 31 March 2024</b>	<b>21,357</b>	<b>25,865</b>	<b>101</b>	<b>1,548</b>	<b>48,871</b>	<b>369</b>
<b>Net book value at 1 April 2023</b>	<b>21,960</b>	<b>31,655</b>	<b>63</b>	<b>2,348</b>	<b>56,026</b>	<b>307</b>
Net book value of right of use assets leased from other NHS providers						84
Net book value of right of use assets leased from other DHSC group bodies						285

### Note 16.3 Revaluations of right of use assets

The Trust is measuring right of use assets applying the revaluation model in IAS 16, and using the Retail Prices Index for this purpose.

### Note 16.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 22.

	2024/25	2023/24
	£000	£000
<b>Carrying value at 1 April</b>	<b>46,488</b>	<b>52,947</b>
Lease additions	2,377	2,681
Lease liability remeasurements	2,535	1,604
Interest charge arising in year	481	528
Early terminations	(362)	(201)
Lease payments (cash outflows)	(11,153)	(11,071)
Other changes	-	-
<b>Carrying value at 31 March</b>	<b>40,366</b>	<b>46,488</b>

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

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

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

### Note 16.5 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025 £000	31 March 2025 £000	31 March 2024 £000	31 March 2024 £000
<b>Undiscounted future lease payments payable in:</b>				
- not later than one year;	8,501	114	10,737	110
- later than one year and not later than five years;	20,907	210	23,739	96
- later than five years.	12,996	219	13,987	185
<b>Total gross future lease payments</b>	<b>42,404</b>	<b>543</b>	<b>48,463</b>	<b>391</b>
Finance charges allocated to future periods	(2,038)	(48)	(1,975)	(20)
<b>Net lease liabilities at 31 March 2025</b>	<b>40,366</b>	<b>495</b>	<b>46,488</b>	<b>371</b>
<b>Of which:</b>				
Leased from other NHS providers		156		84
Leased from other DHSC group bodies		339		287

## Note 17 Inventories

	<b>31 March 2025 £000</b>	<b>31 March 2024 £000</b>
Drugs	5,405	4,910
Consumables	10,388	11,227
<b>Total inventories</b>	<b><u>15,793</u></b>	<b><u>16,137</u></b>
<b>of which:</b>		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £186,697k (2023/24: £175,505k). Write-down of inventories recognised as expenses for the year were £88k (2023/24: £53k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £197k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

**Note 18.1 Receivables**

	<b>31 March 2025 £000</b>	<b>31 March 2024 £000</b>
<b>Current</b>		
Contract receivables	41,092	31,662
Allowance for impaired contract receivables / assets	(5,482)	(4,843)
Allowance for other impaired receivables	(2,435)	(2,308)
Prepayments (non-PFI)	7,334	6,286
PFI lifecycle prepayments	6,198	-
Interest receivable	287	332
VAT receivable	5,394	5,002
Other receivables	2,526	2,046
<b>Total current receivables</b>	<b><u>54,914</u></b>	<b><u>38,177</u></b>
<b>Non-current</b>		
Contract receivables	1,664	1,448
PFI lifecycle prepayments	54,336	58,792
Other receivables	1,554	1,549
<b>Total non-current receivables</b>	<b><u>57,554</u></b>	<b><u>61,789</u></b>
<b>Of which receivable from NHS and DHSC group bodies:</b>		
Current	24,764	15,458
Non-current	1,554	1,549

**Note 18.2 Allowances for credit losses**

	<b>2024/25</b>		<b>2023/24</b>	
	<b>Contract receivables and contract assets £000</b>	<b>All other receivables £000</b>	<b>Contract receivables and contract assets £000</b>	<b>All other receivables £000</b>
<b>Allowances as at 1 April - brought forward</b>	<b>4,843</b>	<b>2,308</b>	<b>2,450</b>	<b>2,114</b>
New allowances arising	2,561	407	2,641	334
Reversals of allowances	-	(240)	-	(77)
Utilisation of allowances (write offs)	(1,922)	(40)	(248)	(63)
<b>Allowances as at 31 Mar 2025</b>	<b><u>5,482</u></b>	<b><u>2,435</u></b>	<b><u>4,843</u></b>	<b><u>2,308</u></b>

### Note 19.1 Cash and cash equivalents movements

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

	2024/25	2023/24
	£000	£000
<b>At 1 April</b>	<b>104,705</b>	<b>93,278</b>
Net change in year	(11,287)	11,427
<b>At 31 March</b>	<b>93,418</b>	<b>104,705</b>
<b>Broken down into:</b>		
Cash at commercial banks and in hand	165	136
Cash with the Government Banking Service	93,253	104,569
<b>Total cash and cash equivalents as in SoFP</b>	<b>93,418</b>	<b>104,705</b>
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
<b>Total cash and cash equivalents as in SoCF</b>	<b>93,418</b>	<b>104,705</b>

### Note 19.2 Third party assets held by the trust

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

	31 March	31 March
	2025	2024
	£000	£000
Bank balances	3	3
<b>Total third party assets</b>	<b>3</b>	<b>3</b>

**Note 20 Trade and other payables**

	<b>31 March 2025 £000</b>	<b>31 March 2024 £000</b>
<b>Current</b>		
Trade payables	29,658	26,602
Capital payables	16,593	9,600
Accruals	76,694	82,588
Social security costs	12,679	11,969
Pension contributions payable	7,522	6,815
<b>Total current trade and other payables</b>	<b><u>143,146</u></b>	<b><u>137,574</u></b>
<b>Of which payables from NHS and DHSC group bodies:</b>		
Current	9,554	6,605
Non-current	-	-

**Note 21 Other liabilities**

	<b>31 March 2025 £000</b>	<b>31 March 2024 £000</b>
<b>Current</b>		
Deferred income: contract liabilities	23,419	26,735
<b>Total other current liabilities</b>	<b><u>23,419</u></b>	<b><u>26,735</u></b>
<b>Non-current</b>		
Deferred income: contract liabilities	1,155	1,446
<b>Total other non-current liabilities</b>	<b><u>1,155</u></b>	<b><u>1,446</u></b>

**Note 22 Borrowings**

	<b>31 March 2025 £000</b>	<b>31 March 2024 £000</b>
<b>Current</b>		
Lease liabilities	8,492	10,735
concession contracts	17,678	15,803
<b>Total current borrowings</b>	<b><u>26,170</u></b>	<b><u>26,538</u></b>
<b>Non-current</b>		
Lease liabilities	31,875	35,753
concession contracts	351,328	359,313
<b>Total non-current borrowings</b>	<b><u>383,203</u></b>	<b><u>395,066</u></b>

## Note 23 Reconciliation of liabilities arising from financing activities

	Lease Liabilities £000	PFI and LIFT schemes £000	Total £000
<b>Carrying value at 1 April 2024</b>	<b>46,487</b>	<b>375,116</b>	<b>421,603</b>
<b>Cash movements:</b>			
Financing cash flows - payments and receipts of principal	(10,672)	(16,116)	(26,788)
Financing cash flows - payments of interest	(481)	(33,057)	(33,538)
<b>Non-cash movements:</b>			
Additions	2,377	-	2,377
Lease liability remeasurements	2,536	-	2,536
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	10,005	10,005
Application of effective interest rate	481	33,057	33,538
Early terminations	(362)	-	(362)
<b>Carrying value at 31 March 2025</b>	<b>40,366</b>	<b>369,005</b>	<b>409,371</b>

	Lease Liabilities £000	PFI and LIFT schemes £000	Total £000
<b>Carrying value at 1 April 2023</b>	<b>52,947</b>	<b>176,669</b>	<b>229,616</b>
<b>Cash movements:</b>			
Financing cash flows - payments and receipts of principal	(10,544)	(14,292)	(24,836)
Financing cash flows - payments of interest	(528)	(32,359)	(32,887)
<b>Non-cash movements:</b>			
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	181,232	181,232
Additions	2,681	-	2,681
Lease liability remeasurements	1,604	-	1,604
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	31,507	31,507
Application of effective interest rate	528	32,359	32,887
Early terminations	(201)	-	(201)
<b>Carrying value at 31 March 2024</b>	<b>46,487</b>	<b>375,116</b>	<b>421,603</b>

## Note 24.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Redundancy £000	Other £000	Total £000
<b>At 1 April 2024</b>	<b>561</b>	<b>1,823</b>	<b>120</b>	<b>778</b>	<b>6,768</b>	<b>10,050</b>
Change in the discount rate	1	6	-	-	(15)	(8)
Arising during the year	32	121	-	690	481	<b>1,324</b>
Utilised during the year	(97)	(156)	-	(300)	(1,064)	<b>(1,617)</b>
Reversed unused	(38)	-	-	(478)	(1,395)	<b>(1,911)</b>
Unwinding of discount	11	40	-	-	79	<b>130</b>
<b>At 31 March 2025</b>	<b>470</b>	<b>1,834</b>	<b>120</b>	<b>690</b>	<b>4,854</b>	<b>7,968</b>
<b>Expected timing of cash flows:</b>						
- not later than one year;	87	156	120	690	2,971	<b>4,024</b>
- later than one year and not later than five years;	286	588	-	-	557	<b>1,431</b>
- later than five years.	97	1,090	-	-	1,326	<b>2,513</b>
<b>Total</b>	<b>470</b>	<b>1,834</b>	<b>120</b>	<b>690</b>	<b>4,854</b>	<b>7,968</b>

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.

Other provisions largely consist of provisions for HMRC determinations and clinician's pension tax reimbursement. The clinician's pension tax reimbursement relates to clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in the 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.

#### Note 24.2 Clinical negligence liabilities

At 31 March 2025, £265,591k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Norfolk and Norwich University Hospitals NHS Foundation Trust (31 March 2024: £281,058k).

#### Note 25 Contractual capital commitments

	<b>31 March 2025 £000</b>	<b>31 March 2024 £000</b>
Property, plant and equipment	16,743	32,564
<b>Total</b>	<b>16,743</b>	<b>32,564</b>

## Note 26 On-SoFP PFI, LIFT or other service concession arrangements

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 1.9.

The service element of the contract was £34,700k (2023/24: £32,900k).

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.

### Note 26.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2025 £000	31 March 2024 £000
<b>Gross PFI, LIFT or other service concession liabilities</b>	<b>603,154</b>	<b>635,538</b>
<b>Of which liabilities are due</b>		
- not later than one year;	49,529	48,229
- later than one year and not later than five years;	198,117	192,912
- later than five years.	355,508	394,397
Finance charges allocated to future periods	(234,148)	(260,422)
<b>Net PFI, LIFT or other service concession arrangement obligation</b>	<b>369,006</b>	<b>375,116</b>
- not later than one year;	17,678	15,803
- later than one year and not later than five years;	87,963	78,635
- later than five years.	263,365	280,678

### Note 26.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2025 £000	31 March 2024 £000
<b>Total future payments committed in respect of the PFI, LIFT or other service concession arrangements</b>	<b>1,100,374</b>	<b>1,138,659</b>
<b>Of which payments are due:</b>		
- not later than one year;	86,365	82,142
- later than one year and not later than five years;	354,904	337,257
- later than five years.	659,105	719,260

**Note 26.3 Analysis of amounts payable to service concession operator**

This note provides an analysis of the unitary payments made to the service concession operator:

	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
<b>Unitary payment payable to service concession operator</b>	<b>89,465</b>	<b>85,764</b>
<b>Consisting of:</b>		
- Interest charge	33,057	32,359
- Repayment of balance sheet obligation	16,116	14,292
- Service element and other charges to operating expenditure	34,707	32,857
- Addition to lifecycle prepayment	5,585	6,256
<b>Total amount paid to service concession operator</b>	<b>89,465</b>	<b>85,764</b>

## **Note 27 Financial instruments**

### **Note 27.1 Financial risk management**

#### **Financial risk management**

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

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

#### **Currency risk**

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

#### **Interest rate risk**

The Trust has borrowings in the form of PFI arrangements and finance leases. For both types of borrowings, the interest rate is fixed, resulting in a low level of associated risk. Remeasurement of the PFI scheme is charged to finance costs, as the scheme 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.

#### **Credit risk**

The majority of the Trust's income comes from contracts with other public sector bodies, therefore the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2024 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 its investment advisers so as to ensure that there is a very low level of risk associated with cash and any deposits with financial institutions.

#### **Liquidity risk**

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

## Note 27.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2025	Held at	Total
	amortised	book value
	cost	
	£000	£000
Trade and other receivables excluding non financial assets	37,580	37,580
Cash and cash equivalents	93,418	93,418
<b>Total at 31 March 2025</b>	<b>130,998</b>	<b>130,998</b>

Carrying values of financial assets as at 31 March 2024	Held at	Total
	amortised	book value
	cost	
	£000	£000
Trade and other receivables excluding non financial assets	28,288	28,288
Cash and cash equivalents	104,705	104,705
<b>Total at 31 March 2024</b>	<b>132,993</b>	<b>132,993</b>

## Note 27.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2025	Held at	Total
	amortised	book value
	cost	
	£000	£000
Obligations under leases	40,367	40,367
Obligations under PFI, LIFT and other service concession contracts	369,006	369,006
Trade and other payables excluding non financial liabilities	113,790	113,790
Provisions under contract	7,298	7,298
<b>Total at 31 March 2025</b>	<b>530,461</b>	<b>530,461</b>

Carrying values of financial liabilities as at 31 March 2024	Held at	Total
	amortised	book value
	cost	
	£000	£000
Obligations under leases	46,488	46,488
Obligations under PFI, LIFT and other service concession contracts	375,116	375,116
Trade and other payables excluding non financial liabilities	116,280	116,280
Provisions under contract	8,440	8,440
<b>Total at 31 March 2024</b>	<b>546,324</b>	<b>546,324</b>

## Note 27.4 Maturity of financial liabilities

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

	31 March	31 March
	2025	2024
	£000	£000
In one year or less	175,503	177,370
In more than one year but not more than five years	220,125	220,241
In more than five years	371,018	411,111
<b>Total</b>	<b>766,646</b>	<b>808,722</b>

**Note 28 Losses and special payments**

	2024/25		2023/24	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
<b>Losses</b>				
Cash losses	4,405	1,251	2	1
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	693	671	433	247
Stores losses and damage to property	4	97	3	62
<b>Total losses</b>	<b>5,102</b>	<b>2,019</b>	<b>438</b>	<b>310</b>
<b>Special payments</b>				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	50	10	48	13
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
<b>Total special payments</b>	<b>50</b>	<b>10</b>	<b>48</b>	<b>13</b>
<b>Total losses and special payments</b>	<b>5,152</b>	<b>2,029</b>	<b>486</b>	<b>323</b>

## Note 29 Related parties

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 which the Trust has had dealings with. They are included in the table below. A de minimus of £5m income or expenditure has been used.

Related Party Transactions	Total income 2024/25	Total expenditure 2024/25	Total income 2023/24	Total expenditure 2023/24
	£000	£000	£000	£000
Value of transactions with board members	-	-	-	-
Value of transactions with key staff members	-	-	-	-
Cambridge University Hospitals NHS Foundation Trust	1,257	9,773	1,460	8,170
Department of Health and Social Care	35,477	-	27,640	-
HM Revenue & Customs	-	49,833	-	45,727
James Paget University Hospitals NHS Foundation Trust	13,172	7,424	10,783	4,512
NHS England	154,109	65	258,906	52
NHS Norfolk and Waveney ICB	780,282	1,306	618,456	1,842
NHS Pension Scheme	-	88,938	-	68,952
NHS Resolution	-	20,891	-	22,426
NHS Suffolk and North East Essex ICB	14,151	32	7,817	3
Norfolk Community Health and Care NHS Trust	2,961	5,797	3,079	5,620
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	10,232	4,015	6,562	3,120

Related Party Balances	Total receivables 2024/25	Total payables 2024/25	Total receivables 2023/24	Total payables 2023/24
	£000	£000	£000	£000
Value of balances (other than salary) with related parties in relation to doubtful debt	(2,435)	-	(2,308)	-
Value of balances (other than salary) with related parties in respect of doubtful debts written off in year	-	-	-	-
Cambridge University Hospitals NHS Foundation Trust	558	2,008	805	1,007
Department of Health and Social Care	1,913	-	518	-
HM Revenue & Customs	5,394	12,678	5,002	11,970
James Paget University Hospitals NHS Foundation Trust	7,055	1,114	3,665	1,038
NHS England	2,259	1,760	5,906	1,030
NHS Norfolk and Waveney ICB	6,072	27	1,737	291
NHS Pension Scheme	-	7,590	-	6,803
NHS Resolution	-	-	-	-
NHS Suffolk and North East Essex ICB	303	-	-	196
Norfolk Community Health and Care NHS Trust	489	142	585	444
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	4,784	413	1,242	739

**Note 29 Related parties (continued)**

<b>Related Party Transactions</b>	<b>Total income 2024/25 £000</b>	<b>Total expenditure 2024/25 £000</b>	<b>Total income 2023/24 £000</b>	<b>Total expenditure 2023/24 £000</b>
Other non DHSC group related parties:				
Bullen Development Ltd - note 1	-	599	-	723
UEA Innovation Partners LLP - note 2	-	485	-	555
QI Partners Ltd - note 2	-	1,755	-	1,690
University of East Anglia - note 3	3,126	2,358	1,664	1,946
NHS Shared Business Services - note 4	-	2,622	-	2,070
Macmillan Cancer Support - note 5	364	-	215	-

<b>Related Party Balances</b>	<b>Total receivables 2024/25 £000</b>	<b>Total payables 2024/25 £000</b>	<b>Total receivables 2023/24 £000</b>	<b>Total payables 2023/24 £000</b>
Other non DHSC group related parties:				
Bullen Development Ltd - note 1	-	-	-	-
UEA Innovation Partners LLP - note 2	-	-	-	-
QI Partners Ltd - note 2	-	-	-	-
University of East Anglia - note 3	1,469	241	798	241
NHS Shared Business Services - note 4	-	362	-	201
Macmillan Cancer Support - note 5	-	-	-	-

Note 1 - A Non-Executive director is a member of the board of this organisation

Note 2 - Chief Executive Officer is a member of the board of this organisation

Note 3 - A Non-Executive director is the Pro-Vice-Chancellor of this organisation.

Note 4 - An Executive director is a member of the board of this organisation

Note 5 - Entity deemed related party within Departmental Group

**Remuneration of Key Management Personnel**

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

	<b>Year ended 31 March 2025</b>	<b>Year ended 31 March 2024</b>
	<b>£000</b>	<b>£000</b>
Short term employee benefits (pay)	1,400	-
Post-employment benefits (employers pension contribution)	135	107

The highest paid Director in 2024/25 received remuneration of £264k, excluding pension related benefits and exit packages, for their services as Medical Director. In 2023/24 the highest paid Director received remuneration of £181k, not including pension related benefits and exit packages, for their services as Chief Operating Officer 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.

**Note 29 Related parties (continued)**

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.

The services of the Norfolk and Norwich University Hospitals NHS Foundation Trust have benefited from payments of £774k for enhancement of patient environment, investment in staff, additional equipment, and research (2023/24: £2,600k) from the Norfolk and Norwich Hospitals Charity.

During the year net assets to the value of £4,699k (2023/24: £232k) were donated to the Foundation Trust, of which £170k (2023/24: £48k) came from the Norfolk and Norwich Hospitals Charity.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has recharged the sum of £376k (2023/24: £262k) to the Norfolk and Norwich Hospitals Charity for the provision of administration and management of the Charity.

The total receivable balance from the Norfolk and Norwich Hospitals Charity at the end of the year was £2,304k (2023/24: £306k).

During the year none of the Department of Health and Social Care Ministers, Trust board members or members of the key management staff, or parties related to any of them, have undertaken any material transactions (other than employment benefits) with the Norfolk and Norwich University Hospitals NHS Foundation Trust.

**Note 30 Prior period adjustments**

There have been no prior period adjustments.

**Note 31 Events after the reporting date**

There have been no events after the reporting year that have had a major impact on these accounts.



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## REPORT TO THE COUNCIL OF GOVERNORS

<b>Date</b>	<b>24 July 2025</b>
<b>Title</b>	<b>Membership Activities and Analysis</b>
<b>Author(s) &amp; Exec Lead</b>	<b>Adam Gretton, Deputy Head of Communications</b>
<b>Purpose</b>	<b>For Discussion</b>

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](#)

- Lesley's Blog - 11 April
- Lesley Dwyer appointed Group CEO
- Group Chair Mark Friend talks about Lesley's new role
- Management Board update
- Care Group leadership teams announced
- Group Delivery Officer and Group Chief Financial Officer for NWUHG appointed.
- Executive Hospital Managing Directors appointed
- Norfolk and Waveney University Hospitals Group update
- NNUH Dementia Fayre preview
- Tessa Jowell Centres of Excellence announced
- Official opening of the Sir Thomas Browne Library – 5 June
- Management Board Update
- Institute of Robotic Surgery plans move forward
- HRH The Princess Royal visits NNUH maternity service
- NNUH Summer Pulse
- Hospital Management Board update
- NNUH at the Royal Norfolk Show
- Management Board update
- TED talk
- Government publishes 10 Year Health Plan
- Norfolk and Waveney University Hospitals Group July update
- Updated media statement on mortality data

## 2.1 Governor activities

The period from May through to July 2025 has remained a busy time for the governors. Our focus has continued in two key areas: informing and supporting the executive and non-executive teams across the transition to the Group model whilst also maintaining strong local engagement. There has been participation in a wide range of staff, patient, and public activities. This has included visits, observations, reviews, and providing feedback. In addition, we have supported the Communications team with membership development and contributed to the work of the NNUH Charity.

Chair Recruitment	
Meetings with Global Alumni	Ongoing meetings with Global Alumni to define competencies, experience and leadership qualities required for the substantive Group Chair role and associated remuneration

<b>REMCO</b>	Meetings of NNUH Governors Nominations and Remunerations Committee (REMCO): May: Approval of Interim Vice Chair Remuneration Meeting of REMCO in common: July 10 <sup>th</sup> : Approval of Substantive Group Chair Advert, Job Description, Person Spec, Covering Letter and Remuneration
<b>NEDs Assurance</b>	
<b>Selection and Recruitment of Group Chair</b>	Ongoing meetings with Global Alumni to define competencies, experience and leadership qualities required for the group Chair role and associated remuneration Meetings of NNUH Governors Nominations and Remunerations Committee (REMCO): May: Approval of Interim Vice Chair Remuneration Meeting of REMCO in common: July 10 <sup>th</sup> : Approval of Group Chair Advert, Job Description, Person Spec, Covering Letter and Remuneration
<b>Observation at Board and Assurance Committees</b>	Governors have attended and observed Board meetings and the following Board Assurance Committees: <ul style="list-style-type: none"> <li>• Finance, Investments and Performance</li> <li>• Research and Education</li> <li>• Quality and Safety</li> <li>• Audit</li> </ul>
<b>Meeting with NEDs</b>	Governors have met with NEDs to discuss the development of the role of the NEDs in the Group model and potential ways that governors might continue to hold NEDs to account
<b>Freedom to Speak Up (FTSU)</b>	Governors have met with Fran Dawson, NNUH Lead FTSU Guardian on two occasions to receive and update on the current situation at the Trust
<b>Informal Governor Meetings</b>	An informal Governors meeting took place on Thursday 22 <sup>nd</sup> . May. A governor-led forum was held on Thursday July 9 <sup>th</sup> .
<b>Staff and Patient Engagement</b>	
<b>Care Assurance Visits</b>	Governors have participated in the following Care Assurance audits: Neurology Outpatients SDEC/Surgical Cardiology Outpatients Dermatology Antenatal Clinic General Medical Outpatients ENT Outpatients Dermatology
<b>Ward and Department Visits</b>	Formal and informal visits have been undertaken at: Diham Ward Radiology (Main Department) Community Diagnostic Centre
<b>Jenny Lind Hospital and Youth Forum</b>	Our 2 designate link governors continue to forge strong relationships with Jenny Lind and the Youth Forum. Both

	governors attended the Youth Forum meeting in May. This has been followed with a meeting with William Van't Hoff, NED at QEH, to learn more about the development of QEH's Youth Council
<b>Cromer and District Hospital</b>	Governors have continued to lead and participate in the monthly Carers Café. Interest and participation in the event have grown significantly The North Norfolk public governors have met regularly with the Divisional Operational Manager and Matron of Cromer Hospital
<b>Attendance at Patient Panels</b>	Governors continue to play an observational role each month at patient panel meetings
<b>Oncology Services</b>	A governor participated in discussions with staff relating to the 2021-26 Cancer Plan
<b>Sustainability</b>	Our governors continue to support all NNUH sustainability initiatives and participate in regular informal meet ups with the sustainability team.
<b>Local Authority Links</b>	Our LA representative governor facilitated a meeting with Fran Whymark, Chair of Health and Wellbeing Board and Brenda Jones, Chair of Norfolk Health Overview and Scrutiny Committee to learn more about whole system collaboration and transformation at neighbourhood level.
<b>Staff Awards</b>	3 governors supported the review and shortlisting of applicants for NNUH staff awards
<b>Environmental Arts</b>	A governor met with Emma Jarvis, Arts Coordinator to learn about the hospital Art Project and scope opportunities for mutual outreach
<b>Charity Support</b>	
<b>Support to the NNUH Charity.</b>	Multiple fundraising events have been supported including raffle ticket sales, N&N Hospitals Charity collection box delivery across the Broadland and North Norfolk area, signposting to enable donations to the charity and support with the planning of the Cromer Hospital Autumn Fayre.
<b>Support to Cromer Hospital Charity</b>	A governor provided signposting to enable donations to NICU Ongoing support with the planning of the Cromer Hospital Autumn Fayre.
<b>Support to Ovacome Charity</b>	Governors supported the Ovacome charity event-on Norwich Health and Wellbeing Day <a href="https://www.ovacome.org.uk/event/norwich-hwd/home">https://www.ovacome.org.uk/event/norwich-hwd/home</a> )
<b>Attendance at other Charity Events</b>	Governors have attended the following: NNUH Hospital Golf Day NNUH Dementia Fayre Cromer Hospital Renal Unit Afternoon Tea NNUH Music Event Charity Music Showcase Wellbeing Walk Launch
<b>Outreach Activities</b>	The following initiatives have been undertaken to support our public and staff outreach <ul style="list-style-type: none"> <li>• 6 governors attended the Royal Norfolk Show</li> </ul>

	<ul style="list-style-type: none"> <li>• Publication of 2 governor profiles in the South Norfolk Link magazine</li> <li>• Engagement with Cringleford, Hethersett, and Mulbarton GP practices</li> <li>• Governor drop ins at Cromer Hospital</li> <li>• Update to the Patient Reference Group</li> <li>• Weekly staff governor drop-in sessions are now set up at the support hub</li> </ul>
<b>Membership</b>	
<b>Membership Survey</b>	The Comms team and governors have co-designed a survey to determine what members of the public would appreciate and expect from being a NNUH member. The survey was first used at the Norfolk Show
<b>Individual Outreach</b>	Governors continue to seek out new membership across outreach events
<b>Development Opportunities</b>	
<b>NNUH Governors Working Groups</b>	The four working groups continue their development and activities. An update paper will be presented at Part 2 of the CoG on July 24th
<b>JPH, QEH and NNUH Joint Governors Workstream</b>	3 meetings have now taken place to progress the engagement and collaboration between QEH, JPH and NNUH governors
<b>Portal</b>	Regular meetings with the Comms Team have taken place to develop the portal and make it easier to access and navigate. Questions are now being submitted on a regular basis
<b>NHS Providers Govern Well Conference</b>	Two governors attended the conference. This included an excellent presentation from the QEH on their Youth Council

### **3.1 Future events**

- AGM – Thursday 25 September. Hospital showcase from 2.30pm in the east atrium, followed by the AGM in the lecture theatre from 4.30pm.

### **3.2 Future meeting date for Council of Governors**

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

- 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 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:

- 10 September
- 5 November.

Please note that there may be some changes to the Trust Board arrangements as the group governance becomes established.

### **4.1 Membership analysis**

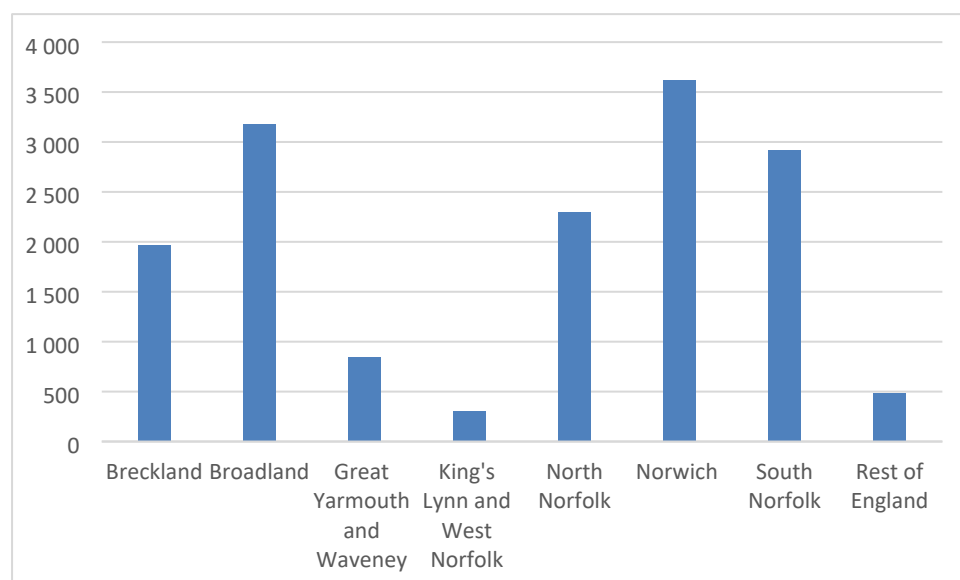
The Trust has an obligation to ensure that its Membership is representative of the population served by the Trust.

## 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	1821
Broadland	2971
Great Yarmouth and Waveney	792
King's Lynn and West Norfolk	266
North Norfolk	2,101
Norwich	3,387
South Norfolk	2,816
Rest of England	317
<b>Total</b>	<b>14,405</b>

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.

<b>Age</b>	<b>Total 14,405</b>	<b>% membership</b>	<b>% of population</b>
17-21	46	0.6%	5.46%
22+	9,935	68%	76.6%
Unknown	4424		

<b>Age bands</b>	
22-29	387
30-39	760
40-49	843
50-59	1,575
60-74	2,635
75+	3,735

<b>Gender</b>	<b>Total 14,405</b>	<b>% membership</b>	<b>% of population</b>
Male	6,469	45.0%	49.1%
Female	7,936	55.0%	50.9%

<b>Ethnicity</b>	<b>Numbers</b>	<b>membership</b>	<b>Norfolk population</b>
Asian	119	0.7%	1.5%
Black	51	0.3%	0.5%
Mixed	72	0.5%	1.2%
Other ethnic group	262	1.8%	0.3%
White	6,640	46.0%	96.5%
Not specified	7,523		
<b>Monitor classifications for socio-economic group</b>			
AB	3,987	27.6%	18.06%
C1	4,097	28.4%	29.28%
C2	3,149	21.8%	25.21%
DE	3,146	21.8%	27.46%

# NNUH Patient Panel Annual Review



2023 – 2024



## Who we are

A group of volunteers with a range of lived experiences of NNUH services as Patients, Carers and people with a passion and interest in ensuring *the best care for every patient* at NNUH

## What we do

Work on behalf of all patients, carers, relatives and visitors in order to improve patient and carer experience in partnership with staff.

Act as the independent and constructive 'voice of the patient/carer'.

Contribute to the continuous improvement of services delivered by the Trust.

## How we do it

Each member has a 'portfolio' of involvement activities which harnesses our lived experiences, professional knowledge and diverse backgrounds. Members bring a wealth of this unique mixture, which enriches our contribution to the Trust's and our experience of being partners for improvement.



# Welcome to our Annual Review 2023-24

Rosemary Moore, Chair of The Patient Panel

**“Welcome to our NNUH Patient Panel annual review 2023-24. As Chair of the Panel I have been proud to lead this team of committed and dedicated volunteers through another year of busy activity and involvement in improvement projects across the Trust.**



This report highlights some of the work we have been part of, as well as sharing some of our stories. Our personal stories and experiences of NNUH and the wider health service, gives us unique insights and motivations to volunteer our time freely to work alongside NNUH colleagues to ensure patients and carers voices are heard and acted upon. We also bring our professional and life experiences to add value to whatever endeavours we are part of.

It is also important to thank and acknowledge the support and openness of NNUH colleagues who have embraced the Panel as true partners for improvement. That our lived and life experiences are valued by those we work alongside is evident in the growing breadth of work we are approached to be part of as well as the mutual respect shown.”

## A bit about Rosemary:

“Having decided to step away from full time work within the NHS I was looking for new challenges and opportunities. I have always been interested in the voluntary sector and was keen to give back to the NHS in some form or another as I had so enjoyed my working life in that arena. An advert in the NNUH Pulse magazine caught my eye and to cut a long story short I found myself duly appointed Chair of, what was then, a non-existent Patient Panel! We have now grown and developed and I find the whole experience of being a Panel member very rewarding, interesting and stimulating.

As a member I get involved in various work streams. Also as Chair I lead the monthly meetings and try to be a point of contact and reference for other members and hospital employees who want to tap into the Panel’s expertise on projects.

Personally I feel the Patient Panel has been helpful in getting the patient voice heard. Putting the patient front and centre of all that the hospital does is so important. As well as patients we think about Carers and staff members. They are also such important groups. Happy staff, happy patients! We are a relatively new group and quite small but I like to think we are well respected within the hospital and can contribute in a positive, albeit at times, challenging way. I hope we are helping to make the hospital experience for all as positive as it can be within what can be very difficult individual and personal circumstances.”

The Panel's breadth and depth of involvement and engagement across NNUH has grown enormously over the last year. As we have become 'embedded' we have developed our understanding of how best we can be 'deployed' to support and work with clinical and non-clinical staff across the Trust - whether on a Committee, Task & Finish Group or as part of a multi-disciplinary team undertaking audits or improvement projects.

Members' 'portfolios' reflect both the needs of the organisation and Patient/Carer Voices as well as reflecting the passions, interests and expertise of Panel members. This creates a mutual aid and benefit feeling all involved. Positively supporting a shared ambition of working together as described in the Trust Strategy "Caring with Pride" and our commitment to patients that "together we will develop services so that everyone has the best experience of care and treatment."

### Check and Challenge – Audits and Assurance Visits

Panel members are key to a number of audits and clinical visits – in particular Patient Led Assessment of the Care Environment (PLACE) and Care Assurance.

At least on a monthly basis Panel members join clinical colleagues to take part in the Care Assurance visits to the wards. Their role in the audits is key to providing a lay perspective on the environmental checks as well as taking the lead in talking to patients and visitors to find out about their experiences and hear their views on the quality of care. This is then fed back to the wards, providing real-time insights and, often, compliments as well as suggestions for change and improvement.

The Panel have been integral to developing and strengthening the way the NNUH approaches the annual PLACE inspection, supporting training additional Patient Assessors to take a leading role on the days of the assessments as well as supporting several 'PLACE Lite' mini assessments throughout the year. These assessments focus on the look and feel of the building, cleanliness, privacy and dignity, how dementia and disability friendly the Trust is as well as the quality of the food.

George joined the Panel in 2022 and quickly identified PLACE and Care Assurance visits as areas he could really contribute to in a positive, hands on way.



"My most regular activities are Care Assurance visits to wards and outpatient departments, which give me a good idea of what the work of the hospital is like at the patient treatment end. I also do Patient Led Assessment of the Care Environment (PLACE) inspections when these take place. Whilst I find it hard to judge what difference I am making I do think the Care Assurance and PLACE work makes a genuine contribution to improvement and change."

## A bit about George...

"I initially trained as a photogrammetrist and used aerial photography to make highly detailed maps. With this work I have experience of the UK, the Middle East and Canada. Back in the UK I trained as a teacher and taught English at three comprehensive schools. Additionally, I have worked at times as an Associate Tutor for UEA and Anglia Ruskin University. I trained graduates to be teachers at UEA, and taught modules of an MA course for ARU. I am married, with three married children and five grandchildren (*aged 4 months to 6 years*).

I came to the Patient Panel after reading an article in The Pulse magazine and thought it sounded like a role with interesting and varied possibilities. I already had a volunteer commitment in another organisation, but this appealed so I applied. What I like best about work for the Patient Panel is the opportunity for constructive involvement and collaboration with people."



## Rosie Bloomfield, Patient Engagement & Experience Facilitator.

"Our PLACE assessments wouldn't be able to run without the support of our patient assessors. They are key to the success of our PLACE programme and we're extremely proud to have formed a large group of very passionate and knowledgeable PLACE assessors. We are so thankful for the time they volunteer to the assessment.

George is one of our experienced PLACE assessors who has not only been key to the assessment but has supported with the training and been paired with new assessors to help support us grow our assessment in recent years. His approach to the assessment and attention to detail makes him a highly valued member of the assessment team.

Feedback from our PLACE assessment is vital to support continual improvement to the environment our patients receive their care in and involving partners in care is essential to ensure future developments are fit for purpose."



## Dementia Support

### Shahnaz Asghar

The Trust developed its Dementia Strategy in 2021 and involved a wide range of stakeholders in its development and now implementation and monitoring. The Patient Panel has been integral throughout this process and since joining the Panel relatively recently, in 2023, Shahnaz immediately identified this as an area of work which complemented her passion for outstanding, compassionate care for all.

At the heart of the dementia strategy is holistic, person-centred care and also ensuring the family and Carers of those with dementia are fully recognised and supported for example through the Carers' Passport which enables a patient's main Carer to be with them when needed, supporting with emotional and practical care such as at mealtimes. Being the voice for patients and Carers on this group is an essential part of Shahnaz's Patient Panel role.

"The reason I have been involved in the Patients Panel because I have been always passionate about patients safety. It has been a privilege to be in Patient Panel as member and working and meeting so many amazing people. Bringing direct experience from patient own experience as users of our hospital services to help improve patients care and involvement with lots of activities and sharing and updating information with the group. As I enjoy to be involved I would recommend everyone to get involved and be part of wonderful team."



"The Purpose of the Dementia Strategy Evidence Group is to ensure the delivery of NNUHs Dementia Strategy 2021- 2026 thorough oversight, coordination and direction of the Dementia workstream groups. Having Shahnaz sitting on this group brings a different voice and perspective and enables the group to have patient/public advocacy in the direction of work that we do."  
**Liz Yaxley, Dementia Services Manager**



## Infection Control

Infection Control is of major importance to patients. Feeling confident that the NNUH is a clean, safe place to go for care and treatment is a basic and fundamental need for all.

Ensuring that the basics of how the Trust manages and oversees this vital element of patient safety has patient experience and voice at its heart. This means that a key and significant member of the Infection Control Committee has to be a Patient Panel member.

**Dawn Cursons, Deputy Director of Infection Prevention and Control -**

"The Trust Hospital Infection Control Committee (HICC) meet monthly with the function to prevent and control healthcare-associated infections by setting infection control policy and monitoring practices to reduce these risks.

Having continued support from our patient panel members is invaluable; and Colin, as a HICC member, contributes to discussions regarding future care developments and improvements. Personal experiences as patients and care givers enrich these conversations and we highly value all aspects of Colin and others' involvement.

Patient panel members play a crucial role in actively participating in these meetings, offering an objective perspective, thorough review of policies and a robust evaluation of processes and the reports presented. This engagement ensures that our services are designed to provide the best possible care for our patients."



**Colin, Patient Panel member sitting on the Committee**

"I have had a wide experience of the NNUH both as a carer and a patient. Some of that has been brilliant, other aspects less so. I became involved with the Patient Panel because I wanted to use my experience to improve the service patients experience. One of my responsibilities as a Panel member is to sit on the Hospital Infection Control Committee which is a privilege and provides me with an opportunity to use the insights I gain from, for example taking part in the monthly Care Assurance visits to wards, to influence and inform Trust policy and processes in this key patient safety arena.

I believe the Panel brings a different perspective to the management of the hospital. Panel members have enquiring minds, diverse backgrounds and experience and a genuine desire to improve the patient experience across all aspects of the hospital."

## Improving Experiences for those with Complex Health Needs



**Judy Tryggvason** came to the Patient Panel following involvement in the Serious Incident process. The opportunity to channel her experiences into making a positive impact and difference were suggested to her via the Family Liaison Officer at the time.

Judy, through her role on the Patient Panel, has brought about changes to how the Trust manages the self-discharge process. In particular, Judy ensured the recommendation from the SI process to 'ensure there is a robust statement within the Discharge Policy and Procedures around self-discharge and the impact of hospital life on patients with Autism Spectrum Disorder (ASD)' was followed through.

"My Family Liaison Officer said "why don't you join the Patient Panel?". I think she had picked up on my ability to think around problems, and suggest solutions outside the box. Together with a larger-than-usual experience of Health and Mental Health services in the area, maybe I could contribute a useful patient's eye view to NNUH workings and procedures, while continuing to push for the changes that were so needed to the Discharge Policy?

That was nearly 3 years ago, and it's been an amazing ride. I had no idea of the scale of the work that goes on to ensure that a Hospital runs effectively, and in the best possible way for its patients. It's not perfect. Nothing is. But the important thing is to have as many checks

and balances in place as possible, to ensure that NNUH is continuously endeavouring to be as good as it can possibly be. And I have been proud to have been part of that process.

And the Discharge Policy? With my eternal thanks to Sarah Higson, Judy Butcher, and Kim Goodby at the Hospital, the new Policy was finally rolled out earlier this year. If I hadn't made the contacts I did through the Patient Panel, I don't think that would have happened."

Judy is now firmly embedded on the MHCC Board, bringing her powerful voice to the Committee, where, as well as the Discharge Policy changes, she has been integral to the development of NNUH approach to the RCRP (Right Care, Right Person) Acute Workstream.

"Giving a patient/public perspective on Hospital Policy and practices can help to guide, and in some cases change, Hospital thinking. It's important that views from outside the organisation are incorporated to ensure a holistic approach to patient care. Also a way to support Staff in all that they do."

**Kim Goodby, Director for Complex Health, Safeguarding and Professional Standards**

"I have worked with Judy for approximately 2 years, as both a Patient Panel member of the Mental Health and Complex Care Board and as a key member of the RCRP Acute Trust workstream. Judy's support, insight and guidance has been invaluable to me during this time and as a group we are extremely fortunate to have had her expertise, integrity, honesty and humour to guide us. Judy has been an important advocate and champion for our patients and has ensured that those with a lesser voice are still heard and considered during the development of Trust strategies and policies in order to ensure that any potential impact on the most vulnerable in our society are considered and mitigated for. "

## Sarah – The View from a New Member



As a Panel we are always looking to welcome new members to swell not just the number but the variety and diversity of voices and experiences.

### Why did you get involved in the Patient Panel?

I attended my first Patient Panel meeting in November 2023. Having retired from a career in the NHS earlier in the year, I very much wanted to be part of a group that ensures that the patient's voice is heard and contributes to helping improve our services at the NNUH for our patients.

I have experience both as a patient at the NNUH and also as a relative of a patient.

### What do you do as a member?

Since becoming a member, my portfolio is gradually increasing. I attend the monthly Patient Panel meetings; I have become a member of the Clinical Support Services Patient Panel which meets once a month. The speakers are from the many services that make up the CSS Division and we support their improvement projects.

I work with colleagues from Patient Engagement and Experience with respect to the Accessible Information Standards (AIS) Policy and its implementation. For example, reviewing Policy updates.

I have recently undertaken the training for the Patient-Led Assessments of the Care Environment with a view to becoming involved in these assessments from October 2024.

### What difference do you think you and the Panel are making?

The Patient Panel is made up of a very diverse group of people who have varying skill sets. Each Panel member brings many qualities and strengths; they all have their areas of expertise.

During Panel meetings various speakers will attend, and I believe they are frequently very grateful for the suggestions, questions and observations that the Panel members make.

Patient Panel members review patient information/posters prior to their publication, giving helpful advice from a patient's perspective.

My contribution has been small in comparison to my other colleagues who have been members for a longer period of time, but I hope that I have already made a small contribution and look forward to getting more involved as time goes by.

## Panel Monthly Meetings

The Panel meets monthly for 2 hours. Part of this is to share and discuss individual work areas and also to provide space for key NNUH staff and others to consult, involve and discuss key issues, strategies and plans with the Panel.

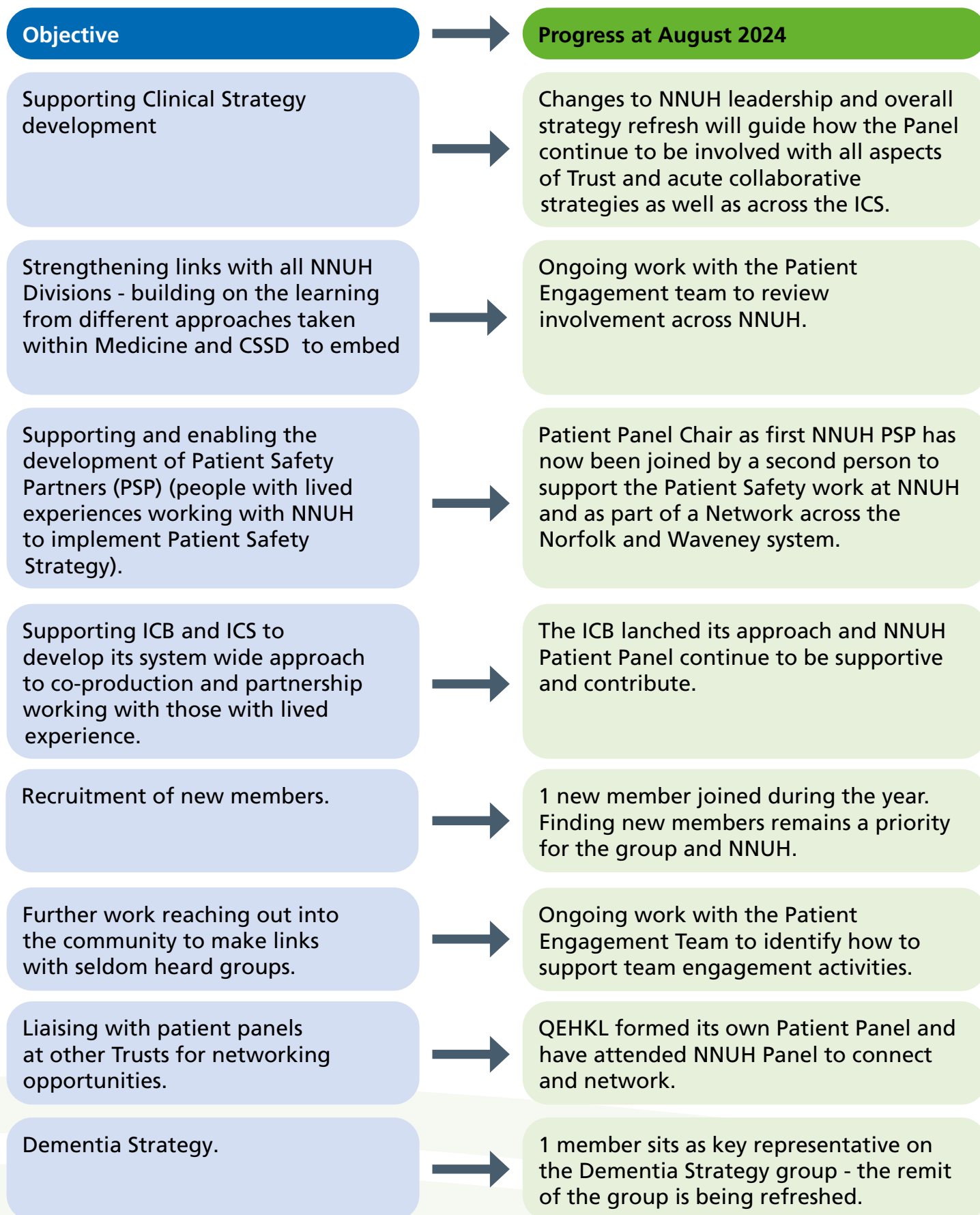
The Panel held 11 Meetings this year – 4 virtual and 7 hybrid virtual/in person.

### Topics covered were varied and wide-ranging:

- Review and collaboration to update the Patient engagement & Experience Strategy objectives and plan to 2025
- Review of Caring with Pride Trust Strategy
- Sustainability 'green plan' review and consultation
- Podiatry service improvement and changes discussions
- Cardiology consultation re developing a digital V paper manual – opted for both!
- Quadram Accessibility and signage discussions to help improve access
- Red to Green patient 'flow' and discharge overview and discussions to inform process and ensure patients at the heart of any changes
- Information and invite to be involved in the judging of new DAISY Awards for exceptional nursing care – several members now sit on the judging panel
- Patient Safety Incident response framework – an introduction to the new approach and new Patient Safety Partner role
- Consultation regarding Patient Voice / Worry & Concern quality improvement project (precursor to Martha's Rule roll out)
- Patient Initiated Request to Move Hospital (PIDMAS) – consulted and provided feedback on process development/issues
- Patient Led Assessment of the Care Environment (PLACE) planning and training
- Freedom to Speak Up Guardian – overview and discussion on overlap with experience of care for patients
- 'Escalation' planning – input into the plan for any escalation areas and use of extra beds – ensuring patients and their families experiences were front and centre
- EPR roll out discussions – contributed to project Focus Groups and ongoing engagement with the development of the procurement plans
- Equality Delivery system (EDS) consultation/review of evidence ahead of publication
- Updates and discussions on the impact of ongoing Industrial Action and Trust Performance
- Patient Letters/Information – ongoing review and involvement in improving readability and accessibility
- East Genomic Service Alliance overview
- Children & Young People engagement and new Forum overview

## Panel Objectives 2023 – 2025

During the year we have made progress against the key areas we identified to focus in to support the Trust's experience of care objectives:



# Patient Panel Members and Portfolios

Each member brings personal, lived and professional, life experiences to their volunteering and the aim is to find a 'good match' – ensuring Trust's patient and carer voice requirements are met alongside personal satisfaction for the Panel member.



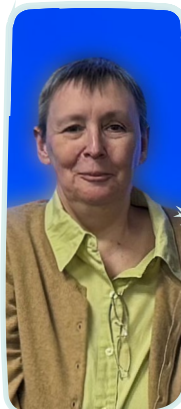
## **Rosemary Moore - Chair**

Patient Engagement and Experience Group (PEEG)  
Quality & Safety Committee  
End of Life Group  
Staff recruitment participation  
Complaints redesign and monitoring group  
Care Assurance visits



## **Richard Drew - Vice Chair**

Clinical Support Services Patient Forum – Chair  
Environmental Arts Project – Chair  
Patient Engagement and Experience Group (PEEG)  
Consent (acute hospitals joint work) – Committee and Task & Finish groups  
Staff recruitment participation  
Hospital Infection Control Committee  
Complaints redesign and monitoring group  
Veterans Group  
Patient Led Assessment of the Care Environment (PLACE) Patient Assessor



## **Eva Zaprel**

Complaints redesign and monitoring group  
Care Assurance visits  
Staff recruitment participation  
Equality, Diversity and Inclusion task and finish group  
PRIDE awards group  
Heart Failure Integrated Board  
PP representative on the DAISY Award scoring panel to staff nominated by the patient, family, or carer for patients who have received exceptional care  
Melanoma research group at the UEA



## **John Patman**

Digital Health Committees and work streams  
Research centre support activities  
Virtual Ward



## **George Mills**

Veterans Group  
Care Assurance visits  
Patient Led Assessment of the Care Environment (PLACE) & PLACE Lite  
Patient Assessor  
CQC Evidence Group  
NHS App and Dr Doctor Communications Development Group



**Judy Tryggvason**

Care Assurance Visits  
Complex Health Board  
RCRP (Right Care, Right Person) Acute Workstream  
Patient Information Forum Documents Review Group



**Lilian Hodgson**

Clinical Support Services Patient Forum  
Environmental Arts Project (Vice Chair)  
PP representative on the DAISY Award scoring panel to staff nominated by the patient, family, or carer for patients who have received exceptional care  
Staff recruitment participation



**Alan Stephens**

Clinical Support Services Patient Forum  
Radiology Aged Assets Group  
Together Against Cancer (TAC) group  
Discharge projects



**Colin Jones**

Hospital Infection Control Committee  
Complaints redesign and monitoring group  
Care Assurance visits  
Tackling Sexual Harassment in the Workplace Group  
CQC Evidence Group



**Shahnaz Asghar**

Dementia Strategy Group  
CQC Evidence Group  
Patient Led Assessment of the Care Environment (PLACE) Patient Assessor



**Sarah Egleton**

Clinical Support Services Patient Forum  
Accessible Information Standards (AIS) Policy development  
Patient Led Assessment of the Care Environment (PLACE) Patient Assessor



**Philip Aldred** (new member)

Patient Led Assessment of the Care Environment (PLACE) Patient Assessor

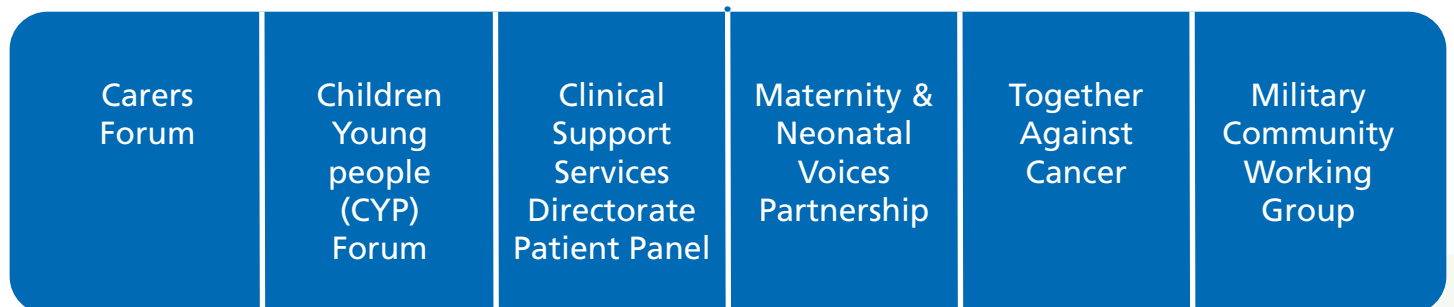
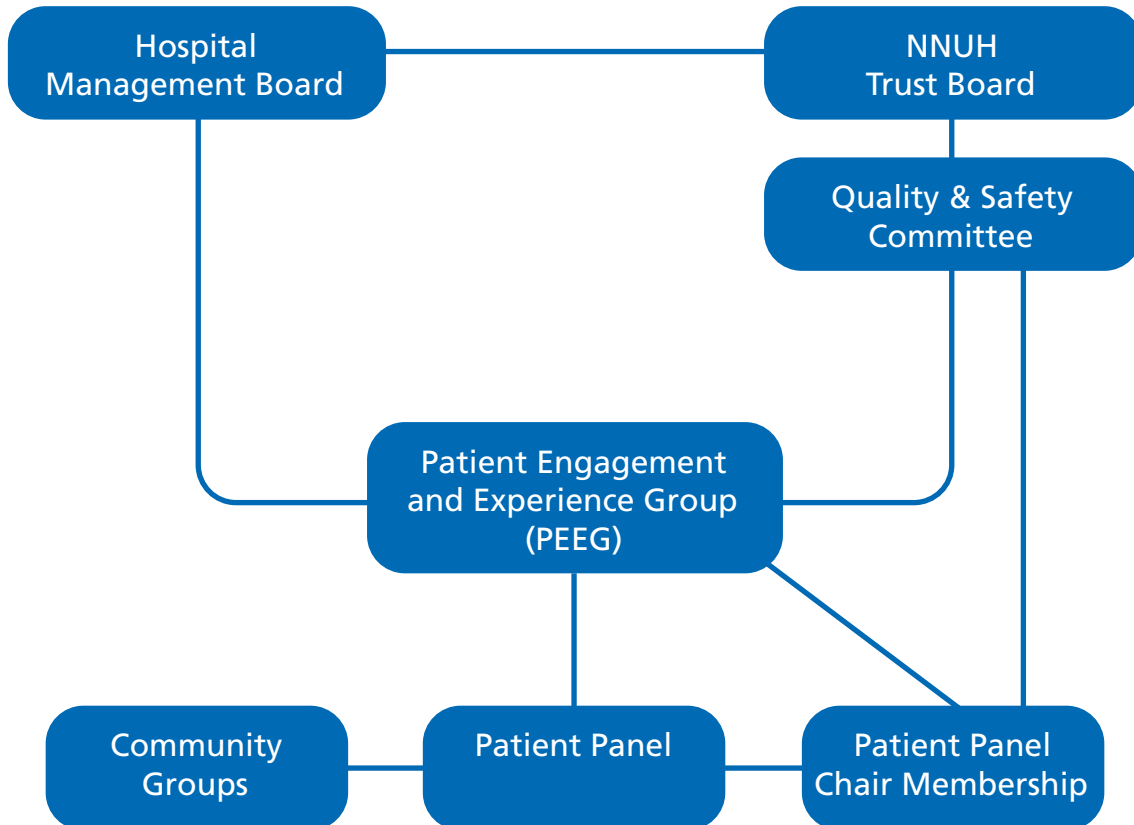


**Barry Capon** (left during the year)

Carers' Forum  
Complaints redesign and monitoring group  
PRIDE awards group  
Clinical Support Services Patient Forum

# Patient Panel governance chart and links to other NNUH Patient/Carer Voice groups

The patient Panel reports into the Patient Engagement and Experience Group (PEEG) which shares updates with the Quality and Safety Committee (Q&S), the Management Board and, ultimately, Trust Board. The Patient Panel Chair is a member of both PEEG and Q&S. View the full governance chart below.





**Reflections and thank you from Rachael Cocker,  
Chief Nurse, on behalf of NNUH Trust Board**

“The Patient Panel at the Norfolk and Norwich University Hospital (NNUH) plays an integral role in shaping the quality of care provided by the Trust. Through their dedication, insight, and tireless commitment, they ensure that patient and Carer voices remain at the heart of decision-making processes. Their work has a profound and lasting impact on improving experiences for patients and their families.

I welcome this opportunity to Celebrate the Work of the NNUH Patient Panel. Their invaluable feedback and guidance across a wide range of issues, from service improvements to ensuring accessibility and inclusion make a real difference and impact. Their participation helps bridge the gap between the hospital staff, management, and the community it serves. Through open dialogue, members advocate for positive changes that reflect the needs and priorities of patients and Carers. Whether reviewing policies, suggesting service adjustments, or contributing to new initiatives, their contributions create a culture of collaboration and understanding.

The Annual Review, conducted by the Patient Panel, is a testament to their detailed and rigorous approach. This report demonstrates their ability to critically evaluate performance, celebrate achievements, and identify areas for growth. It captures patient and Carers insights in a meaningful way, offering clear recommendations that often serve as the foundation for strategic improvements. The attention to detail in this review is a hallmark of their work. The Panel invests substantial time and effort to ensure the report is comprehensive, reflective of a wide range of people’s experiences, and grounded in constructive feedback. It is not just a reflection of their commitment to improvement but also a clear indicator of their professionalism and compassion.

To the members of the NNUH Patient Panel: thank you. Your dedication to representing the voices of patients and families does not go unnoticed. Your efforts empower others and help to create a hospital environment where care is truly patient-centred. Through your collaboration with staff and stakeholders, you champion the values of accountability, inclusivity, and excellence.

Your work is inspiring, and on behalf of all those who benefit from your advocacy, we express our deepest gratitude for all that you do.”



## NNUH Patient Panel

### TERMS OF REFERENCE

#### 1 CONSTITUTION AND PURPOSE

- 1.1 At the discretion of the Patient Engagement & Experience Group (PEEG), a group has been established to be known as the NNUH Patient Panel:
- The Patient Panel is made up of a group of volunteers who represent patients, families and carers of NNUH.
  - We're passionate about NNUH being an outstanding provider of services for the people of Norfolk.
  - We identify means of improving the patient experience at NNUH, encourage their application, and represent patients' interests in all areas of the Trust.
- 1.2 The **Purpose** of the Patient Panel is to:
- Work on behalf of all patients, carers, relatives and visitors in order to improve patient and carer experience in partnership with staff.
  - Act as the independent and constructive 'voice of the patient/carer'.
  - Contribute to the continuous improvement of quality and services delivered by the Trust ensuring that the views of service users are sought, co-ordinated, fed back and used.

#### 2 AUTHORITY

- 2.1 The Patient Panel has no executive powers other than those specified in these Terms of Reference. The Patient Panel is authorised to investigate any activity within its Terms of Reference and all Trust staff are expected to co-operate with the Patient Panel to facilitate satisfaction of its duties.
- 2.2 The Patient Panel has authority to establish sub groups or working groups as it considers appropriate, efficient and necessary. These groups will report to the Patient Panel.

#### 3 MEMBERSHIP

- 3.1 Membership of the Patient Panel shall comprise:
- Any person who is a NNUH patient, carer, family member, who is not a Trust employee, may be invited to become a member of NNUH Patient Panel.
  - The invitation to become a member of the Panel will be made by the Panel Chair and the NNUH Associate Director for Patient Engagement & Experience (or other nominated team member), following an application and interview process which is coordinated via the Volunteer Services Department - each member of NNUH Patient Panel is recruited as a Volunteer and must undertake full NNUH volunteer training and complete appropriate checks.
  - The number of members to be a maximum of 20.

- Each member of NNUH Patient Panel shall have one vote. In the event of a tied vote the Chair, or whoever has been elected to chair the meeting, will have a casting vote.
- As a member of NNUH Patient Panel each person will have a portfolio of roles which shall be by agreement with the Chair, the NNUH Associate Director for Patient Engagement & Experience (or other nominated team member), and the member.
- Each member of NNUH Patient Panel shall serve a term of three years. At the end of that period the member shall attend a review with the Chair and the NNUH Associate Director for Patient Engagement & Experience (or other nominated team member), at which point the member shall either cease being a member of NNUH Patient Panel or begin a new three year term of membership. The usual limit on number of terms served will be 2 terms however, this may be waived in exceptional circumstances following a review as above.

In attendance:

- Associate Director for Patient Engagement & Experience
- Members of Patient Engagement & Experience Team

3.2 Only members of the Patient Panel or those in attendance are entitled to be present at its meetings. The Patient Panel may however invite non-members to attend its meetings as it considers necessary, at the discretion of the Chair, and typically the following may be invited to attend meetings of the Patient Panel:

- Chief Nurse and other Board members (Exec and Non-Exec)
- Governors
- Trust staff relevant to agenda items, project work, reports etc
- Partners from other organisations, patient panels etc

3.3 An annual review of membership and portfolios will be undertaken by the Chair in conjunction with the Patient Engagement & Experience Team to ensure shared priorities and objectives are being achieved.

3.4 If a member is absent from more than two consecutive Panel meetings without good reason, NNUH Patient Panel reserves the right to remove that person from NNUH Patient Panel, by means of a vote at the Panel meeting.

3.5 NNUH Patient Panel Meetings will not be open to the press or public.

3.6 The Chair will be a Patient Panel member and elected by the membership. The Chair of the NNUH Patient Panel will serve for a minimum of two years with an option to extend to four, with support of the Panel membership and the Trust. The usual limit on number of terms served will be 2 terms however, this may be waived in exceptional circumstances following a review as above.

3.7 The Vice Chair will be a Patient Panel member and elected by the membership. The Vice Chair/s of the NNUH Patient Panel will service for a minimum of two years with an option to extend to four, with support of the Panel membership and the

Trust. The usual limit on number of terms served will be 2 terms however, this may be waived in exceptional circumstances following a review as above.

#### **4 SUPPORT ARRANGEMENTS**

- 4.1 The Patient Panel will receive administrative and development support from the Patient Engagement & Experience Team. The Committee/Group will establish an annual work programme, summarising those items and reports that it expects to consider at forthcoming meetings and this will be reflected in future meeting agendas.

#### **5 MEETINGS AND QUORUM**

- 5.1 NNUH Patient Panel meetings shall be held every month, at the hospital site, other suitable venue or held virtually, and will usually be of two hours duration - All reasonable effort will be made to ensure that meetings are held in venues/rooms which are accessible to all people and information is available in all formats.
- 5.2 NNUH Patient Panel meetings will be considered quorate provided at least one third of members, one of whom is the Chair or Vice Chair, and one member of the Patient Experience Team are present.
- 5.3 Responsibility for calling meetings of the Patient Panel shall rest with the Panel Chair supported by the Patient Engagement & Experience Team. Notice of each meeting confirming the venue, time, and date together with the agenda of items for discussion and supporting papers will be circulated to each member of the Panel by one week prior to the meeting.
- 5.4 Minutes and/or a record of Action Points arising from meetings of the Panel shall be made and circulated to its members.
- 5.5 In the event of the absence of the NNUH Patient Panel Chair from a meeting, the NNUH Patient Panel Vice Chair shall chair the meeting.
- 5.6 In the event of the absence of both the NNUH Patient Panel Chair and Vice Chairs 15 minutes after the appointed start time of the meeting, those present shall elect a Chair for the meeting from those full members present. If the Chair/Vice Chair then arrives they will take over the running of the meeting.

#### **6 DUTIES**

In furtherance of its Purpose, key duties of the Committee/Group are to:

- To gain feedback from patients, carers, relatives and visitors; user groups, support groups and local community groups on significant issues in their area of specialism.
- To maintain an overview of patient and public involvement across NNUH.
- To contribute towards the development of Trust policies and procedures.
- To provide a user perspective in the development of the Trust's service plans.

- To understand and challenge where necessary the plans, procedures and methods of the Trust with a view to assisting, through working in partnership, in the improvement of those plans, procedures and methods.
- To consider patients' and public feedback, including the findings of the Trust's annual patient survey and in-house surveys, highlighting good practice and making recommendations for improving services for patients.
- To develop links with other groups engaged in patient and public involvement across the Integrated Care System (ICS) footprint, regionally and nationally.
- To monitor the Trust's service standards and make recommendations to the Trust Management Team based on experiences, ideas and needs of the patients and the public.
- Oversee work of any reporting groups established from time to time, approving their Terms of Reference and receiving such reports as the Panel considers appropriate.
- Liaise as appropriate with other elements of the Trust's governance and managerial structure, notably Patient Engagement & Experience Group (PEEG) – given its role with regard to patient engagement & experience.
- Prepare a prospective outline annual Work Programme based of members' portfolios and Trust requirements for patient involvement & engagement, making such reports and recommendations to PEEG as are appropriate and required.
- Undertake an annual review of Committee/Group effectiveness and satisfaction of these Terms of Reference.

## **7 REPORTING**

- 7.1 On a monthly basis, an appropriate report shall be made from the Patient Panel by the Chair to PEEG. The Panel shall draw to the attention of the PEEG any issues that require its particular attention or require it to take action.
- 7.2 The Panel shall produce an annual Work Programme for its future work, summarising those items and reports that it expects to consider at forthcoming meetings.
- 7.3 The Patient Engagement & Experience Sub Board reports to the Quality & Safety Committee and its role is to monitor the full range of activities related to improving the patient and carer experience, as part of the governance structure of the organisation.
- 7.4 The Chair of the NNUH Patient Panel (or Vice Chair/nominee in their absence) will be a member of the Patient Engagement & Experience Sub Board and the Quality & Safety Committee.
- 7.5 Patient Engagement & Experience Sub Board will receive a monthly update from the NNUH Patient Panel Chair and will receive the NNUH Patient Panel Annual Report and other reports produced by the Patient Panel.

7.6 NNUH Patient Panel will receive copies of approved Patient Engagement & Experience Sub Board minutes for information.

**8 PROCESS FOR MONITORING EFFECTIVENESS OF THE PATIENT PANEL**

8.1 The Patient Panel will report annually on the outcome of its annual review. This annual report will also include information on the planned work of the Panel in the year ahead.

8.2 The Terms of Reference of the Patient Panel will be reviewed annually by the Panel and any proposed changes submitted to the PEEG for approval.

**9 DECLARATIONS OF INTEREST**

9.1 All members must declare any actual or potential conflicts of interest relevant to the work of the Panel, 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.

Date agreed by the NNUH Patient Panel: 28.05.25

Date for Annual Review: June 2026

Date approved by PEEG: 23/06/25