Our Vision
The best care
for every patient

NHS
Norfolk and Norwich
University Hospitals
NHS Foundation Trust

Annual Report and Accounts




2025/26

Norfolk and Norwich University Hospitals NHS Foundation Trust

Annual Report and Accounts 2025/26

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

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Chair's foreword

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

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

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

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

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

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

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

- Provide care as close to home as is clinically appropriate.

Facing challenges and pursuing improvement

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

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

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

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

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

Acknowledgements and gratitude

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

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

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

partners for their unwavering commitment to the patients and residents of Norfolk and Waveney.

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

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

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

David Roberts, Group Chair

Chief Executive and Executive Managing Director foreword

There's never a quiet time in healthcare and the past year has been characterised as a period of change for our hospitals whilst we continue to live with rising demand for our services and pressure on finances.

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

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

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

At NNUH, we can see how much commitment there is to achieve our vision of providing ***the best care for every patient***. In many cases, we are the only ones in the region providing specialist services and we are nationally recognised for what we do - there is huge potential to build on this.

Addressing long waits for treatment is a real priority and we have to get our performance consistently right so that the excellence shines through. Coming together as the Norfolk and Waveney University Hospitals Group also helps us to tackle shared performance, finance and workforce challenges.

As part of our planning for the next two years, we are looking at how we can adapt for excellence and embrace the 'left shift' of care from acute to community, as part of the national 10 Year Health Plan. This includes putting in place strong neighbourhood health partnerships, focusing on end-of-life care, frailty and long-term conditions. In addition to this, we are keen to strengthen our partnerships with UEA and Norwich Research Park to increase the number of clinical academic posts and ensure all staff groups are engaged and active in research.

Performance

We remain one of the top performing hospitals in the country for treating, transferring or discharging patients within four hours of attending our urgent and emergency care services. This is a truly impressive achievement given that our Emergency Department colleagues continue to experience a year-on-year increase in attendances.

Reducing waiting times - particularly long waits for routine care - have been a focus across the year. Thanks to the efforts of all

our teams, and the assistance of a national elective ‘sprint’ programme, we ended March with 63% of patients receiving treatment within the 18-week waiting time standard. A number of specialties, including Respiratory, ENT and Gastroenterology, also implemented targeted changes to increase activity, improve pathway efficiency, and reduce long waits for patients The elective waiting list has reduced by more than 15,000 during the year, with long waits of over 52 weeks nearly halved.

Cancer performance continues to improve and it is particularly pleasing to see our 28-day cancer Faster Diagnosis Standard being the best it has ever been at 84.2% in February.

At the start of 2026, we welcomed the arrival of two new state-of-the-art surgical robots, funded entirely by gifts in wills and other donations, which has doubled robotic-assisted surgery capacity at NNUH. This £2.8 million investment from the N&N Hospitals Charity is already providing quicker, less invasive surgery and helping thousands of patients recover faster. Robotic technology is improving precision, enabling less-invasive procedures, reducing recovery times for patients and opening the door to exciting future advancements in surgical training, innovation and patient outcomes.

Staff report

Our hospital has seen a lot of change over the last 12 months with new Care Group management structures in place to ensure that decision making is as close as possible to the frontline. We have also been through a voluntary redundancy process to deliver a balanced budget for the year.
This change was reflected in the NHS Staff Survey with more than 4,700 staff taking part during October and November. The results show a decline in scores for 78 of the 111 questions - something we take very seriously as an Executive and Hospital Leadership Team. We also saw a decline in the number of staff recommending NNUH as a place to work and receive care. Plans are already under way to strengthen support for managers, improve communication and implement a framework for safe and sustainable working. Compassionate leadership is vital to our culture, our people and the care we provide, which is why we have identified the need to redesign our leadership development programme to better support line managers and staff at all levels. This includes supporting and developing leaders of the future. It was encouraging to see improved responses around inclusivity and more positive team behaviour, but it was particularly concerning to see such low levels of staff engagement and morale.

Financially, we hit our goal of breaking even at the end of the 2025/26 year, which is a significant achievement, and ended the year with a £4.9m surplus following receipt of bonus deficit support funding during March. For this upcoming financial year, we have a breakeven plan for 2026/27. However, because the 2025/26 position was delivered with considerable non-recurrent mitigations, the 2026/27 plan does require us to find £52.2m of productivity improvements.

Prof Lesley Dwyer, Chief Executive of Norfolk and Waveney University Hospitals Group (NWUHG) and Shane Gordon, Executive Managing Director of the Norfolk and Norwich University Hospitals

Performance Report

2025/2026

Overview of Performance

Welcome to our 2025/26 annual report which describes our achievements during the year, covering our service improvements, finances and performance in key areas.

Purposes and Activities

Our Trust is one of the busiest in the region, with more than 9,000 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.

Our organisation is 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 in Bowthorpe, Central Norwich Eye Clinic, Adelaide Street Pain Management Centre, mobile breast screenings, mobile cancer treatments and Community Midwifery.

We are part of the Norfolk and Waveney University Hospitals Group, linking more closely with the James Paget University Hospital and the Queen Elizabeth Hospital, King's Lynn. The Group Board provides shared strategic leadership and oversight of agreed Joint Functions, while each statutory Trust Board retains its Reserved Functions and statutory accountability.

A priority for us is to work more closely with GP, community and voluntary organisations currently as part of the Norfolk and Suffolk Integrated Care System to provide more hospital care nearer to people's homes.

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.

We run more than 60 specialist services as a tertiary centre, including more than a dozen specialist cancer and radiotherapy treatments, and we are one of the biggest cancer centres in the country.

We provide complex spinal surgery services, specialist Neonatal Intensive Care, neurosciences services and specialist cardiac services. Our Trust runs specialist dermatology, rheumatology, endocrinology, adult congenital heart disease services, treatment of complex liver and pancreatic diseases in adults, cystic fibrosis services and intestinal failure services.

At the Jenny Lind Children's Hospital, we run specialist endocrinology and diabetes services for children, gastroenterology, hepatology and nutritional support, haematology, ophthalmology, orthopaedic, urology, respiratory and rheumatology services.

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 1 May 2008 in accordance with the National Health Service Act 2006.

Key issues and risks

One in four people living in Norfolk and Waveney are aged 65 and over and this group is expected to grow faster than any other group over the next ten years. 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. 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 and priorities is to reduce 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.

These are in addition to our commitment to continuous improvement, driving change and improvement across all aspects of our care.

Performance analysis

Emergency and urgent care

Our Emergency Department (ED) has remained one of the strongest performers nationally across 2025/26, consistently delivering timely emergency care for our patients.

Across the year, performance has remained above the national improvement trajectory, with over 78% of patients admitted, transferred or discharged within four hours. This has been sustained despite rising demand for urgent and emergency care and continued pressure on inpatient capacity. As one of the busiest EDs in the region, treating over 150,000 patients annually, this reflects the significant effort across teams to maintain flow and patient safety.

Performance against 12-hour waits following a decision to admit has also remained largely within the 5% threshold for most of the year. As expected, this position came under pressure during the winter period, driven by increased demand, higher patient acuity, and reduced discharge rates impacting hospital flow.

A number of actions have supported recovery. In particular, the implementation of a revised ambulance handover improvement plan in March 2026, which contributed to a reduction in long waits, with 12-hour delays returning to below 5% by the end of the financial year. This also improved ambulance handover times, with fewer patients waiting over 45 minutes to be transferred into the Emergency Department.

In recognition of sustained improvement, NHS England awarded £2m through its improvement incentive scheme during summer 2025, reflecting progress in our ED performance. During 2025/26, more than 17,000 patients were treated at the Cromer Minor Injuries Unit (MIU), helping to manage demand and ensure patients receive care in the most appropriate setting.

Overall, around four in five patients are now seen within four hours at NNUH. While this remains below the national 95% operational standard, performance is strong relative to comparable large Emergency Departments and demonstrates continued progress in improving patient flow.

Acute Frailty Intervention Service launched

In alignment with the NHS Long Term Plan and to meet increasing demand, we launched the Acute Frailty Hub to provide rapid assessment and early intervention for patients living with frailty, enabling same-day discharge and increasing the number of people returning safely to their homes.

Sharon Wrath, Lead Nurse for Frailty, said: “Previously we had an area called the Older People’s Emergency Department (OPED) and Older People’s Ambulatory Care (OPAC), a three-bedded bay that’s been relocated to the former Discharge Lounge, and the two services are now known as Frailty SDEC.

“Operating across two dedicated areas under the umbrella of the Frailty Hub is Frailty SDEC and the Frailty Unit, formerly known as Loddon Ward.

The Frailty Unit is a 72-hour short-stay ward supported by a dedicated multi-disciplinary team (MDT) with access to front door services to support early discharge.”

Cancer care

Our Trust is one of the largest cancer centres in the UK, seeing more than 6,000 patients each year.

There are three core cancer waiting time standards across the NHS:

- **Faster Diagnosis Standard (28 days):** Patients should receive a confirmed diagnosis or an all-clear within 28 days of an urgent suspected cancer referral. The national target is 80%.
- **31-Day Decision to Treat Standard:** Patients should start treatment within 31 days of the clinical decision to treat. The national target is 96%.
- **62-Day Referral to Treatment Standard:** Patients should begin first definitive treatment within 62 days of an urgent referral (including GP referral, screening, or consultant upgrade). The national target is 75%.

During 2025/26, the Trust has remained below the national standard and national average for cancer waiting times. However, performance has shown clear and sustained improvement over the course of the year. At the start of the financial year, 62-day performance was 53.7%. This improved to 68% by year-end, against an NHS England improvement trajectory of 65%, reflecting focused work to strengthen pathways, increase diagnostic capacity, and improve coordination across services.

Performance against the Faster Diagnosis Standard has also improved, with the Trust achieving its highest ever position of 84.2% in February and exceeding the national standard - a 5% increase from the start of the year.

In recognition of this progress, the Trust was stepped down from a Tier 1 national oversight programme by NHS England.

Patient experience remains a key strength. The most recent Cancer Patient Experience Survey reported a score of 8.9 out of 10, consistent with the previous year and reflecting the high quality of care and support provided to patients.

NNUH doubles robotic surgery capacity thanks to community support

In January 2026, we doubled our robotic-assisted surgery capacity with the arrival of two new da Vinci robots.

The systems were purchased and delivered as part of the Trust's programme to grow its capacity as a leading robotic surgery centre and maintain its position at the forefront of surgical innovation.

The investment forms part of the £3.2m Robotic Surgery grant from the N&N Hospitals Charity – thanks to gifts in wills and donations from the local community.

These new robots double the Trust's current robotic surgery capacity to a total of four surgical robots, meaning NNUH has the joint-most surgical robots on a single site in the East of England.

This advanced technology enables complex procedures to be completed with greater ease, reduces recovery times and minimises the risk of complications. It will also further enhance the surgical education programme with resident doctors gaining access to the latest technologies in theatre.

Waiting lists for routine care

The core NHS standard for elective care is that 92% of patients should start treatment within 18 weeks of referral.

Recognising the scale of recovery required, NHS England set interim targets within the 2025/26 planning guidance: a minimum of 65% of patients to be treated within 18 weeks by March 2026, increasing to 70% by March 2027, with a longer-term ambition to return to the 92% constitutional standard by March 2029.

In addition, a key priority for 2025/26 was to reduce the proportion of patients waiting over 52 weeks for treatment to less than 1% of the total waiting list.

During the year, the Trust has made significant progress in reducing elective waiting times and overall waiting list size. The waiting list reduced from over 86,000 patients at the start of the financial year to just over 67,000 by the end of March - its second lowest level since March 2021.

Performance against the 18-week standard has also improved, with the Trust exceeding a 63% commitment set as part of the national elective recovery 'sprint', focused on increasing activity and accelerating patient pathways.

This progress has been supported by the commitment of clinical and operational teams across the Trust, who have led significant pathway improvements within their own services. During the elective recovery 'sprint', specialties including Respiratory, ENT and Gastroenterology, alongside many others, implemented targeted changes to increase activity, improve pathway efficiency, and reduce long waits for patients.

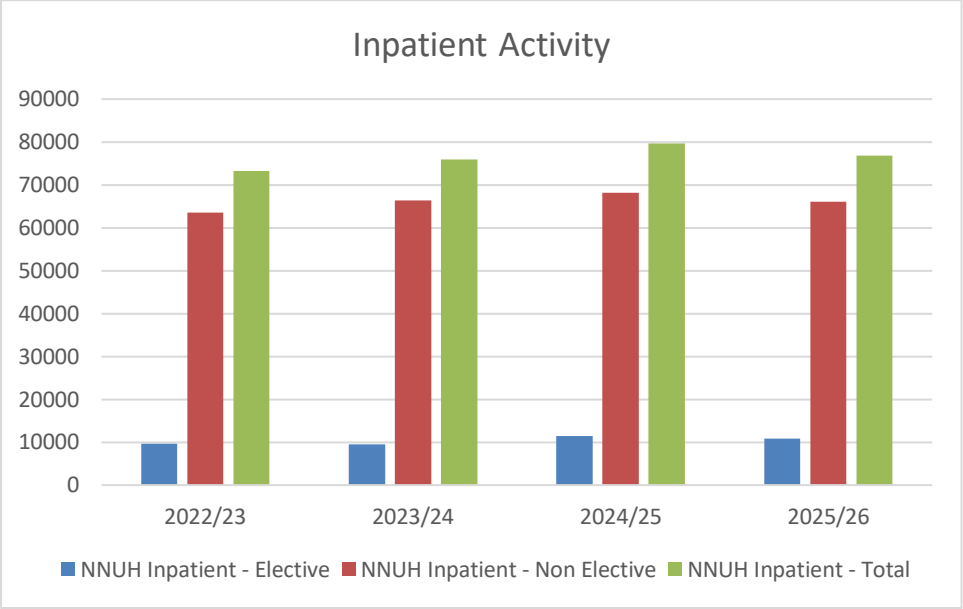
The Trust has also made sustained progress in reducing long waits, supporting a step-down from a national oversight programme by NHS England. This reflects a continued focus on recovery, productivity and pathway transformation to improve timely access to care.

Increasing imaging capacity with our Community Diagnostic Centre

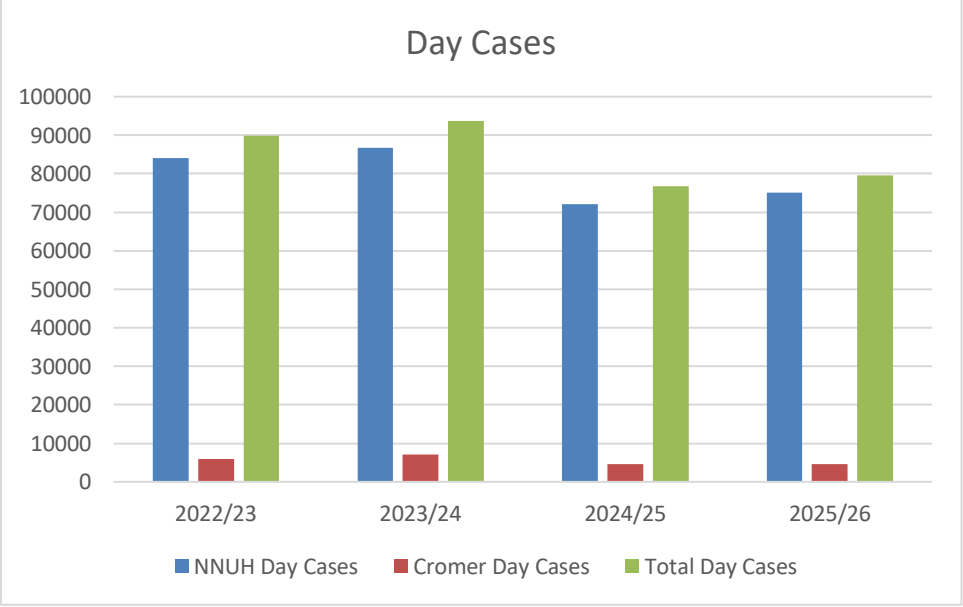
Since opening in February 2025 our Community Diagnostic Centre (CDC) has delivered improved performance across all its imaging services, with measurable improvements in patient flow and reduced diagnostic backlogs.

These gains have contributed to shorter waits for key tests and supported our Trust-wide ambition to provide timely, high-quality care. In the first 11 months of being fully operational the CDC programme offering MRI, CT, General Ultrasound and X-Ray has delivered just over 110,000 exams, with particularly high performances and improvements in CT and MRI. The centre is expected to record completion of 120,000 exams in the full year, with particularly high turnaround and time improvements in CT and MRI.

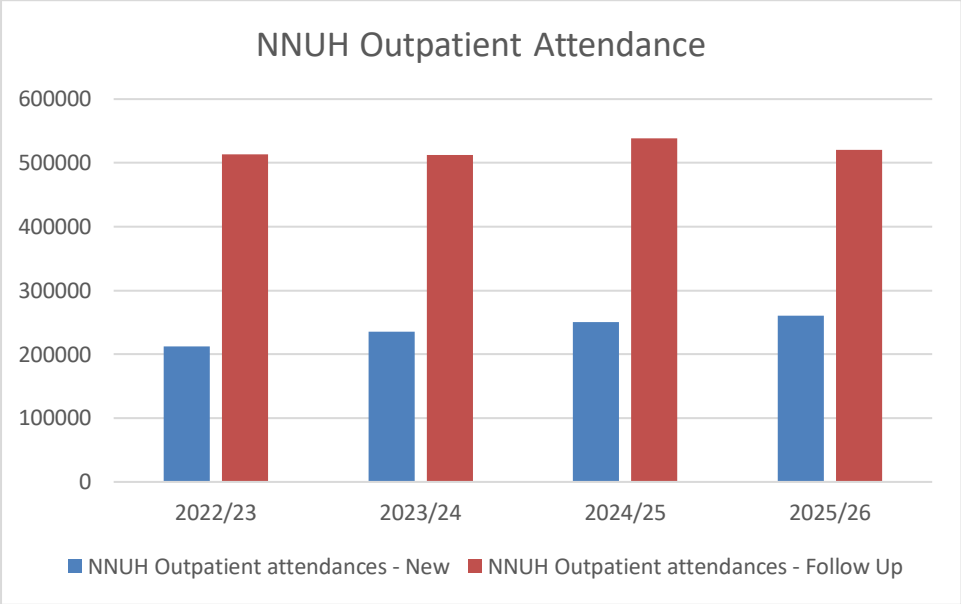
Seshni Mohammed, our Imaging Services Manager, said:
"Thanks to the resilience, adaptability and professionalism of our teams, the CDC is now a well-established diagnostic service. So a huge thank you to all colleagues—clinical, administrative, operational, governance, estates, digital and support teams—who have contributed to the CDC's success. Your commitment has ensured patients receive high-quality, timely diagnostics in a modern and welcoming environment."

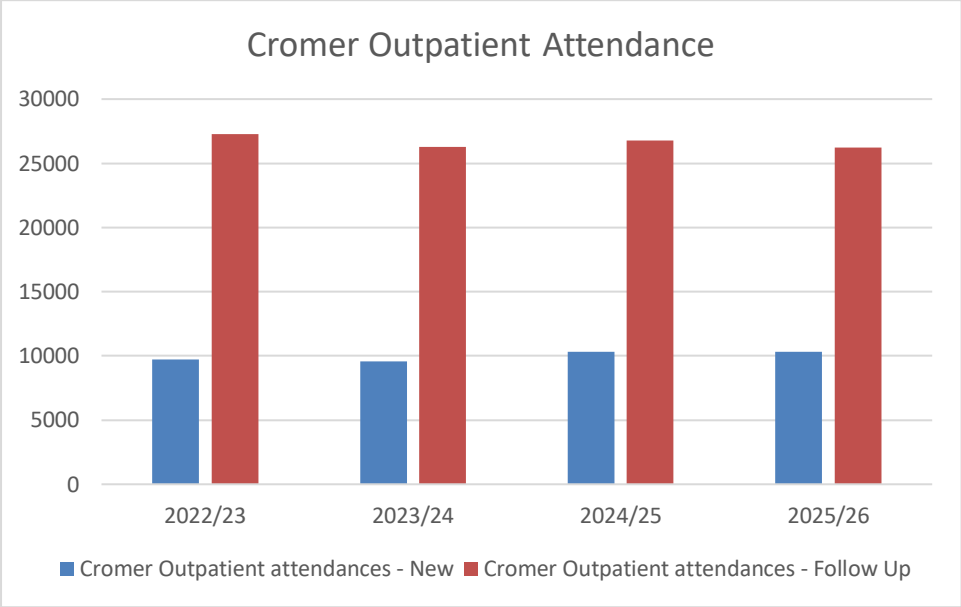


In 2025/26, we treated 10,785 patients who had planned procedures that required a hospital admission and 66,118 emergencies (also known as non-elective). A further 79,651 patients received treatment as day cases, 4,609 of which took place at Cromer and District Hospital.

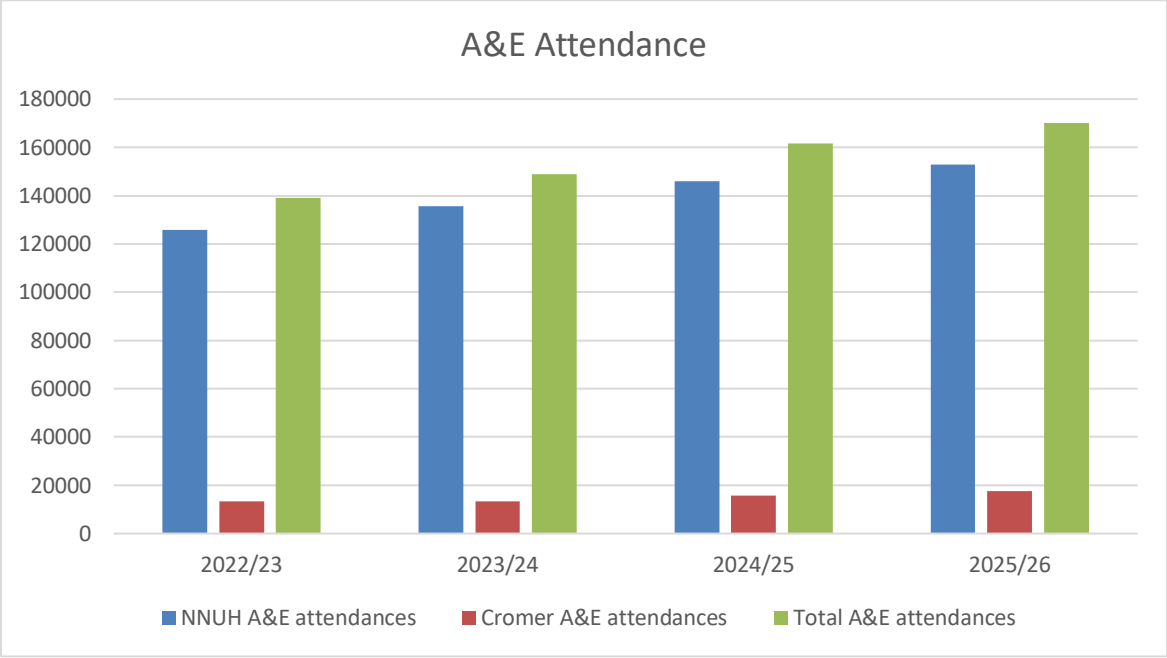


There was a total of 781,041 out-patient attendances in 2025/26 at the Norfolk and Norwich University Hospital and 36,538 out-patient attendances at Cromer and District Hospital during the year.





Demand for urgent and emergency care services continued to rise with 170,209 attendances at the Norfolk and Norwich University Hospital's Emergency Department and at Cromer Minor Injuries Unit.



How we measure performance

During 2025, we transformed how we run services moving away from four divisions to 10 Care Groups.

This new structure began on 6 May 2025 to reduce bureaucracy and ensures that decision-making is as close as possible to patients and frontline care. The new structure reduces the levels of leadership or management between the group executive and patients. Each care group is led by a multi-disciplinary team with clinical and operational leadership, in most cases a triumvirate of medical, nursing and operational leads, who are responsible for their own services and budgets and manage their own risks within a clear framework and authorising environment.

The Care Group leads report to the Hospital Leadership Team and are part of the Hospital Management Group responsible for the operation and performance of the Trust, reporting to the Trust Board.

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 and Hospital Management Group.

Key themes are shared with staff following HMG meetings with staff on the intranet and in monthly briefing sessions. 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.

KPIs, Risk and Uncertainty

The Trust has a Risk Management Policy 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.

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 Executive Risk Assurance Group and the Hospital Management Group,

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

For more information, see the Directors' section on page 43.

Care Quality Commission (CQC) ratings

In 2025, we received two inspections from the Care Quality Commission (CQC) to our Radiotherapy and Nuclear Medicine departments as part of the Ionising Radiation (Medical Exposure) Regulations in England.

The CQC found good levels of compliance across all aspects of Nuclear Medicine and identified some areas for improvement in Radiotherapy.

The Trust's CQC ratings remain unchanged – overall we are rated as "Requires improvement" following an inspection published in August 2024. We are "Good" for "Caring" and "Effective" and remain "Require Improvement" for "Well led", "Safe" and "Responsive".

Martha's Rule launched across all areas of the hospital

In March, Martha's Rule was launched across all services, including departments looking after children and babies.

This follows a successful pilot involving adult in-patient areas. Martha's Rule ensures patients and their loved ones have opportunities to regularly communicate about their condition, and the ability to seek support if they are concerned. It is a vital way of helping improve patient safety.

The rule introduces three key components:

- Patients are asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information is acted on in a structured way.
- All staff can, at any time, ask for a review from a different team if they feel a patient is deteriorating, and they are not being responded to.
- Escalation routes are available to patients themselves, their families and carers and advertised across the hospital.

Group Governance Framework and Operating Model

During 2025/26, Norfolk and Norwich University Hospitals NHS Foundation Trust worked with James Paget University Hospitals NHS Foundation Trust and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust to establish the Norfolk and Waveney University Hospitals Group.

The Group model is not a merger. Each Trust remains a sovereign NHS Foundation Trust with its own Board of Directors, Constitution, Council of Governors, provider licence, Annual Report and Accounts, and Accounting Officer responsibilities. Shared strategic leadership is provided through the General Purpose Joint Committee, known as the Group Board, which exercises agreed Joint Functions under the Provider Collaboration Agreement.

Each Trust Board retains its Reserved Functions and remains accountable for its statutory duties, including approval of the Annual Report and Accounts, constitutional matters, significant transactions, provider licence compliance, risk and internal control, and the quality, performance, and sustainability of services provided by the Trust.

At hospital level, operational management is exercised through the Hospital Management Group, chaired by the Executive Managing Director. The Hospital Management Group is supported by specialist management groups for quality, finance and performance, and people and culture. These are management arrangements, not Board committees.

Further information on the Trust's governance arrangements during 2025/26 is set out in the Directors' Report.

Tackling inequalities

Health inequalities are systemic, unfair and avoidable differences in health across the population, and between different groups within society. Differences in health outcomes may be influenced by many factors, or a combination of factors. These factors may be fixed (for example heritage, other protected characteristics), or unfixed (homelessness, current smoker, prisoner).

In common with the rest of the NHS, our hospital trust is focusing on the national Core20 Plus 5 approach that identifies five key clinical areas requiring accelerated improvement.

Across Norfolk and Suffolk, the Core20plus priority groups focus on deprivation, ethnicity, coastal and rural communities and inclusion health groups (e.g. people experiencing homelessness, Gypsy, Roma and Traveller communities, asylum seekers).

This is important with 42 communities in Norfolk 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.

Local improvements to our services

Within the last year, we have undertaken a review of our **Accessible Information Standards** (AIS). This ensures people with disabilities, impairments, or sensory loss receive information in accessible formats. This has also included a local survey, education, and promotion of resources available in the Trust.

We have introduced and rolled out an **Interpreter on Wheels** service which helps ensure patients who require translation services can receive and communicate effectively. The Interpreter on Wheels offers over 240 foreign languages 24/7 and British Sign Language 8-5 Monday - Friday.

Our **Complex Health Hub** 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

We are also 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.

During the year our community engagement activities, primarily led by our Patient Engagement and Experience Team, have continued to focus on seeking out the views from our local communities especially those who are under-represented.

Governance

Our medical directorate and Chief Operating Officer team lead the work on addressing inequalities. We have a corporate strategy - Caring with PRIDE – which includes actions to address inequalities and we have a joint Health Inequalities and Equality, Diversity and Inclusion Group which leads on our strategic direction.

Roald Dahl Clinical Nurse Specialist supporting children with complex conditions

Our Jenny Lind Children's Hospital welcomed our first Roald Dahl Clinical Nurse Specialist role to provide additional support to children with serious and complex conditions.

Kerry Hall joined the team to help coordinate care, reduce hospital admissions and ensure children and their families receive the right support at the right time.

Kerry said: "I applied for this role because of my passion for working with children with complex medical needs. I love watching them thrive despite all the challenges and ups and downs they encounter. Many children on my caseload have repeated attendances and admissions, with lots of professionals involved, so being able to step back and advocate for the child as a whole person and the family as a unit is such a privilege. Their courage and resilience is what inspires me, and anything I can do to lighten their load I'm happy to do, whether that's chasing referrals, phoning for updates or doing a home visit.

"My role encompasses a real variety of things: admission and discharge planning, home visits, practice improvement, guideline creation, health passports and care plans, support for families, signposting and referrals, organising MDTs and phone check-ins. I work closely with our Lead Transition Nurse and other teams like the children's community nursing team and East Anglian Children's Hospice symptom management."

Work with carers

As part of our work on inequalities, a range of support is offered to carers within our hospitals who can sometimes neglect their own health in order to care for others. We aim to support carers in a range of ways:

- Carer beds so family member/s can stay overnight in the same room as their loved one
- Carer packs providing essential items to make a carer's stay easier such as shower gel, toothbrush/ paste, flannels, deodorant, tissues
- Butterfly Volunteers who offer companionship/respite to the patient/carer
- Open visiting so family can visit when they want and stay as long or as little as they want
- If one family member is staying, refreshments can be offered to them by the bedside
- Written information about what to expect as their loved one reaches the end of life
- Carer's passport which supports free parking and discounts on meals in the main canteen
- Memory boxes
- The Spiritual Healthcare team also offer bereavement support
- Carer's information leaflet.

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.

Anti-bribery legislation

The whole of the NHS, including our Trust, is committed to providing a transparent view of how taxpayers' money is spent.

Managing Conflicts of Interest in the NHS came into effect in 2017, which introduced 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 recognise 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:

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 2025/26.

Social and Community Report

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 several 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 in 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 27 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 2025 and worked with the Spiritual Healthcare Team to organise a Commemoration Ceremony for the 80th Anniversary of VE Day and a Remembrance Service in November that was attended by over 500 NNUH staff, patients and visitors. Our Family Liaison Practice Facilitator has been supporting a variety of projects which helps to improve our patients and families' experiences, working on projects related to improving communication, customer service and supporting open visiting at the trust.

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

What the Patient Panel does

- Work on behalf of all patients, carers, relatives and visitors 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. 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 several committees, working and project groups including the Patient Engagement & Experience Group, Mental Health and Complex Care Board, Dementia Strategy Group, Health Inequalities Group and Infection Control Committee as well as supporting the production of appropriate patient information via the Patient Information Forum.

In 2026/27 we are looking to recruit more patient panel members to join the team, so we can work more closely with the care groups and collaborate in co-designing services. If you are a member of the public and would be interested in joining the patient panel, please contact cherry.king@nnuh.nhs.uk and we can share the process of applying to be a patient panel member with you.

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 has 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.

The forum has fed back to departments regarding improvements needed to hospital appointment letters, particularly around access needs prior to attending. A particular focus has been with our Emergency

Department, their admission plans and whether carers or the cared for person is present. This led to work this year on carers training across the hospital, starting with the Emergency Department. The Forum support work which is ongoing across the hospital and were recently consulted on the development of the Easy Read version of the Visitors Charter which has now been approved for use.

In June 2025, during Carers Week we organised a successful Coffee for Carers event. The NNUH Carers Forum worked together with Priscilla Bacon Lodge, Carer charities and other teams such as the Dementia Support Team and the Palliative Care team to arrange supporting and signposting organisations to speak to Carers about their rights and what support is available to unpaid Carers and Cared for people.

Military Community Working Group

The Military Community Working Group (MCWG) has been set up 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. Awareness training has been initiated using the NHS Armed Forces Training and Education Programme (NTEP). This has been rolled out to leadership groups via AND meetings in Dec 2025 and Feb 2026 with more sessions planned between February and June 2026. So far, we have 16 members of staff trained on Module 1 (introductory module) and 7 trained on the Leadership module 2. This is great progress and an area we will continue to focus on.

The group collaborated with Spiritual Healthcare and the charities team to coordinate poignant and well attended events for the 80th Anniversary of VE Day, Remembrance and other significant calendar dates. This included onsite events with music and readings and online coverage hosted by Hospital Radio. Dignitaries, Reservists and Veterans attended in uniform and wreaths were laid.

The identification of veterans has been improved by the more consistent approach to the use of PAS flags, and several Veterans and their families have been supported directly through our Veteran Champions visiting on wards and preparing patients for operations. Awareness campaign ‘ASK’ was launched November 2025 with screensavers across the Trust reminding staff to ‘ask the question’ to find out if a patient has served and may be experiencing barriers within their healthcare. Care groups have been encouraged to introduce a Veteran Champion for more hands-on signposting opportunities and to avoid a ‘single point of failure’ which has seen a vast majority of Armed forces related enquiries referred to the Patient Experience Team. The question is now asked of Volunteers, and they are informed of the Military Community Working Group in case this is something of interest.

Maternity and Neonatal Voices Partnership (MNVP)

The MNVP has continued to put the voices of parents and families at the heart of maternity and neonatal care. Changes within NNUH and Local Maternity and Neonatal System (LMNS) programme team inevitably slowed the progress of some project this year, including work around information sharing and informed consent with students.

The loss of our dedicated Community Engagement lead in April and our Neonatal Lead in the summer has also reduced our capacity for attending events, reaching specific communities and recruiting volunteers. Not currently being able to recruit to the vacant roles in the MNVP team is going to limit progress in 2026. However, three outreach volunteers regularly attend baby groups each month, helping to raise awareness of the MNVP and gather valuable feedback from parents.

There has been encouraging progress in strengthening neonatal voices within NICU. Monthly “cake and chat” sessions for parents, co-produced patient information leaflets, and service-wide actions taken in response to feedback have all supported more parent-centred care.

A particularly positive step has been the development of a new standard operating procedure to support joint working between the Neonatal Intensive Care Unit (NICU) and the Children’s Wards teams, helping to ensure parents feel informed and supported when babies are being prepared to transfer. The NICU families feedback regarding communication has made a great impact. Families spoke to us about not feeling fully informed or prepared for all eventualities. The Family Care Team and NICU ward manager worked together to embed this service user perspective in training updates.

The MNVP has instigated collaboration between the NICU and Postnatal Ward to improve the experience of care for women and birthing people having a baby on the unit.

In maternity the focus has been on accessible communication to support informed decision making, building on a decision making for pregnancy and birth poster, staff training, Recite Me accessibility toolbar on NNUH website and a full review and revamp of NNUH maternity website content to ensure the full maternity journey is covered and information is accessible. We have developed video content for key topics e.g. induction of labour and discharge from the postnatal ward. There has also been a relaunch of the NNUH Maternity Facebook and Instagram accounts with a comprehensive schedule of content. We launched the Place of Birth patient information leaflet to give balanced representation of all birthplace options to support informed choice. There has been an improvement in joining up working with the MNVP and key staff members through a refreshed Maternity Governance meeting. This has been important for having oversight of audits, risk logs which is helping to triangulate feedback themes and prioritise MNVP lead time.

Youth Forum

The Norfolk and Norwich University Hospital (NNUH) 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 2025:

- **15 steps outpatient walk arounds**: the Youth Forum carried out walk arounds of Outpatient areas that see Children and young people outside of the JLCH footprint. This was to review the accessibility of these areas for children and young people and make any recommendations for

improvements. The Youth Forum also supported with creating resources in line with these recommendations.

- **Environmental Arts**: the Youth Forum also supported with the redecoration of the Children's Emergency Department (CHED). There was a particular focus for the YF's support with the quiet room which is an area to meet the needs of young people attending who have mental health, learning or sensory needs.
- **Hear My Voice Campaign**: The YF worked with the Transition Lead Practitioner on a campaign called Hear My Voice. This is a project aimed at Young People from 13 years old to involve them more in the shared decision making regarding their health and treatment plans. The YF have co-produced resources aimed at equipping both patients and health professionals with the tools and skills to maximise meaningful involvement in Health decisions. A Youth Forum member also presented this work at World Patient Safety Day.
- **Media Collaboration**: Youth Forum members have been interviewed on Future Radio. They talked about the work of the Youth Forum and how to join the YF.
- **Adolescent room re-design**: this is an on-going project that was delayed due to the CHED redecoration but the YF are keen to continue with this this year.
- **Board of Governors:** The YF members met with some members of the Board of Governors to talk about the role of a Governor and how the YF can be represented at Board meetings. This is an on-going project to strengthen the links.

Planned Initiatives for 2026:

- **Interview Panel**: The YF will begin to join the interview panels for recruiting new Paediatric members of staff. We will trial this when recruiting this years Newly Qualified Nurses.
- **Mandatory Training:** The YF will be producing a session for this year's Paediatric teams mandatory training. This will be focused around adolescent health needs, adolescent development and accessible communication including the Hear My Voice Campaign.
- **Outpatient walk arounds:** the YF will continue to carry out 15 step challenges in outpatient areas and would like to extend to clinical/inpatient areas.
- **Recruitment:** One of the big areas of focus for this year will be on recruitment of new members to the YF, including further radio appearances and advertising via posters and social media.

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

In December 2025 we ended our contract with our survey provider Envoy. The new Civica system and the comment analysis function will enable a much deeper dive into the data, thematics and complete breakdown of feedback gathered. Providing an opportunity for improved learning and understanding of our service users' experiences across the Trust. There are multiple routes to collecting feedback including SMS text messages, QR Codes, postcards, links on our websites and volunteers who play a crucial role in collecting feedback on wards and via post-discharge phone calls.

The process to move to Civica has been supported by the old provider Envoy, the new Civica team and the NNUH data team being operational and functioning for the care groups to access patient experience information. Work to include corporate services, other departments and training for teams or individual staff on navigating and using the systems full capabilities is ongoing.

The Patient Experience Team have delivered all the newly created posters with the Civica QR codes and links attached to all departments within the Trust. These are now displayed and visible in areas for patients, families, carers and visitors to utilise.

Since going live with Civica in January we have already had 5918 responses with 91% being positive. We received 85 compliments with the recurring theme being 'Support provided by staff', 'Attitude of staff' and the 'Care received'. The number of responses will increase as more awareness of the new system and improvements on the gathering of feedback is developed.

Feedback collected from FFT has been used by our Care Group leaders to understand how our patients feel about their experiences and how we can make positive improvements from their experiences, following a quality improvement methodology and test changes to our approach based on feedback from both staff, patients, families, carers and visitors.

Healthwatch Norfolk

Visits from Healthwatch Norfolk continued in several areas within the hospital. In 2025 Healthwatch Norfolk visited the West Atrium area, The Therapy Outpatients Department, The Community Diagnostics Centre and The Frailty Unit. 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 Project Team completed an independent review for the ICB of the Norfolk & Waveney Maternity and Neonatal Voices Partnership (MNVP) that

included input from NNUH. The team also visited our Discharge lounge to speak to staff, patients and Carers for a research project on Adult Social Care for over-65s.

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

Our work within the hospital 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 Children and Young Persons Mental Health, Frailty with a focus on digital access and Community language translation and interpretation.

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 1284 times across the hospital for over 406 hours and we've accessed 33 different languages. We collaborated with Patient Safety, Medical Illustrations and Communications to create a video for use with staff and patients about the IOWs and how to use them.

We worked with the NICU team to record a patient story about a Sudanese woman who used the Interpreter on Wheels devices to stay informed about her baby's health and progress. We've shared that story with the Quality & Safety Committee.

We continue to receive positive feedback about the IOWs from NNUH staff members:

***"I have used the IoW for the past several months in Antenatal clinic and have found it effortless to use. I have found the audio quality better than using the telephone and it is easier to position the IoW so that we can all hear the conversation. It is very easy to use and set up and the additional option of using video call also adds to the patient experience."* ~ Obstetric Registrar**

Cromer Hospital Receiving their Interpreter on Wheels

Patient Advice and Liaison Service (PALS) and Complaints

The PALS team are central to providing confidential, on the spot advice and support to patients and families raising concerns, helping to resolve concerns promptly and at the earliest opportunity, de-escalating complaints wherever possible. Where this hasn't been possible, they will assist patients and families if they wish to make a formal complaint. The Complaints team support the investigation of concerns relating to treatment and care, aiming to provide explanations and apologies in a formal written response and identify service improvements.

In this last year we have undertaken a review of the PALS and Complaints team, in response to a need to improve the accessibility and responsiveness of services. The review saw the separation of the teams, with distinct leadership and support to focus on delivery of each service.

Within the PALS service there has been a focus on improved availability, visibility and presence, which have led to enhanced service user experience and relationships across the Trust. The service is now supporting 'here and now' concerns, helping to support those who raise concerns about their care whilst inpatients. There has been an increase in ward visits to support patients and ward staff, with improved patient experience and engagement. The team have over 1,300 contacts per month with people accessing the service, through email, phone call or drop in that may require signposting, escalation or mediation between staff and patients to achieve early resolution. The service is helping to de-escalate concerns by engaging early and increasing accessibility, with an observed reduction in formal complaints.

Our work within the Complaints service has concentrated on enhanced management and support of our complaints officers to provide professional, high-quality responses and case management. Following this review, we now have dedicated, specialist management of complaints with an over-arching senior leadership, enhancing leadership and management for better team morale, engagement and experience.

The review and investment into these teams are beginning to demonstrate improvements in the activity and performance of both teams, with an overall improvement in patient and family experience.

Our current complaints process has undergone a significant review, with a shift in the approaches taken to support patients and families to receive timely responses to their concerns. From April 2026, the team have been set the challenge to overhaul the complaints process, the vision being to create a single consistent approach to the management of complaints, ensuring equity of access to patients and their representatives who use our services and have concerns or wish to raise a complaint.

The new process will see improved collaboration with care groups, to facilitate and support a timely response to complaints. There will be an opportunity within the new process to resolve a complaint at the earliest opportunity through telephone and face to face communication which will enhance the engagement with patients and families, resulting in an improved patient experience. It will also enable the trust to learn from their complaints and these lessons will inform future service development and improvement.

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.

A team of volunteers carry out audits and surveys on wards gathering patient experience which can help drive improvements and shape our future services. They also collect card surveys from our outpatient clinics and conduct telephone surveys with patients the day after discharge.

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 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:

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.

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.

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.

Outpatient Reception and Bleep Buddy Volunteers

Volunteers play a key role in supporting our busy outpatient receptions, assisting patients and visitors with wayfinding, providing information, and validating car parking. *Meet and Greet Volunteers* work alongside reception teams to escort patients to appointments, locate and push wheelchairs, and offer a welcoming presence throughout the outpatient areas.

Our *Bleep Buddy Volunteers* carry hospital DECT phones and can be contacted by staff across the hospital to respond to a variety of ad hoc requests. This may include escorting patients, collecting patient notes, delivering medications from the pharmacy, or providing support with basic administrative tasks. These volunteers help ensure smooth daily operations while enhancing patient experience and supporting clinical teams.

Sustainability: 2025/26 Delivery

Greening with PRIDE

Our updated Green Plan: Green with Pride, was adopted by our Trust Board on 2 April 2025. 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 Care Groups and Corporate 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 Focused leadership: support their staff and leaders to learn, innovate and embed sustainability into everyday actions through communication and engagement to engender and support empowerment and transformation.

Net Zero Clinical Transformation: focus on carbon hotspots and service improvements, reducing waste and single use consumables/equipment where practicable through being more informed and responsible consumers.

Medicine: review Medication usage and waste, to identify high carbon areas and alternatives identified/ implemented wherever feasible. Together, NNUH will review Medication usage and waste, to identify high carbon areas and alternatives identified/implemented wherever feasible - i.e. low carbon inhalers where appropriate.

Food and Nutrition: work with Serco to deliver the National standards for healthcare food and drink: high-quality, healthy and sustainable (by default) food and minimised waste.

Digital Enablement: improve access, quality and productivity through digital enablement. It will prioritise sustainability in both procurement design and the management of services.

Making our Infrastructure Count: use technology to reduce its energy consumption, preparing for electrification/other decarbonisation in the future.

Adaptation: develop a Climate Change Adaptation Strategy that includes longer term planning for business continuity. Together, NNUH will develop a Climate Change Adaptation (and Resilience) Strategy that includes longer term planning for business continuity and monitoring of overheating and flooding incidences.

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 more sustainable procurement processes to ensure full lifecycle consideration and monitoring with its contracts and its engagement with NHS Supply Chain.

Making it Happen: work towards having the right oversight and resources in place to support the wider embedment of Green Plan principles. This will include the development of an 'invest to save' mechanism in time.

Our Story so far:

Clinical Inductions: sustainability now features in all clinical inductions including the summer Resident Doctor intake.

Staff Awards: the Special Award For Sustainability was won by Therapies in 2025 for their walking aid recycling scheme with a commendation for Endoscopy for their tireless commitment to sustainability over a number of years.

Norfolk and Waveney University Hospitals Group: NNUH continues to work closely with its Norfolk and Waveney Hospitals Group colleagues in driving forward the sustainability agenda with both the James Paget and Queen Elizabeth Hospitals each having a standing invitation to the Trust's Sustainability Management Meeting.

Centre for Sustainable Healthcare Green Nursing Team competition: NNUH's Maternity and Gastroenterology teams won the national Green Nursing Challenge, run by the Centre for Sustainable Healthcare, for their pioneering combined Inflammatory Bowel Disease (IBD) and Maternity Clinic.

Led by Phillipa Noble, Lead Maternal Medicine Midwife, Heather Simpson, IBD Specialist Nurse, Miss Beth Laverick, Obstetric Consultant, and Dr Alvin Ochieng, Gastroenterology Consultant, the new clinic brings together nursing, midwifery, obstetric and gastroenterology specialists in one streamlined Multidisciplinary Team (MDT) clinic. The aim: a simpler, more timely and supportive pregnancy journey for women with complex Inflammatory Bowel Disease (IBD) needs.

Implementing a multidisciplinary care approach has improved clinical outcomes and patient experience, with women feeling more supported, informed and less travel burden and challenge of balancing often complex life demands amongst a complex pregnancy. The greatest impact is seen among women facing health inequalities and additional social or psychological challenges, ensuring more equitable and integrated support.

Centre for Sustainable Healthcare Green Team competition: NNUH, funded by the Hospital's Charity, held a successful Green Team competition in partnership with the Centre for Sustainable Healthcare.

Radiology developed a one stop shop that optimised patient travel for paediatric patients who had both ultrasound and nuclear medicine appointments. The Trust's Emergency Department's (ED) nursing team looked at the benefits of push administration over IV with respect to sepsis treatment. Norfolk and Norwich's Recognise and Respond team highlighted the benefits of ongoing therapy support after discharge from the Critical Care Unit in terms of length of stay. Hand surgery took a whole patient pathway approach looking at 'rub not scrub', visors, sterile pack rationalisation, reusable gowns and hats, To Take Out medications (TTOs) and patient hydration. Pathology identified a single use plastic used in specimen transport they wanted to substitute for a reusable solution subject to contractual discussions while

Anaesthetics looked at reusable solutions to arm positioning and extubation support for patients during surgery. The combined projects had projected annual savings of £480,000 and 109 tonnes of CO2e.

ED were highly commended while Hand Surgery won the competition because of their full patient experience focus.

Public Sector Decarbonisation Scheme: NNUH, with support from the Carbon Energy Fund, applied for and was successful in securing £8,944,984 from the Department of Energy and Net Zero's Public Sector Decarbonisation Scheme. The funding, which needs to be matched by NNUH's capital programme to the value of £1,219,771, will be used to deliver a heat pump onsite by March 2028, saving the Trust 2,900 tonnes CO2e per annum.

Solar panels: further to the aforementioned scheme, the Trust provided an additional £110,000 for solar panels during 2025/26.

Theatre ventilation shutdown: further to a successful trial in 2023/24 the Trust secured £113,000 from the NHS Energy Efficiency Fund to deliver Building Management System (BMS) upgrades in support of rolling out the project to all laminar flow theatres subject to ongoing Surgical Site Infection surveillance.

Waste: paper towels are now recycled by our PFI's Facilities Management provider and Bio-bins, an alternative to plastic pots, are now being used for the disposal of placentas.

Sustainability: Taskforce on Climate-related Financial Disclosures NHS England's NHS foundation trust annual reporting manual adopted a phased approach to incorporate the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures are as interpreted and adapted for the public sector by HM Treasury. 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.

These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

Governance

The Trust receives quarterly updates via its Finance and Performance Management Group reports that monitor progress against goals and targets for addressing climate related issues specifically in relation to the Green Plan. Our Care Groups, will in time, take some responsibility with regard to sustainability management but given their relatively new status this has been difficult to achieve to date.

Broader organisational plans and performance monitoring with respect to sustainability will be reviewed once the Norfolk and Waveney Hospitals Group governance has been established.

A member of the Hospital Leadership Team is assigned as Senior Responsible Officer and has formed a Sustainability Management Meeting 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 Leadership Team as appropriate/required.

In response to NHS England's increased 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.

Strategy

The actual and material impact of climate related risk and opportunities on the organisation's operations, strategy and financial planning is an area that NNUH is always looking to consider further. In terms of the risk and opportunities that have been developed over the short, medium and long term the organisation has its Green Plan as its guiding principal document for change.

In terms of the impact on Operations, the Trust recognises the relevance of the warming world and how this affects our staff, visitors and patients as well as our Estate and digital infrastructure. As such these are both identified in our sustainability risk register and reviewed regularly, in line with their impact, likelihood and control effectiveness. The Trust's Emergency Preparedness, Resilience and Response team considers heatwave and flooding risk to the organisation and has already considered heat impact on pharmaceuticals, theatre operations, Health and Safety/security and Infection, Prevention and Control in particular.

When it comes to Clinical Strategy, the Trust, with its Norfolk and Waveney Hospital Group Partners does look at trends around changing patterns in intensity, treatment and behaviours but recognises that climate driven adjustments might need to be embedded more in future work as materiality increases.

Financial planning this year has looked at the longer-term trends regarding carbon fines and offset them against the increased revenue costs of heat decarbonisation. This financial risk is regularly reviewed given the impact and likelihood, with control effectiveness which is currently rated at 3 given our progressing heat decarbonisation project.

In a 2C warming world scenario those areas that support operations, strategy and financial planning i.e. products and services delivered, supply chain and value chain, adaptation and mitigation activities, investment in R&D and access to capital / funding will likely be affected, with the effects increasing over time. The Trust will continue to work with our Partners including NHS Supply Chain to mitigate any effects through the Adaptation Plan identified in the Green Plan. While in the first instance this work will involve the Climate Change Risk Assessment, in time the work will be extended to cover all these elements to ensure the value chain is managed throughout our operations, strategy and financial planning.

For the avoidance of doubt, the materiality of these challenges will increase over time and will be monitored regularly by our Sustainability Management Meeting.

Risk management

The Sustainability Management Meeting identifies and assesses climate-related risks and escalates within the organisation as appropriate. The Trust recognises that this requires careful consideration of future performance and delivery, particularly with respect to operations, strategy and financial planning.

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 progressing the decarbonisation of heat project mentioned previously.

Risks are escalated by Sustainability Management Meeting to Finance and Performance Management Group and Hospital Leadership Team thereafter, 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 and will be reported annually. The metric around fossil fuel consumption is related to our key risk specifically and is being addressed via a Phase 4 Public Decarbonisation Scheme project to be delivered by March 2028.

Focus area	Metric	Data
Workforce	Named board-level lead for Green Plan	None
Medicines	N2O volume and emissions	Data not received
	Entonox volume and emissions	Data not received
Travel and transport	% 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?	Yes
	Does the organisation operate sustainable travel-related schemes for staff?	Yes
Estates and facilities	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	47.3% on Mainsite (Feb) 100% at main offsites
	% of sites with a heat decarbonisation plan	Mainsite only
Supply chain and procurement	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
Food and nutrition	Weight of food waste: spoilage, production, unserved and plate waste	Totals measured for patient meals
Adaptation	Number of overheating occurrences triggering a risk assessment (in line with “heatwave” plan)	2 incidences recorded
	Number of flood occurrences triggering a risk assessment	0

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 surplus of £4.9m was achieved as a result of £4.9m of bonus Deficit Support Funding that was provided from NHS England.

Thus, the reported financial position for the full year was a surplus of £4.9m compared to a breakeven plan. Excluding the bonus Deficit Support Funding the Trust delivered a breakeven position.

Financial Improvement

Throughout the financial year, the Trust has been active in developing efficiency plans. For the year ended 31 March 2026, £43.7m of efficiency savings were delivered against a plan of £43.7m. There has been a focus on capacity planning and productivity improvements to deliver financial improvement in tandem with activity recovery. 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 £96.4m.

Capital Expenditure

The Trust invested £55.9m in new and replacement capital assets (excluding leases) during the year (2024-25: £70.6m). The most notable investments were:

- Electronic Patient Record – £12.5m
- Clinical Equipment Replacement – £23.4m
- Capital Maintenance – £8.3m
- New build works – £7.0m

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 2025/26, the Trust benefitted from £2.2m of charitably donated assets (2024/25: £4.7m). The Trust is truly grateful to everyone who has donated to the N&N Charity to make this possible.

Operational Future

During 2025/26 the Trust has worked as part of the Norfolk and Waveney University Hospitals Group to develop a Group-wide medium-term plan to better meet the needs of our patients over the next five years.

Focus for the next two years will be on recovering and stabilising operational performance in elective, cancer, and urgent and emergency care pathways, improving productivity and achieving financial sustainability. This will create the right conditions for transformational improvement to support wider system ambitions to improve population outcomes, shift care out of acute settings into our communities and to deliver truly integrated, value-based models of care by 2031**.**

Efficiency schemes for 2026/27 include theatre and outpatient productivity, inpatient length of stay, neighbourhood health and left shift, and procurement and contract management changes.

NHS England has set out a financial framework that supports multi-year planning across 2026/27 to 2028/29, providing clarity over funding arrangements and commissioner allocations to support the Trust and system partners to deliver these priorities. The Trust has submitted a breakeven plan for 2026/27.

Financial Accounts 2025/26

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

Better Payment Practice Code - measure of compliance

	Year ended 31 March 2026		Year ended 31 March 2025	
	Number	**£'000**	**Number**	**£'000**
Total Non-NHS trade invoices paid in the year	120,814	472,889	142,496	487,783
Total Non-NHS trade invoices paid within target	114,304	447,357	133,206	463,292
Percentage of Non-NHS trade invoices paid within target	95%	95%	94%	95%
Total NHS trade invoices paid in the year	2,863	59,685	2,858	54,913
Total NHS trade invoices paid within target	2,683	58,324	2,589	51,517
Percentage of NHS trade invoices paid within Target	94%	98%	91%	94%

Interest paid under the Late Payment of Commercial Debts (Interest) Act 1998
Disclosures relating to any interest paid can be found in note 11 to the accounts.

Approval of the Performance Report

I confirm my approval of the Performance Report.

Professor Lesley Dwyer

Chief Executive Date: 25 June 2026

Accountability Report

2025/2026

The Board of Directors

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

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

Board and Group Governance Framework

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

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

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

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

Chair, Vice Chair, and Senior Independent Director

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

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

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

Board Committees

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

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

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

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

Audit Committees in Common

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

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

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

External Audit Independence

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

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

The significant issues considered by the Audit Committees in Common in relation to the financial statements included the going concern assessment, valuation of land and buildings, capital accounting, management judgements and estimates, remuneration disclosures, and the fair, balanced, and

understandable assessment of the Annual Report and Accounts. The Committee considered management's response to these matters, received External Audit findings, and reviewed whether the final Annual Report and Accounts provided a fair, balanced, and understandable account of the Trust's position.

Nomination and Remuneration Committees in Common

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

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

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

Hospital Operating Model and Management Arrangements

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

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

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

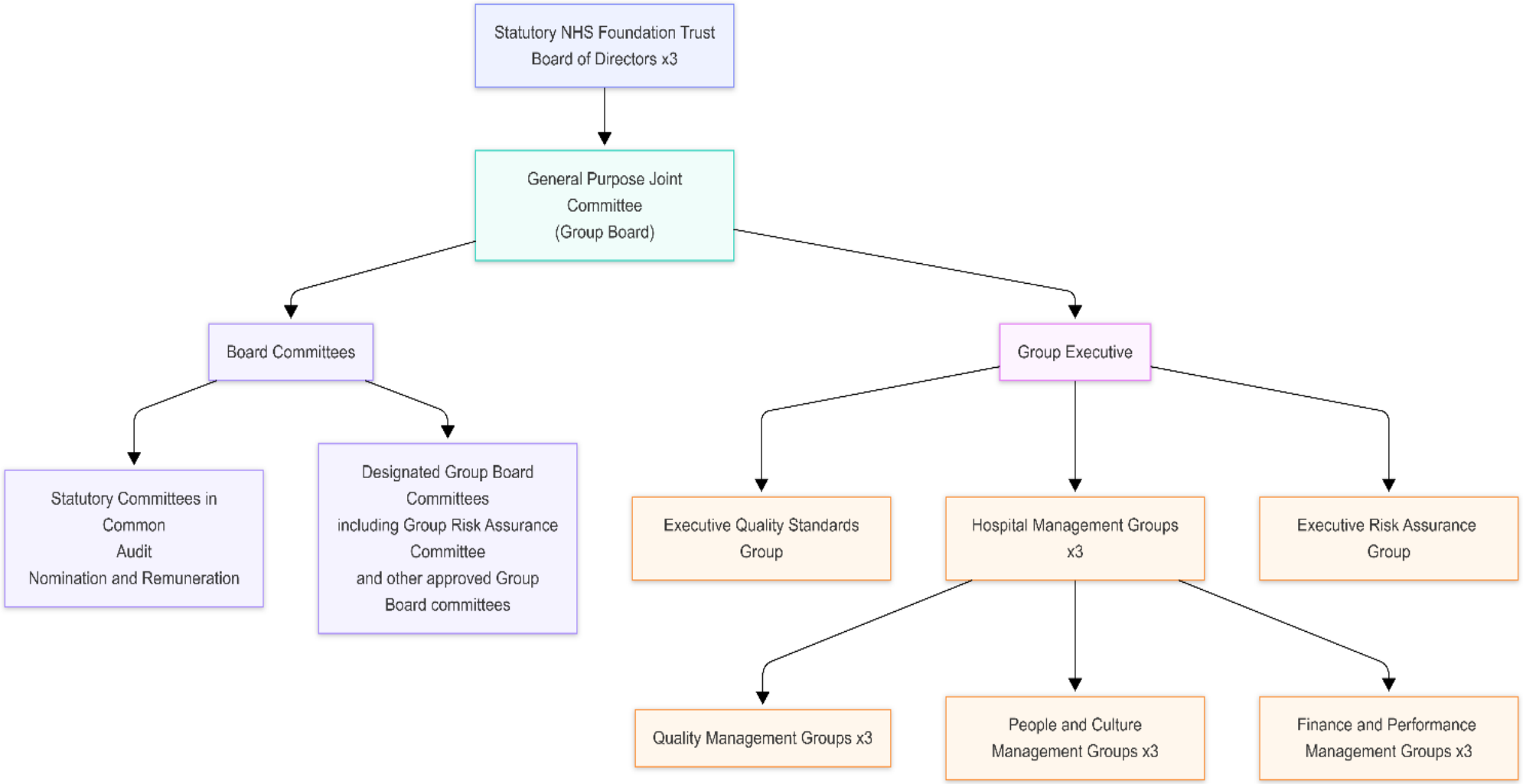
The specialist management groups include:

- People and Culture Management Group, responsible for workforce planning, staff experience, cultural development, safe staffing controls, employment-related compliance, and implementation of risk management in relation to workforce, culture, and people-related controls.
- Finance and Performance Management Group, responsible for internal financial control, operational performance monitoring, efficiency, alignment with Group strategic priorities, and implementation of risk management in relation to finance, performance, productivity, and operational recovery.
- Quality Management Group, responsible for clinical effectiveness, patient safety, care quality standards, patient outcomes, quality improvement oversight, and implementation of risk management in relation to quality, safety, clinical effectiveness, and patient experience.

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

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

Common Governance and Management Architecture



Board Composition, Succession, Appointment, and Development

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

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

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

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

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

New and continuing Directors were supported through induction and development activity focused on the Group governance model, statutory duties, Reserved Functions, Joint Functions, the Provider Collaboration Agreement, the Scheme of Reservation and Delegation, Board committee arrangements, risk and internal control, the Annual Governance Statement, and the role of the Council of Governors.

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

Board Effectiveness and Evaluation

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

This approach reflected the practical reality of the year. Existing Trust Boards continued to discharge statutory duties during the transition period, while the three Trusts developed the Group governance model,

established the General Purpose Joint Committee, appointed the Group Chair and Directors, and approved the governance instruments required to support the new arrangements.

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

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

Members of the Trust Board of Directors

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

The Board of Directors during 2025/26 included the following:

Group Board Membership and Designated Roles

Name	**Group Board role and designated portfolios**	**Voting status**
David Roberts	Interim Group Chair; Chair, Group Nomination and Remuneration Committees in Common, by virtue of being Group Chair	Voting
Sally Collier	Group Non-Executive Director; Senior Independent Director; Designated Non-Executive Director for Maintaining High Professional Standards	Voting
Stephen Javes	Group Non-Executive Director; Chair, Group Audit Committees in Common	Voting
Nikki Gray	Group Non-Executive Director; Chair, Group Risk Assurance Committee	Voting
Professor Philip Baker	Group Non-Executive Director; Chair, Group Research, Innovation and Education Committee	Voting

William Van't Hoff	Group Non-Executive Director; designated Non-Executive Director for Freedom to Speak Up	Voting
Jo Churchill	Group Non-Executive Director; Board Perinatal and Maternity Safety Champion	Voting
Jack Bowman	Group Non-Executive Director; Digital and Technology Transformation Lead	Voting
Professor Lesley Dwyer	Group Chief Executive	Voting
Joanne Segasby	Group Chief Delivery Officer and Deputy Group Chief Executive	Voting
Marcus Thorman	Group Chief Finance Officer	Voting
Dr Rob Sherwin	Group Chief Medical Officer	Voting
Rachael Cocker	Interim Group Chief Nurse	Voting
Dr Shane Gordon	Executive Managing Director, Norfolk and Norwich University Hospitals	Voting
Jonathan Gardner	Executive Managing Director, James Paget University Hospitals	Voting
Michelle Arrowsmith	Executive Managing Director, The Queen Elizabeth Hospital King's Lynn	Voting
Ian Walker	Interim Group Director of Governance	Non-voting
Dr Ed Prosser-Snelling	Group Director of Digital	Non-voting
Charlie Helps FRSA	Group Secretary	Non-voting

2. Group Committee Membership Grid: Non-Executive Directors

Committee	**Chair**	**Non-Executive members**
Group Audit Committees in Common	Stephen Javes	Jo Churchill; Nikki Gray
Group Nomination and Remuneration Committees in Common	David Roberts, as Group Chair and Chair in Common	All voting Non-Executive Directors, with membership configured according to the function being exercised

Group Risk Assurance Committee	Nikki Gray	Sally Collier; William Van't Hoff
Group Research, Innovation and Education Committee	Professor Philip Baker	Jack Bowman; William Van't Hoff

3. Executive attendance at Committees

The Group Research, Innovation and Education Committee also includes executive participation, including the Group Chief Nurse, Group Chief Medical Officer, and one rotational Executive Managing Director.

Executive attendance at the Group Audit Committees in Common, Group Risk Assurance Committee, and other Board committees is by role, invitation, or Terms of Reference. Executives attend to account for management action, risk ownership, controls, evidence, performance, and improvement, but do not displace the Non-Executive character of Board scrutiny.

NWUHG Group Board attendance: December 2025 – March 2026

Name	**Group Board Role**	**17 Dec 2025 (Public)**	**17 Dec 2025 (Private)**
David Roberts	Interim Group Chair	Present	Present
Sally Collier	Group Non-Executive Director	Present	Present
Stephen Javes	Group Non-Executive Director	Present	Present
Professor Philip Baker	Group Non-Executive Director	Present	Present
Jack Bowman	Group Non-Executive Director	Present	Present
Johanna (Jo) Churchill	Group Non-Executive Director	Present	Present
William Van't Hoff	Group Non-Executive Director	Present	Present
Nikki Gray	Group Non-Executive Director	Absent	Absent
Professor Lesley Dwyer	Group Chief Executive Officer	Present	Present
Jo Segasby	Group Chief Delivery Officer	Present	Present
Marcus Thorman	Group Chief Finance Officer	Present	Present

Dr Rob Sherwin	Group Chief Medical Officer	Present	Present
Rachael Cocker	Interim Group Chief Nurse	Present	Present
Dr Shane Gordon	Executive Managing Director, NNUH	Present	Present
Chris Bown	Interim Executive Managing Director, QEHKL	Present	Present
Jonathan Barber	Interim Executive Managing Director, JPUH	Present	Present
Dr Ed Prosser-Snelling	Group Director of Digital (Non-voting)	In Attendance	In Attendance
Ian Walker	Interim Group Director of Governance (Non-voting)	In Attendance	In Attendance
Jo Hannam	Group Communications Lead (Non-voting)	In Attendance	In Attendance
Charlie Helps	Group Secretary (Non-voting)	In Attendance	In Attendance

Norfolk and Norwich Hospital Management Group

Through the transition to the formal Group model during 2025/26, Norfolk and Norwich University Hospitals has been led at hospital level through its Hospital Management Group, chaired by the Executive Managing Director. At the end of March 2026, the hospital leadership arrangements were:

- Dr Shane Gordon, Executive Managing Director
- Chris Cobb, Chief Operating Officer
- Lucy Weavers, Interim Chief Nurse
- Dr Bernard Brett, Medical Director
- Linda Martin, interim Director of Estates & Facilities
- Mike Shemko, Acting Head of Digital Health
- Lorraine Hooper, interim Director of Finance
- Kathryn Jones, interim HR Director

Changes to NNUH hospital leadership during the year included:

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

CEO Lesley Dwyer was the CEO of Norfolk and Norwich University Trust until 01.02.2025 when she moved to be CEO of the Norfolk and Waveney University Hospital Group (NWUHG). Following this Tracey Bleakley became interim EMD 01.02.2025-12.11.2025, Followed by Marcus Thorman Interim EMD 12.11.2025- 08.12.2025. Shane Gordon became Substantive EMD 08.12.2025 to present.

Alex Berry Director of Transformation left NNUH on 31.10.2025.

Rachael Cocker was Chief Nurse at NNUH until 05.01.2026 when she was appointed Interim Chief Nurse at the NWUHG. Lucy Weavers was appointed as Interim Chief Nurse at NNUH on 05.01.2025.

Bernard Brett was Medical Director at the Norfolk and Norwich until 01.04.2026 when he moved to NWUHG to lead the Vanderbuilt Programme. Tarnya Marshall was appointed Interim Medical Director on 01.04.2026.

Marcus Thorman was appointed as NWUHG Chief Finance Officer whilst also covering NNUH until Lorraine Hooper was appointed in October 2025. Lorraine Hooper was Interim Chief Finance Officer until April 2026. Clare Hinton was appointed as Interim Director of Finance in April 2026.

Ed Prosser Snelling was Head of Digital at Norfolk and Norwich until being appointed as Group Digital officer for NWUHG in September 2025 when Mike Shemko was appointed interim Head of Digital at Norfolk and Norwich until he became Chief Data Officer for NWUHG in June 2026 whereby Tarandeep Dhillon-Smith was appointed as the Digital Lead for Norfolk and Norwich.

Sarah Gooch was appointed Interim Director of HR at NNUH until November 2025, Jaqui Hunter-Grice became Interim Director from Mid January to Mid February. Louise Ludgrove was then appointed Director of People and Culture from 01.04.2026 until 30.04.2026. Kathryn Jones was then appointed as the Interim Director of People and Culture 30.04.2026 until 14.05.2026. David Partridge is now the Interim Director of People and Culture appointed on 14.05.2026.

Main Activities of the Norfolk and Norwich Committees and Board during the Year 01 April 2025 – 31 March 2026. Norfolk and Norwich Committees and Board transition over the Group 01.10.2025 therefore the below attendance records are dated 01.04.2025 – 01.10.2025.

Audit Committee
The Audit Committee met on one occasion.

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Members	23 June 2025
Mr Julian Foster (Chair)	✓
Ms Sandra Dinneen	✓
Mr P Baker	✓

Attendance at meetings of the Board of Directors

The Board of Directors met on five occasions, including one Extraordinary Trust Board (ETB) meeting.

	2 April 2025	07 May 2025	04 June 2025	23 June 2025 ETB	2 July 2025	10 Sept 2025
Dr Bernard Brett	✓	✓	✓	✓	✓	✓
Prof Phil Baker	✓	✓	✓	✓	✓	✓
Dr Pamela Chrispin	✓	X				
Ms Clare Fernandez			✓	✓	✓	x
Mr Chris Cobb	✓	✓	✓	✓	✓	✓
Mrs R Cocker	✓	x	✓	x	✓	✓
Ms Sandra Dinneen	✓	✓	✓	✓	x	✓
Prof Lesley Dwyer	✓	✓	✓	✓	x	✓
Mrs S Gooch	x	X	✓	✓	✓	x
Mr Julian Foster	✓	✓	✓	✓	✓	✓
Mrs N Gray	✓	✓	✓	✓	✓	✓
Mrs Joanna Hannam	✓	✓	✓	✓	✓	✓
Mr M Thorman	✓	✓	x	✓	x	✓
Dr Ujjal Sarkar	✓	X	✓	x	x	✓
Mr Tom Spink	✓	✓	✓	✓	✓	✓

Quality and Safety Committee – meeting and attendance

The Quality and Safety Committee met on 6 occasions

	29 April 2025	20 May 2025	24 June 2025	22 July 2025	19 August 2025	23 September 2025
Dr Pamela Chrispin (Chair of Committee and Non-Executive Director)	✓					
Dr Bernard Brett (Medical Director)	X	✓	✓	✓	x	✓
Ms Rachael Cocker (Chief Nurse)	✓	✓	✓	✓	✓	✓
Prof Lesley Dwyer (Chief Executive)	X	✓				
Ms Tracey Bleakley (Interim Managing Director)			✓	✓	x	✓
Ms Claire Fernandez (Associate Non-Executive Director)	X	✓	✓	✓	✓	✓
Mrs Joanna Hannam (Non-Executive Director)	✓	✓	✓	✓	✓	✓

Finance, Investments and Performance Committee – meeting and attendance
The Finance, Investments and Performance Committee met on four occasions.

Name	30 April 2025	03 June 2025	23 July 2025	24 September 2025
Ms Nikki Gray (Non-Executive Director)	✓	✓	✓	✓
Alex Berry (Director of Transformation)	✓	✓	✓	✓
Mr Chris Cobb (Chief Operating Officer)	✓	✓		✓
Mrs Rachael Cocker (Chief Nurse)	x	**x**		X
Prof Lesley Dwyer (Chief Executive)	✓			
Mrs Tracey Bleakley (Interim Executive Managing Director)		✓	✓	✓
Mr Julian Foster (Non-Executive Director)	✓	✓		✓
Mrs Sarah Gooch (Director of Workforce)	✓	✓	✓	✓
Mrs L Martin (Interim Director of Estates and Facilities)	✓	✓		X
Mr Marcus Thorman (Interim Chief Finance Officer)	✓	✓	✓	✓
Ed Prosser-Snelling (Chief Digital Officer)	✓	✓	✓	
Mr Mike Shemko (Interim Head of Digital)				✓
Mr Tom Spink (Trust Chair & Non-Executive Director)	✓	✓	✓	✓

Nominations & Remuneration Committee
The Nominations and Remuneration Committee met on one occasion

	05 March 2025
Professor Lesley Dwyer	✓
Dr Pamela Chrispin	✓
Ms Sandra Dinneen	✓
Mr Philip Baker	
Mr Julian Foster	✓
Mrs Nikki Gray	✓
Mrs Joanna Hannam	✓
Dr Ujjal Sarkar	✓
Mr Tom Spink	✓

People and Culture Committee – meeting and attendance
The People and Culture Committee met on two occasions.

	23 June 2025	15 September 2025
Sandra Dinneen (Non-Executive Director and Chair)	✓	
Dr Bernard Brett (Interim Medical Director)	✓	
Chris Cobb (Chief Operating Officer)		✓
Rachael Cocker (Chief Nurse)		
Tracey Bleakley (Interim Executive Managing Director)	✓	
Lesley Dwyer (Chief Executive)		
Mrs Sarah Gooch (Director of Workforce)	✓	✓
Joanna Hannam (Non-Executive Director)	✓	✓
Ujjal Sarker (Non-Executive Director)	✓	

Directors' Interests and Independence

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

Directors are required to declare relevant interests on appointment and to update declarations during the year where circumstances change. Declarations are reviewed through the Trust's established processes

and published in accordance with applicable requirements. The Trust-specific register of Directors' interests and any relevant in-year changes are set out below.

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

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

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

Board and Committee Attendance

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

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

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

Committee Activity During the Year

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

The statutory Committees in Common remained accountable to their respective statutory Trust Boards while considering common business together where appropriate. Designated Group Board committees supported the Group Board in relation to delegated Joint Functions within their approved terms of reference.

Audit Committees in Common

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

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

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

Nomination and Remuneration Committees in Common

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

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

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

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

Group Risk Assurance Committee

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

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

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

The Committee sought and scrutinised assurance on the effectiveness of controls, the adequacy of mitigations, the consistency of escalation, the quality of evidence supporting reported risk positions, and the actions required where assurance gaps, control weaknesses, or matters outside risk appetite were identified. Its scrutiny supported the Group Board’s oversight of Board-level risk and assurance reporting, significant control issues, and the further embedding of risk-based assurance across the Group.

Board Effectiveness, Induction, Appraisal, and Development

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

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

distinction between Board governance, executive management, hospital management arrangements, and the role of Committees in Common and designated Group Board committees.

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

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

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 2025/26 financial year or

previous year.

Council of Governors

The Council of Governors comprises people elected by Trust members and appointed by partner organisations. It is made up of Public Governors who are elected by our Trust's public, patient or carer members together with elected staff members. There are also two appointed governors - one representing and nominated by the local authority and the other the University of East Anglia.

Lead Governor Elaine Bailey said: "Collectively and individually, our role is to be a critical friend and guardian of NNUH's and the wider Norfolk and Waveney University Hospitals Group's (NWUHG) values. The Governors represent the interests of patients, staff and the local community and play an active role in ensuring their voices inform NNUH's and NWUHG's work and development."

The Governor role acts as a link to the hospital community by involving members directly in our long-term vision and planning and supporting patient and wider public involvement, membership recruitment and engagement. The Council also has legal duties including holding NWUHG's Non-Executive Directors to account for the performance of the Board of Directors. This is achieved through regular formal and informal Council meetings, attendance at public Group Board meetings and joining NEDs to undertake departmental visits together.

Other duties include:

- appointing and setting the pay and terms and conditions of NWUHG's Chair and Non-Executive Directors
- ratifying the appointment of the Group Chief Executive
- appointing the external auditors and receiving the annual report and accounts

Key governor activities over the last year have included:

- Selection and approval of the NWUHG Chair and Non-Executive Directors
- Developing Jenny Lind Hospital and Cromer Hospital link governor roles
- Implementing governor working groups to help develop our membership, determine key priorities relating to patient, community and staff engagement and continuing to seek robust assurances from our GNEDs
- Participating in outpatient Care Assurance visits, identifying areas of best practice
- Visiting hospital departments to meet staff and hear first-hand about services
- Engaging with our Trust members, patients and the wider community through engagement events and surveys

- Supporting NNUH, Cromer Hospital and Jenny Lind Hospital Charity events

Elaine added: “This year, a major focus has been supporting the Trust through its transition to the Group model. Working collaboratively with governor colleagues from the Queen Elizabeth and James Paget Hospitals, we have identified approaches that will enable us to fulfil our statutory duties across the Group whilst continuing to preserve the distinct identities of each Council and the hospitals they represent. This wider engagement has also presented an excellent opportunity to learn from one another and increase our patient and community outreach.”

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. Elections were not held in Autumn 2025 and will take part in the early part of 2026/27.

As at March 2026 the Governors were:

Public Governors

- Elaine Bailey — North Norfolk
- Chris Baxter — Rest of England
- Erica Betts — Breckland
- 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
- Derek Moncur — Norwich

Staff Governors

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

Partner Governors

- Alison Thomas — Norfolk County Council
- Vacancy — University of East Anglia

Changes during the year:
The following Governors left the Council of Governors in 2025/26:

- Richard Wharton — Medical and Dental
- Peter Bush — Norwich
- Adele Swallow — Broadland
- David McNeil — Breckland

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 Group Chair or Board Secretary is not appropriate. Governor Elaine Bailey was selected by Council members to act as Lead Governor from December 2024. Chris Hind was selected as Deputy Lead Governor in August 2025.

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

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).

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

Governor expenses

The Governor role is unpaid and £1731.24 in travel expenses has been claimed during 2025/26.

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

Year	Public members
2023/24	14,853
2024/25	14,539
2025/26	14,105

Members can contact the Membership Office by e-mail at membership@nnuh.nhs.uk

Attendance at formal meetings of the Council of Governors

The Council of Governors held five meetings in 2025/26. Attendance at Council meetings is set out in the next page:

		24 April 2025	24 July 2025	19 November 2025
1.	Mrs Shahnaz Asghar	✓	✓	✓
2.	Mrs Elaine Bailey	✓	✓	✓
3.	Mr Chris Baxter	✓	✓	✓
4.	Mrs Erica Betts	✓	✓	✓
5.	Mr Peter Bush[1]			
6.	Ms Annie Cook	✓	✓	✓
7.	Ms Cherry Cubelo	✓	✓	✓
8.	Mrs Carol Edwards	✓	✓	✓
9.	Dr Daniel Epurescu	X	✓	X
10	Dr Bruce Fleming	✓	✓	✓
11	Ms Michelle Frost	✓	✓	✓
12	Mrs Ines Grote	✓	✓	✓
13	Ms Catherine Hainey	✓	X	✓
14	Mr Chris Hind	✓	✓	✓
15	Mrs Gemma Lynch	✓	✓	✓
16	Mr Kevin May	✓	✓	✓
17	Mr David McNeil	✓	✓	✓
18	Mr Derek Moncur	✓	✓	
19	Cllr Alison Thomas	✓	✓	✓
20	Mr Richard Wharton[2]	✓	X	X

[1] Peter Bush left

[2] Richard Wharton left

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

The Board of Directors of Norfolk and Norwich University Hospitals NHS Foundation Trust has applied the principles of the NHS England Code of Governance for NHS Provider Trusts on a “comply or explain” basis.

The Board considers that the Trust applied the principles of the Code of Governance for NHS Provider Trusts during 2025/26. Where the transition to the Group model affected the timing or operation of governance arrangements, this is explained in the relevant sections of this report.

During 2025/26, the Trust transitioned to a formal group operating model alongside James Paget University Hospitals NHS Foundation Trust and The Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust, forming the Norfolk and Waveney University Hospitals Group. The principles of the Code of Governance have been embedded within the Group Governance Framework, the Provider Collaboration Agreement, and the Terms of Reference for the General Purpose Joint Committee, known as the Group Board. The Board is satisfied that these collaborative arrangements preserve the statutory independence of the Trust while supporting effective corporate governance, accountability, and Board effectiveness expected of an NHS Foundation Trust.

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

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

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 the 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 continue to focus on a long-term investment in the skills, experience and wellbeing of everyone in Team NNUH.

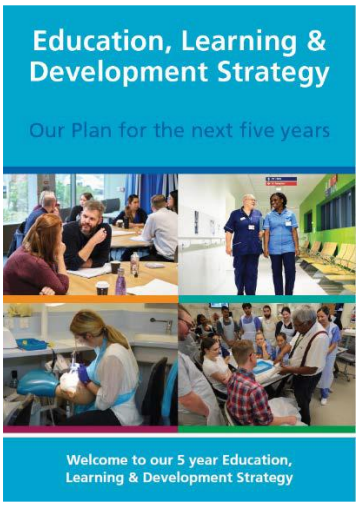
It's imperative that we have a culture of inclusion, support and respect at the heart of everything we do. Making NNUH a hospital for all people and a great place to work and learn is about how we invest in, support and value each other every day. This is supported by the Trust's Diversity, Inclusion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

Education Strategy

Our Multi-Professional Education, Learning and Development Strategy, launched last year, outlines six strategic ambitions designed to ensure that our education and development activities align with - and actively support - our corporate, regional, and national priorities. These ambitions were shaped through extensive research, consultation, and collaboration across our workforce and partners.

We are now approaching completion of the year-one delivery roadmap, with key objectives progressing as planned. This continued delivery is helping us build momentum and realise our long-term vision for excellence in education, learning and development across the organisation.

The 2025/26 iteration of Our People Promise plan was launched in July 2025.



NNUH People Promise (2025/26) – building a positive workplace culture

✓ Learning from Stay Conversations are being realised
✓ Seen a reduction in the number of staff leaving
✓ Creation of generic Job Descriptions for common roles
✓ NNUH is part of the ICS collaborative recruitment project on benchmarking and sharing best practice
✓ A Right to Work specialist in post, working directly with colleagues and managers
✓ Colleagues helped to maximise pension flexibilities, including retire-and-return and retire flexibly, whilst continuing to work
✓ Infant feeding room opened in August 2024
✓ 3 bookable Pods for meetings now used daily
✓ Additional outside benches
✓ Car parking self-assessment is ongoing, with the waiting list reducing from over 2000 to 740 (June2025)
✓ All colleagues who work 12-hour shifts have now been offered a car parking permit
✓ Rouen Road Space survey completed, with a working party looking at how best to utilise the space
✓ Better support during hot weather, including cooler facilities
✓ Wellbeing Hub with a drop-in service to access support and advocacy services
✓ Schwartz Rounds re-introduced
✓ Launch of Start Well End Well trials
	1. Promoting a safe workplace which is free from bullying, harassment and discrimination
	
	Owner:
	Bernard Brett, Medical Director
		• Clear and accessible reporting methods for addressing, challenging, and providing feedback on workplace behaviours.
		
		• Senior Leaders champion positive behaviours and actively address poor conduct
		
		• Expand trust-wide resources, such as lecture series and recordings, focusing on promoting positive conduct and addressing poor behaviours.
			• Bring existing tools into one accessible place - Sexual safety FTSU
			  ○ Create a landing page on the Beat for staff to access all reporting tools in one place.
			• By using the guidance in the NHS England Expectations of a Line Manager
			  ○ Roll out and promote the NNUH Expectations of a Line Manager
			  ○ Continue to promote the Sexual Safety at Work Policy, Civility and Respect Policy, PRIDE Values.
			  ○ Raise awareness of all tools available for managers and colleagues
			• A Culture lecture series has been launched - the Beat
			  ○ Create a landing page on the Beat for lecture recordings and future dates.

	2. Empowering colleagues to voice concerns which are heard and valued Owner: Sarah Gooch, Director of Workforce	• Colleagues feel listened to and managers feel empowered to respond to their team members concerns	• Further promote the FTSU on the Beat • Establish a task and finish group to focus on preventing harm • Upskill managers with access to information and training • Develop a toolkit and flowchart to signpost colleagues

✓ Menopause training delivered, and new menopause staff group formed ✓ Sleep workshops made available to all ✓ Line Manager training on the wellbeing services available ✓ Wellbeing calendar of events updated monthly on the Beat ✓ Preference Rostering roll out programme began in 2023 and is ongoing. Currently 27 wards participate in preference rostering ✓ Living our Values Board were established, to recognise achievements through PRIDE and other awards ✓ A staff recognition framework called "Awards to Reward" was rolled out, detailing all the ways we can thank colleagues for great work ✓ Expanded the support available to you under our "No Excuse for Abuse" approach ✓ Roll out of new Civility and Respect Code to provide better guidance and support for calling out poor behaviours ✓ A new Diversity, Inclusion and Belonging Strategy launched, to support a more inclusive culture for our staff and patients ✓ Sexual Safety Policy launched in April 2025 ✓ Grand rounds reintroduced ✓ New Speak Up Policy launched in 2023, making clear the routes available for you to raise concerns and have these positively resolved ✓ Work underway on the NHS Expectations of a Line Manager tool, to support managers gain all the skills and knowledge to carry out their roles ✓ Attendance Training updated, with training available for managers ✓ Licence to Lead foundation programme continues ✓ Performance Improvement policy, previously called capability policy updated and relaunched ✓ HR Matters newsletter, communicating all HR updates for managers and teams	**3. Enabling managers to address poor performance to create a positive working environment** Owner: Tracey Bleakley, Executive Managing Director	• Enhance management visibility and accessibility to their teams • Empower and develop managers to effectively address performance, ensuring staff receive constructive feedback, support, and development to benefit both individuals and their teams.	• Create a Gemba guide for Line Managers • Complete and roll out a Performance Management Workshop, • Complete and roll out a Difficult Conversations Workhop, • Continue to encourage managers to attend the Promote the PDR Workshop. And promote the guide • Promote the HR Toolkits
	4. Encouraging colleagues to access wellbeing support to reduce exhaustion and burnout Owner: Rachael Cocker, Chief Nurse	• Promote wellbeing initiatives to enhance staff wellbeing, enabling them to balance work and home, thereby alleviating work pressures. • Equip managers with the skills and understanding of all available tools to prioritise staff wellbeing.	• Continue the roll out of Start Well End Well programme • Promote the tools available on the beat for managers to support their team members wellbeing ○ Continue promotion of Wellbeing Training for Managers - the Beat • Promote all available tools for managers to support attendance
	5. Streamlining processes to support colleagues and enhance their ability to perform their jobs effectively Owner: Chris Cobb, Chief Operating Officer	• Enhance clarity around rostering and flexible working opportunities • Empower line managers with greater authority and decision-making capabilities regarding issues crucial to their team's needs and effectiveness.	• Encourage managers to use the Flexible Working Policy and Guide - the Beat ○ Working party formed. Re-launch of policy imminent • Advertise Rostering Guides and Training available - the Beat • Continue the roll out of Preference Rostering, currently on 27 wards • Continue the Clinical Care Group Restructure - the Beat • Roll out and promote the NNUH Expectations of a Line Manager

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

1. Promoting a safe workplace which is free from bullying, harassment and discrimination:

- Comprehensive programme of Culture Lecture Series, available face to face and on Teams, with recordings available:
    - April 2025: Sexual Safety
    - June 2025: Updating good medical practice
    - July 2025: Staff Survey and People Promise Plan update
    - August 2025: Freedom To Speak Up and Lived experience
    - September 2025: Civility Saves Lives
    - October 2025: Promoting an anti-racism organisation
    - November 2025: Burnout
    - January 2026: Digital Cultures and behaviours
    - February 2026: Developing a research culture
- July 2025: An update from our Executive Managing Director, reminding colleagues of our grievance and civility policies
- August 2025: Sexual Safety training eLearning made available

2. Empowering colleagues to voice concerns which are heard and valued

- All tools to report sexual safety concerns, Freedom to Speak Up, and Post Graduate Medical Education made easier to access in one place on the intranet
- October 2025: Promotion of Speak Up month
- Communications published outlining positive changes based on staff survey feedback, featuring updates on facilities and wellbeing
- October 2025: Listening hub launched for colleagues to discuss any concerns they may have with a senior manager
- October 2025: Process set up to track Freedom to Speak Up eLearning compliance and data shared with Care Groups to encourage progress
- February 2026: Freedom to Speak Up promoted at Staff Council meeting, including completion of the Speak Up training

3. Enabling managers to address poor performance to create a positive working environment

- HR Matters newsletters issued on a regular basis covering key topics:
    - March 2025: Capability policy; leavers and the retirement process, right to work processes, guide to sickness reporting, staff survey action plans and promotion of attendance management workshops.
    - September 2025: Flexible working policy; launch of sexual safety at work policy; Specific promotion of menopause awareness training, Oliver McGowan training and freedom to speak up training.
    - December 2025: Update on Annual Leave policy and Special Leave guidelines
    - February 2026: Family friendly policy update, guidance for managers on referrals to Workplace Health & Wellbeing and making reasonable adjustments
- HR Toolkits developed to support managers:
    - Line manager toolkit for improving performance
    - Right to work toolkit
    - Managing Change guidance
    - Managing Fixed term contracts guidance
- September 2025 - Difficult Conversations workshop launched

- January 2026 – Personal Development Review/Appraisal workshop updated to include section on performance management
- Minute taking training made available as eLearning

- **4. Encouraging colleagues to access wellbeing support to reduce exhaustion and burnout**
- Promotion of tools available to support attendance:
  - Attendance & Wellbeing Toolkit
  - Health & Wellbeing Passport Toolkit
- July 2025: Virtual Schwartz round took place on Hidden Challenges
- 'Start well, end well' trialled in Critical Care
- August 2025: Menopause Awareness webinar held with a Consultant in Obstetrics and Gynaecology. Recording made available on the intranet
- Regular bespoke wellbeing drop-in sessions made available for administrative and clerical colleagues
- October 2025: Schwartz round took place on Coping with Change
- Programmes focusing on 'Stay well this winter' promoted to all staff
- Wellbeing What's On calendar updated regularly on the intranet
- December 2025: Promotion of National Grief awareness month
- December 2025: Schwartz round took place on Kindness Counts.
- Chair yoga classes promoted on the intranet
- Wellbeing Café promoted, with mindful colouring

5. Streamlining processes to support colleagues and enhance their ability to perform their jobs effectively

- July 2025: 'Ask the Experts' drop-in sessions relating to the rostering system held. A guide created to support managers and colleagues called 'Navigating change – supporting you through organisational restructure'
- Annual Leave policy updated with a specific focus on taking regular breaks throughout the year
- January 2026: Service redesign workshops launched
- February 2026: AI awareness day took place to develop skills and knowledge in this area

Staff numbers and costs

Our staff numbers have decreased from 9,580 to 9,404 in line with the Trust's Workforce Plan.

Average number of employees (WTE Basis)	2025/26			2024/25
	Permanent	Other	Total	Total
Medical and dental	863	603	**1,465**	1,424
Ambulance staff	-	-	**-**	-
Administration and estates	1,192	40	**1,232**	1,365
Healthcare assistants and other support staff	2,278	326	**2,604**	2,708
Nursing, midwifery and health visiting staff	2,545	205	**2,750**	2,765
Nursing, midwifery and health visiting learners	140	-	**140**	139
Scientific, therapeutic and technical staff	902	17	**919**	883
Healthcare science staff	286	8	**294**	296
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	8,205	1,199	**9,404**	9,580
Of which:				
Number of employees (WTE) engaged on capital projects	101	15	**115**	57

	2025/26			2024/25		
	Total	Permanent Staff	Other total	Total	Permanent Staff	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	485,950	423,989	61,961	460,436	396,225	64,211
Social security costs	61,077	53,289	7,788	47,545	40,914	6,631
Apprenticeship levy	2,356	2,056	300	2,288	1,969	319
Pension cost - employer contributions to NHS pension scheme	56,605	49,388	7,217	53,666	46,182	7,484
Pension cost - employer contributions paid by NHSE on provider's behalf (9.4%)	37,078	32,350	4,728	35,017	30,134	4,883
Pension cost - other	81	-	81	115		115

Termination benefits	12,445	12,445	-	1,715	1,715	
Temporary staff - external bank	-	-	-	-		
Temporary staff - agency/contract staff	5,465	-	5,465	11,862		11,862
TOTAL GROSS STAFF COSTS	**661,058**	**573,517**	**87,541**	**612,644**	**517,139**	**95,505**

Breakdown of male and female staff as at 31 March 2026

Category	Female	Male	Total
N&WUHG Directors / Non-Executive Directors *	6	9	15
NNUH Directors	3	3	6
NNUH Other Senior Managers	1	1	2
NNUH Employees	7,439	2,323	9,762

*** The NNUH is the "host" for the Norfolk and Waveney University Hospitals Group ("the Group"). As such, the table above includes those in Director / Non-Executive Director roles at "the Group"**

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 » Equality and Diversityhttps://www.nnuh.nhs.uk/publication/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

The table below includes Norfolk and Waveney University Hospitals Group colleagues employed by NNUH:

Figures Converted by DH to Best Estimates of Required Data Items			
Months	**Average FTE 2025**	**Adjusted FTE days lost to Cabinet Office definitions**	**Average Sick Days per FTE**
12	8,821	90,716	10.3

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse
Period covered: January to December 2025

Staff Turnover

Information on staff turnover can be found at the link below: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

NHS Staff Survey 2025

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 2025 were published in March 2026.

The response rate to the Staff Survey 2025 saw an improvement of 1% to 48% - with 4,732 respondents, compared with 4,508 in 2024. This is slightly higher than the Acute Trust average of 47%.

In line with the commitment in the National People Plan, the NHS Staff Survey outcomes align to the People Promise, which sets out what NHS staff can expect from their leaders and from each other. These set out, in the words of NHS people, the things that would most improve their working experiences. The NHS Staff Survey will track our progress towards staff engagement, staff morale and the seven elements of the People Promise:

Indicators ('People Promise' elements and themes)	2025/26		2024/25		2023/24	
	Trust Score	Benchmark Group score	Trust Score	Benchmark Group score	Trust Score	Benchmark Group score
People Promise:						
We are compassionate and inclusive	6.9	7.3	6.9	7.2	6.9	7.2
We are recognised and rewarded	5.5	5.9	5.5	5.9	5.5	5.9
We each have a voice that counts	6.1	6.6	6.2	6.6	6.3	6.7
We are safe and healthy	5.7	6.1	5.4	5.6	5.3	5.6
We are always learning	5.3	5.6	5.4	5.6	5.3	5.6
We work flexibly	6.1	6.2	6.2	6.2	6.2	5.7
We are a team	6.4	6.8	6.4	6.7	6.4	6.7
Staff engagement	6.2	6.7	6.3	6.8	6.3	6.9
Morale	5.3	5.9	5.5	5.9	5.5	5.9

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 including daily news, blogs from senior leaders, information, policies, guidelines, discussion forums, an event calendar and departmental information on our intranet.

There is a weekly round-up of news and information emailed to all staff, plus a regular programme of events and awareness days. The Executive Managing Director also runs a recorded monthly open meeting in the lecture theatre and online, open to all staff, which covers current issues and strategy as well as updates on performance, finance and workforce issues, which keeps staff up to date on a range of issues affecting our hospitals.

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

The staff survey results, along with feedback from staff groups will inform the 2026 iteration of the People Promise Plan,

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 new Diversity, Inclusion and Belonging (DIB) Steering Group launched April 2025 to enable a focus on workforce and the delivery for the Diversity, Inclusion and Belonging Strategy. This group brings together our staff networks (NNUH Together, Women Staff Network, LGBT+, Disability and Long-Term Conditions) and Care Group DIB Groups, who are all key partners. We continue to work with our networks on developing and delivering plans to improve staff experience.

The DIB Steering Group monitor the EDI performance which is reported to the relevant governance groups including the People and Culture Management Group and the Hospital Management Group. The DIB Steering Group also ensure that reports are published in line with national reporting requirements.

In addition to the DIB Steering 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 2026. Key indicators taken from the WRES 2025 report are:

- **WRES Indicator 1 – 20.28%** of our overall workforce are from a Black, Asian or ethnic minority background. The Black and Minority Ethnic workforce increased by 2.18%, with Black and Minority Ethnic representation showing year-on-year improvement.

- **WRES Indicator 2** – white candidates are **1.91x** more likely to be appointed from shortlisting compared to Black and Minority Ethnic candidates (previous year 1.53x).

- **WRES staff survey indicator 5 – 28.35%** of Black and Minority Ethnic staff and **24.58%** 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 (both decreasing from previous year). This has improved compared to 2024 reporting where **32.21%** of Black and Minority Ethnic and **26.94%** 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 – 44.29%** of Black and Minority Ethnic staff and **53.48%** of white staff have reported that they believe the Trust provides equal opportunities for career progression or promotion. The Trust is now below 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 2026.

Key indicators taken from the WDES 2025 report are:

- **WDES Indicator 1 – 5.87%** of our staff have disclosed they have a disability, which is a 1% increase on the previous year and 29% of staff have disclosed a disability via the national staff survey.

- **WDES Staff Survey Indicator 4a – 29%** of disabled staff and **23.6%** 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 2024 reporting which reported **33.4%** of disabled staff and **25.5%** of non-disabled staff experienced such behaviour from patients/service users.

- **WDES Indicator 4b – 28.0%** of disabled staff and **19.5%** of non-disabled staff reported they had experienced harassment, bullying or abuse from other colleagues which remains similar to the previous year.

- **WDES Indicator 5 – 46.8%** of disabled staff and **53.65%** 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 remained static for both our disabled and non-disabled staff. Our engagement score is **5.9** for disabled staff and **6.5** for non-disabled staff (6.0 and 6.5 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 2024 – 31 March 2025, the Trust reported 13 trade union representatives equivalent to 12.51 FTE.

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

Percentage of time	Number of employees
0%	0
1-50%	11
51%-99%	1
100%	1
Total	13

The total spend on paying employees who were relevant union officials for facility time during the relevant period was £235,136.23 which represented 0.04% of the Trust's total pay bill (previously reported for 2024 £76,034.34 which represented 0.01% of the Trust's total pay bill). The total hours on paid trade union facility time totalled 5,071 (2024 - 3,441) which represented 34.15% (previously 2024 - 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 national requirements, with regular updates and training sessions provided to staff through the intranet and webinars, along with guidance and advice issued by NHS Counter Fraud Authority and the Trust LCFS. This process is detailed in our Anti-Fraud and Bribery Policy.

Exit packages

- Reporting of compensation schemes - exit packages 2025/26
- 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	3	39	**42**
£10,000–£25,000	7	84	**91**
£25,001–£50,000	5	72	**77**
£50,001–£100,000	2	65	**67**
£100,001–£150,000	1	18	**19**
£150,001–£200,000	1	5	**6**
> £200,000	1	0	**1**
Total number of exit packages by type	**20**	**283**	**303**
Total Resource Cost £'s	**988,543**	**11,710,668**	**12,699,210**

- 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**

Exit packages: non-compulsory departure payments

The following table is subject to audit:

	2025/26 Payments Agreed		2024/25 Payments Agreed	
	Number	£'s	Number	£'s
Voluntary redundancies including early retirement contractual costs	268	11,451,634	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-

Contractual payments in lieu of notice	27	255,576	26	231,881
Exit payments following employment tribunals or court orders	1	3,457	-	-
Non-contractual payments requiring HMT / DHSC approval (special severance payments)*	-	-	-	-
Total	**296**	**11,710,668**	**26**	**231,881**
of which: non-contractual payments requiring HMT / DHSC approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

As a single exit package can be made up of several components, each of which will be counted separately in this table, the total number above will not necessarily match the total numbers in the first table which will be the number of individuals.

*Includes any non-contractual severance payment made following judicial mediation and payments relating to non-contractual payments in lieu of notice.

The Remuneration Report provides details of exit payments payable to individuals named in that Report.

Off-payroll payments

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

Table 1: Highly paid off-payroll worker engagements as at 31 March 2026 earning £245 per day or greater

Number of existing engagements as of 31st March 2026, of which:	Number of individuals
Number that have existed for less than one year at a time	0
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 between four or more four years at time of reporting	0

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31st March 2026 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31st March 2026 of which:	Number of individuals
Not subject to off-payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35*	0
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	0
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 2025 and 31st March 2026

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	28

Consultancy expenditure

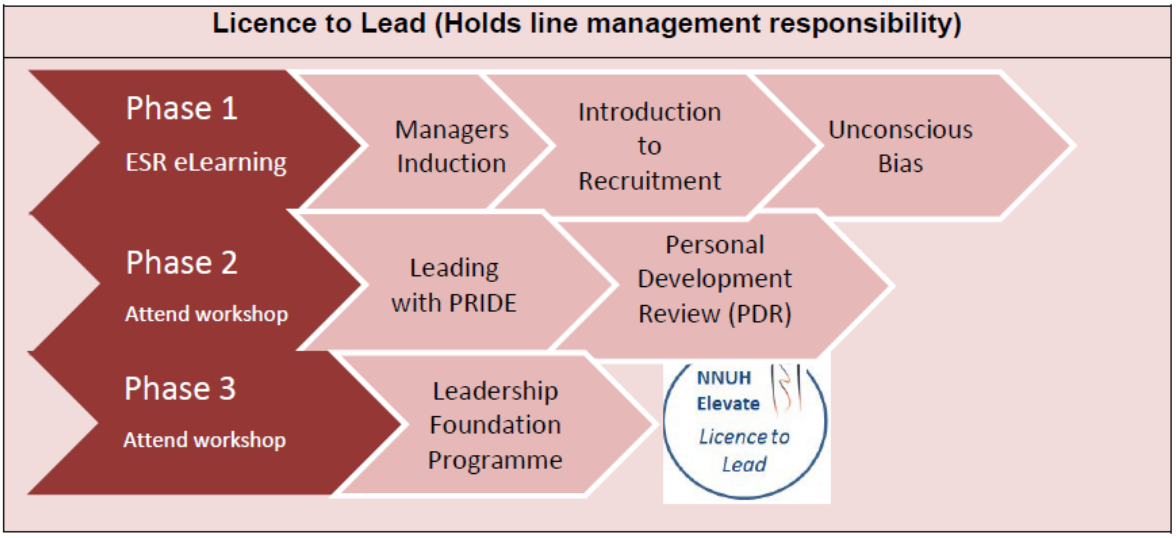
£4,118,343 was spent on consultancy expenditure in 2025/26. The 2024/25 expenditure on consultancy was £1,583k.

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 2,600 managers having commenced the programme. Of these, 779 have completed their licence in full with a further 1,205 having completed at least 60% of the learning (data as at February 2026).

Connected Leaders

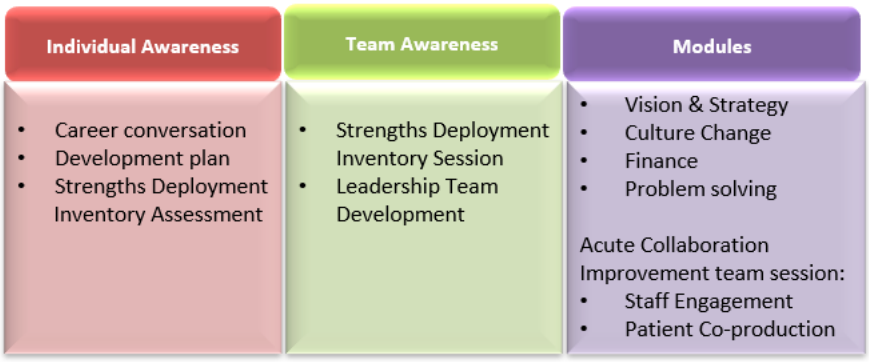
The NHS Leadership Long Term Plan recognises that 'great quality care needs great leadership at all levels.

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.

Our Connected Leaders programme was uniquely designed to develop multi-professional leadership teams, together and 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 programme has been developed and utilised to support the move to Group Model and forming of the groupwide Specialty Clinical Networks, supporting 12 multiprofessional leadership teams to come together.

Programme overview:



The evaluation feedback has recognised the positive development of leadership skills. Participants 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 2025/26, we have seen 147 colleagues commence an apprenticeship; 133 are existing colleagues and 14 are new apprentices, with 5 aged between 16–18 years. The total number is lower than in 2024/2025 (167).

We continued to offer a diverse number of apprenticeship programmes with 30 delivered between clinical and non-clinical subjects; this included the new additions of the Physiotherapy and Occupational Therapy Degree apprenticeships, and Digital and Data apprenticeships.

Moving into 2026/2027, the team will continue to advertise and promote opportunities and highlight career pathways through the apprenticeship route to students and individuals seeking employment.

In 2025/2026, we supported other health and social care organisations by working with the Norfolk County Council to share excess Apprenticeship Levy Funds. We have committed over £500,000 to support the training of staff at health and social care providers across Norfolk including GP surgeries, Pharmacies and Dental Practices. This has allowed us to support our system partners to build the wider health and care workforce within the Integrated Care System and prevent funds from expiring from the Trust's Apprenticeship Levy.

Work Experience
We have continued to offer ad-hoc work experience placements across the Trust in a variety of settings including Speech and Language Therapy, Cardiology, Digital Health, and Neurology. In total we received 347 applications from a variety of students for ad-hoc placements. 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 Year 10 and 11 Insight Weeks in July 2025, October 2025 and February 2026. In total for all three programmes, we received 153 applications and hosted 41 students across the three programmes. 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

2026 and will be open for Year 10 students with the final programme of the year being held in October 2026 for both Year 10 and 11 students.

We also hosted the pilot of our new programme, the Year 10 and 11 Medicine Insight Day. In partnership with Post Graduate Medical Education, we delivered a day of talks and interactive activities led by medical students and foundation doctors to provide young people with an introduction to careers in medicine. The programme took place in November 2025 and received 126 applications, from which 19 students were selected to participate.

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 more departments across the Trust over the next year.

Career Engagement
During 2025/2026 we have attended a total of 39 Careers Fairs across 27 schools, colleges, sixth forms and Job Centres engaging with students aged 14 and over interested in a career within the NHS.

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 42 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 28 T-Level Health students since 2023, with four students now working in Health Care Support Worker roles since the Trust first established placements in 2023.

We are expecting to welcome 11 students across two providers during this academic year.

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 2025/26 we ran two cohorts with applications open to any Trust colleague (including bank), sessions run for a 12-week period and are online only. 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 17 years.

Each year, up to ten students gain experience in three different job roles, with the aim of moving into paid employment either at the Trust or within the wider community by the end of the programme. Since beginning in 2008, over 150 students have accessed the programme, with 82 successfully gaining employment — 39 of whom secured roles at the Trust or with Serco.

Following the recruitment for the 2025/2026 programme, 8 students started in September 2025 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 2025/2026, we were contacted by 16 individuals who registered their interest, all of whom received a direct response. Of the 6 who followed up, 3 have been supported with work shadowing and career support within their interested areas at the Trust as well as signposted to system partners such as East of England Ambulance Service and the Queen Elizabeth Hospital. We have also held two virtual sessions in Physiotherapy and Major Projects.

Workplace Health & Wellbeing (Occupational Health)

Workplace Health & Wellbeing (WHWB) has continued to see a significant demand for occupational health services in order to support staff with ongoing pressures such as the elective recovery programmes, industrial action, organisational change, and a difficult winter season resulting in the hospital being in escalation over several weeks.

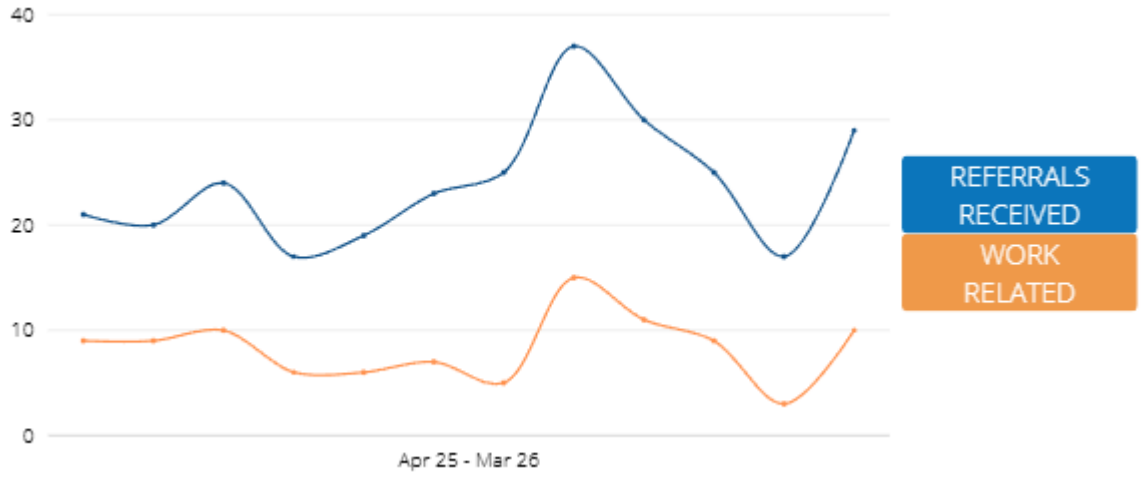
Core Occupational Health Services

Service Delivery
Core occupational health services have continued over the course of this year including absence referrals, and 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 staff have been reported as:

- Psychological Referrals: Work-related stress consistently emerged as a leading cause. Issues identified include workload pressure, interpersonal conflicts, lack of support and change.

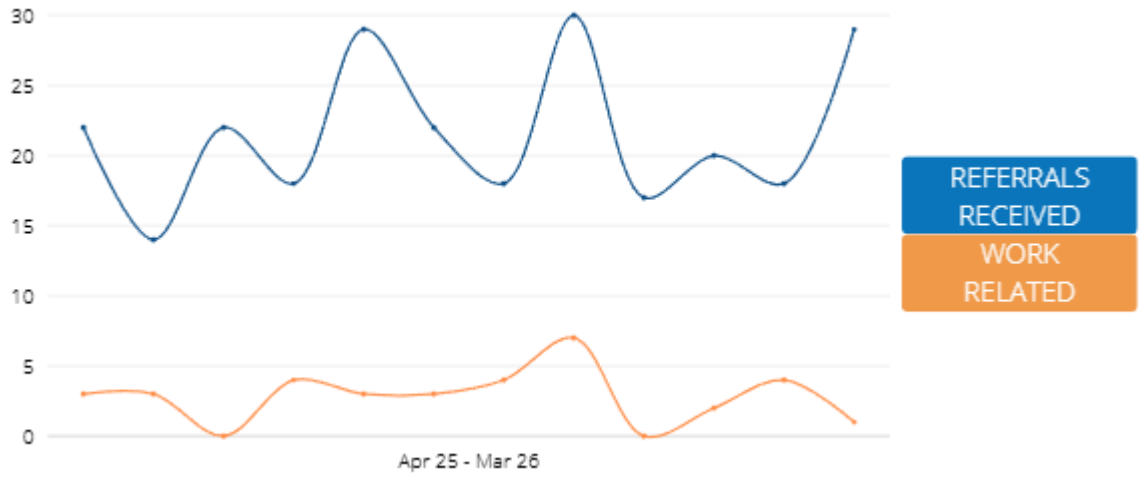
Stress Referrals data



- Burnout / Moral Injury - staff report exhaustion, anxiety and feeling overwhelmed. This can be linked to the ratio of staffing in relation to number of patients (when in escalation). Work is progressing on developing toolkits for colleagues and managers in balancing work, health and life.

- Musculoskeletal (MSK) cases: increased at a steady rate each quarter, with a growing number of issues relating to violence and aggression at work.

MSK Referrals data



Immunisation Services for staff
There has been a decrease in the number of immunisation events that have been required in this last year, due to the reduced number of new starters.

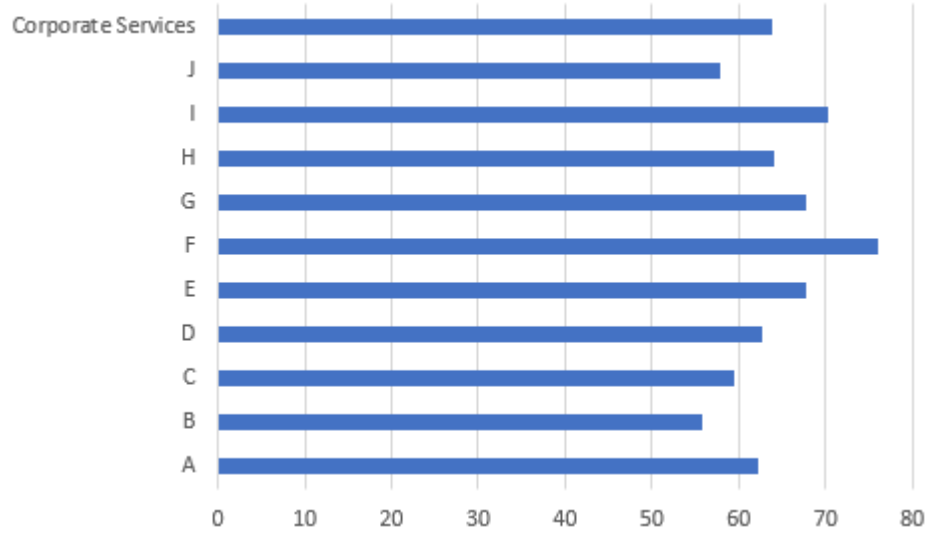
WHWB have updated their clearance process for those staff working in critical care undertaking hemofiltration activities. Additional screening (in line with renal unit screening) has been undertaken and will continue for any new individuals undertaking this role.

Autumn Booster Campaign

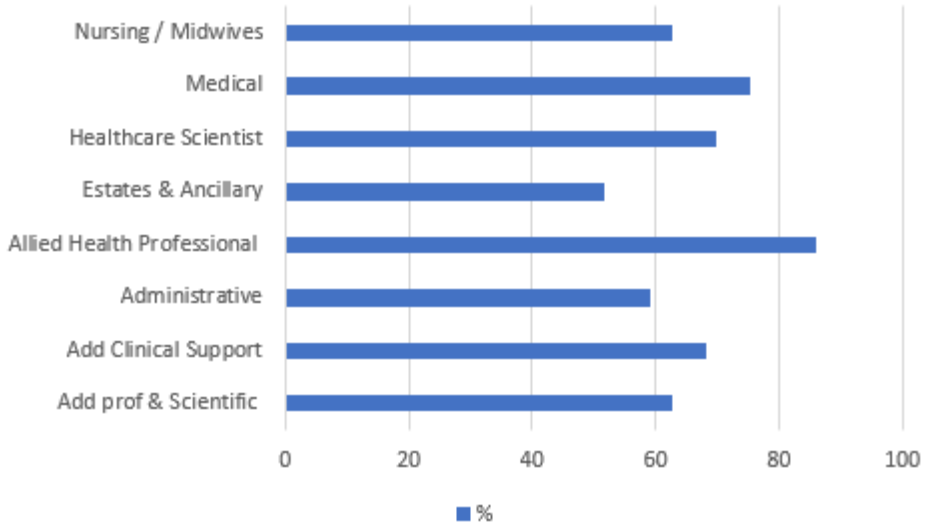
Influenza Vaccination programmes
Once again, the WHWB team mobilised a temporary team to provide a seasonal vaccination programme which this year only required Influenza boosters. NHS England set a requirement for a 5% increase of uptake which was successfully achieved.

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

Care group uptake levels



Staff group levels of uptake:

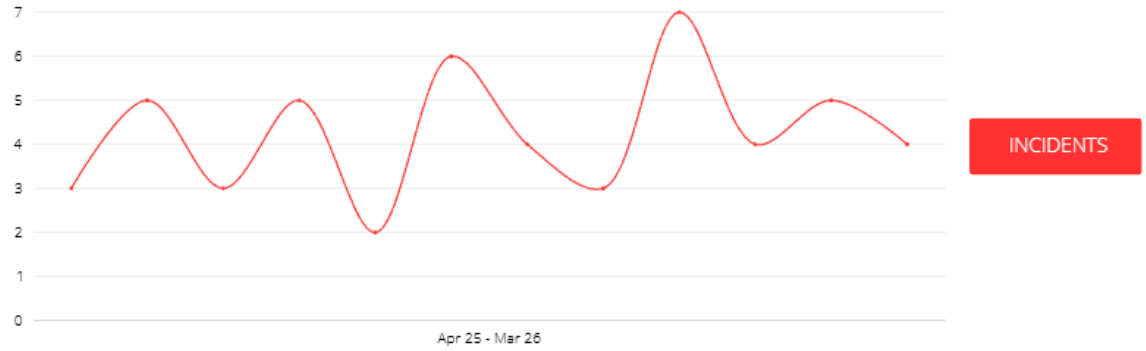


Exposure incidents

Our blood exposure support line continues and all staff who have such incidents are assessed and supported with any necessary treatment. Blood exposure incidents, including needlestick injuries, averaged approximately 14 cases per month which is a similar level of the previous year which was 16 per month last year. Many exposure incidents could have been prevented through appropriate Personal Protective Equipment usage and care when using sharps.

Needlestick injury data

Blood splash exposure incident data



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 Personal Protective Equipment when faced with patients displaying respiratory symptoms.

Contact tracing cases has remained at a significantly high level averaging 33 cases per quarter. Key trends identified have been:

- Staff not wearing Filtering Face Piece (FFP3) fit tested masks
- Lack of awareness of type of Personal Protective Equipment to be wearing
- Awaiting diagnosis / confirmation before wearing Personal Protective Equipment
- Not wearing Personal Protective Equipment whilst undertaking Aerosol generating procedures of confirmed infectious case – e.g. intubating a suspected meningitis case

A personal protective equipment task and finish group was established with a dedicated action plan to support the findings set out above. It has been agreed to extend the compliance data monitoring of FFP3 fit testing to all inpatient clinical areas taking into account the changes of UK Health Security Agency guidance over the last year. This has been actively discussed at Health & Safety Committee and Quality, Safety and Effectiveness Management Group.

Health Surveillance
A dedicated Health Surveillance Policy has been created and approved and line manager training on requirements is being undertaken. Health surveillance processes are commencing for the areas of most risk.

Policy Review / Development
During the reporting period, a comprehensive review of Workplace Health and Wellbeing procedures, protocols, and supporting documentation was undertaken to ensure continued alignment with national guidance, evolving clinical practice, and Trust operational requirements.

Trust Procedures
The Prevention and Management of Tuberculosis (TB) in Staff procedure has been revised to include formal recognition of Workplace Health and Wellbeing referrals to respiratory services, enhanced guidance on clearance processes for new healthcare workers with a high-risk TB history, and additional out-of-hours advice.

The Immunisation of New and Existing Healthcare Workers procedure was revised to reflect ongoing national changes relating to exposure-prone procedures (EPP). Updates include clarification of clearance requirements for Critical Care Unit staff undertaking haemodialysis duties, following consultation with the UK Health Security Agency (UKHSA), and amendments to pertussis vaccination requirements for specific staff groups.

The Workplace Health Assessment Screening Procedure was also reviewed and updated.

Trust Protocols: The Trust Protocol for Radiological Examination Referrals by Named Senior Occupational Health Nurse Advisors in Workplace Health and Wellbeing was updated to reflect the World Health Organisation TB country profile as the recognised source for international TB incidence rates.

Supporting Guidance and Information: A wide range of supporting documents were reviewed and updated, including guidance relating to blood and body fluid exposure, sharps injuries, hepatitis B prophylaxis, post-exposure prophylaxis (PEP), and consent processes. Several documents, including the Parent/Guardian Consent Form for Source Exposure, were submitted for approval and are awaiting ratification.

Ergonomic and musculoskeletal health resources, workplace stress assessments, and national guidance on latex allergy were also reviewed to ensure continued relevance and accessibility for staff.

Contact Tracing Documentation: All infection contact tracing documentation was reviewed and updated to reflect changes in reporting processes and revised close-contact criteria where appropriate. This included contact tracing forms and logs for tuberculosis, viral haemorrhagic fever, mumps, rubella, scabies, shingles, and pertussis.

Support to Organisation through contribution at meeting attendance:
Regular attendance and contribution through verbal and written reports are provided at the following organisational meetings:

- Health & Safety Committee
- Infection, Prevention & Control Committee
- Joint Staff Side Committee
- Staff Network groups and Staff Council
- ICS Wellbeing Leads
- Staff Survey Prioritisation Group
- Quality, Safety and Effectiveness Management Group
- People and Culture Management Group

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

In May 2025, WHWB undertook its annual SEQOHS (Safe, Effective, Quality OH Service) 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.

Leadership and Contributions to Occupational Health

The Associate Director of Workplace Health, Safety and Wellbeing, has played a pivotal role in generating income for the organisation through her leadership of MoHaWK (Management of Health at Work Knowledge system). MoHaWK, operating under the Faculty of Occupational Medicine, serves as the sole national Occupational Health (OH) system designed to support local audit and benchmarking initiatives. In addition to this, the Associate Director of Workplace Health, Safety and Wellbeing is actively involved in supporting the SEQOHS accreditation scheme, demonstrating her commitment to maintaining high standards within the field.

The Associate Director of Workplace Health, Safety and Wellbeing concluded her term as Chair of the NHS Health at Work Network in March 2025, a position she had held since April 2021. During her tenure, she represented the organisation on various National Working Groups, ensuring the organisation remained at the forefront of implementing any advancements in guidance, legislation, or best practice within Occupational Health.

In July 2025, the Associate Director of Workplace Health, Safety and Wellbeing was appointed as Chair of Faculty of Occupational Medicine (FOM) Ethics Committee.

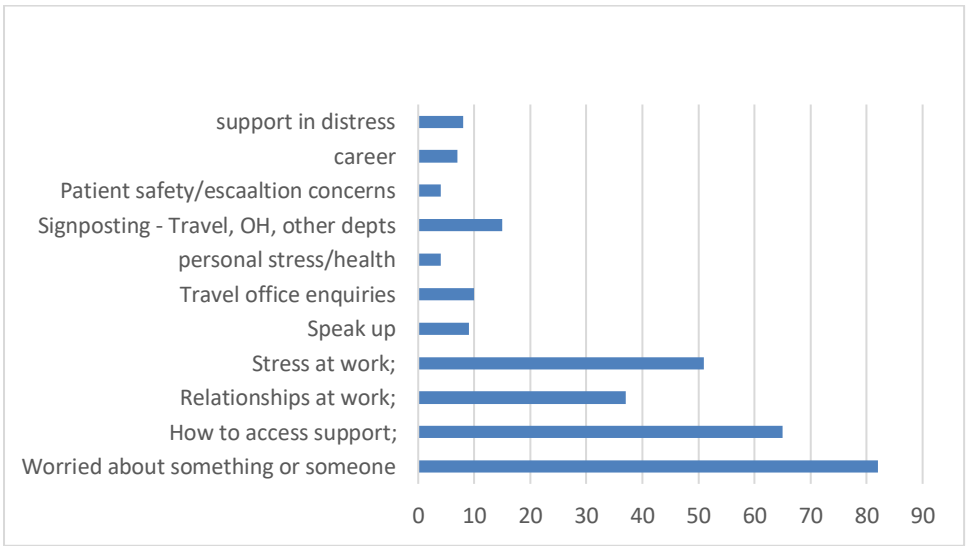
Wellbeing

The Wellbeing team has continued to strengthen the Trust's approach to supporting staff health, wellbeing and experience. Throughout the year, the team has delivered a wide range of initiatives, training, and targeted interventions designed to promote a positive, compassionate and supportive working environment.

Key developments are outlined below.

Staff Support Hub

The Staff Support Hub, located in the East Atrium, operates Monday–Friday (10am–3pm) and is supported collaboratively by colleagues from Workplace Health and Wellbeing, Chaplaincy/Spiritual Healthcare, Professional Advocates and Freedom to Speak Up. The hub continues to provide a safe, confidential space for staff to seek support, reflect on challenges and access signposting. Managers are increasingly encouraging staff to make use of this facility.



Training Programmes:
The team has provided a varied programme of wellbeing-related training across the year, including:

- **Menopause:** Quarterly sessions and active contribution to the Norfolk & Waveney Integrated Care Board Menopause Awareness Week.
- **Sleep:** Sleep-focused video resources
- **Wellbeing Training:** Monthly workshops delivered in partnership with NHS Talking Therapies, including new "Wellbeing & Mental Health Training – Guidance for Leaders and Champions." This ceased in December 2025 due to provider restructuring.
- **Team Training:** Delivery at Cromer Study Day, Pharmacy induction, Audiology Study Day and inclusion within the Trust Culture Lecture Series, covering resilience, burnout, civility and general wellbeing support.

Wellbeing Programme

- **Start Well End Well:**
  Introduced in alignment with the People Promise action plan, supporting staff on a day-to-day basis as they navigate the challenges of each shift. Trial implementation in Critical care, with discussions underway in Post Anaesthetic Care Unit & Emergency Department
- **Schwartz Rounds:**
  Quarterly Schwartz Rounds were successfully delivered. Two new facilitators were trained, bringing renewed energy and creativity.
- **Winter Wellbeing campaign**:
  A comprehensive programme of evidence-based activities was delivered throughout winter, promoting rest, recovery and resilience. Offers included sound baths, Walk & Talk sessions, chair yoga, craft cafés and "Wellbeing on Wheels" visits. The Wellbeing on Wheels will become a regular feature, supported by a new booking system enabling teams to request visits into the next year.
- **Physical Activity and Other Groups:**
  Regular staff groups continue, including Running Club, Walking Group, Yoga, Pilates and Dance sessions.

Targeted Support:

- **Team Support:** Walkabouts, drop-ins and reflective discussions for teams experiencing pressures, including Pharmacy, ED, Cromer, Cotman Centre, Rouen Road, Switchboard and Norwich County Hall. Support has been especially important during ongoing Trust and Group-level restructuring.
- **Pets as Therapy:** Monthly sessions at NNUH and quarterly sessions at Rouen Road.
- **Library Partnership:** Ongoing collaboration on "Book of the Month" and VR headsets for wellbeing.
- **Wellbeing on Wheels:** Increased engagement with the winter programme, supported by a structured booking system which will be expanded Trust-wide.
- **Monthly Support Groups:** Continued peer support for Long-Term Conditions, Menopause and Neurodiversity.
  - Leaders Lunch sessions have attracted strong attendance.
  - A new Bereavement Support Group and Café was launched in response to themes emerging from 1:1 wellbeing conversations.
  - The Men's Cave continues despite facilitator capacity pressures, with the model under review.
  - The A&C Late Lunch was re-designed into an open Coffee & Chat Café with themed discussions.

Individual Support:

- One-to-one staff support has been strengthened by the introduction of a new booking system, improving accessibility and reducing administrative burden.
- The team provides ongoing support and signposting via the Staff Support Hub.

Communication And Engagement:

- The Wellbeing & Benefits Expo (October 2025) was highly successful, attracting substantial staff engagement.
- Workplace Health & Wellbeing provided visibility and support at key events including:
    - International Nurses & Midwives Day (May 2025)
    - Estates & Facilities Day (June 2025)
    - Business Games (June 2025)
    - Norwich Pride (July 2025)
    - AGM (September 2025)
    - World Menopause Day (October 2025)
- The team reviewed wellbeing resources on the Trust's intranet site and developed new guidance, including support for managers and colleagues when staff disclose suicidal thoughts or self-harm. Monthly blogs and updates continue to be shared through Trust channels.
- NHS Norfolk & Waveney Talking Therapies host monthly information stands.
- Collaborative toolkits for managing organisational change and burnout were produced and added to the Trust's intranet site, along with an updated Directory of Mental Health & Wellbeing resources and new staff information leaflets.

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.

Key Operational Activities:

- **Comprehensive Inspections:** Regular inspections were conducted reviewing 64 areas adhering to the NHS Staff Council Health & Safety Standards. A variety of areas were inspected including off-site locations, wards, theatres, outpatient departments and offices.
  - 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.

  Waste (Blue Medical bins): To support correct waste segregation, the department has been involved in implementing wider use of the blue medical waste bins in clinical areas for the disposal of IV lines and bag that may contain residual non-hazardous pharmaceutical products. This has included updating the waste policy.

- **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. The EcoOnline (Sypol) contract was reviewed this year and is in place for the next 3 years.

- **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.

  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)

- **Building Safety:** The Health and Safety team has supported the Trust in reviewing health and safety concerns with new builds, including the Community Diagnostic Centre. In addition, support provided for the deteriorating West Annexes.

- **NHS Staff Council, Health, Safety and wellbeing Group. Workplace health and safety standards:** gap analysis against the standards completed. 26 actions identified, 21 completed, remaining 5 are in progress.

- **Violence prevention and reduction steering group:** initiated June 2025 to support reduction of violence and aggression incidents and reduce severity of harm. NHS England, the violence prevention and reduction standard assessment completed, and strategy drafted. Support given to the implementation of body-worn cameras for trained, nominated Emergency

Department clinical colleagues and support to Emergency Department Prevention and Management of Aggression trainers.

- **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. The Health and Safety Committee reporting was reviewed to support effective preventative and mitigating actions. From January 2026, in addition to the statutory quarterly Health and Safety Committee meetings, additional monthly meetings are being held to support communication between Care Group Leads and Health and Safey to provide regular assurance to Quality and Safety Board and to drive completion of actions.

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.

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

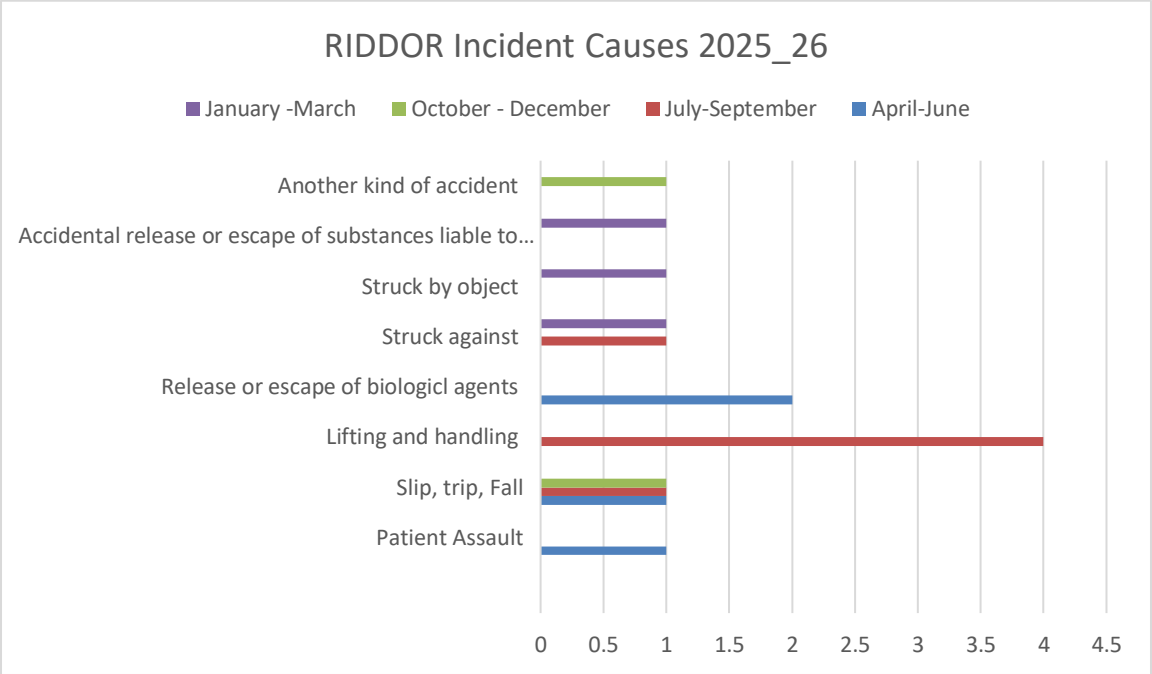
- Violence (including assault, abuse or harassment)
- Needlestick injury
- Accidents and Injuries (not slips, trips and falls)
- Slips, trips and falls
- Moving and Handling

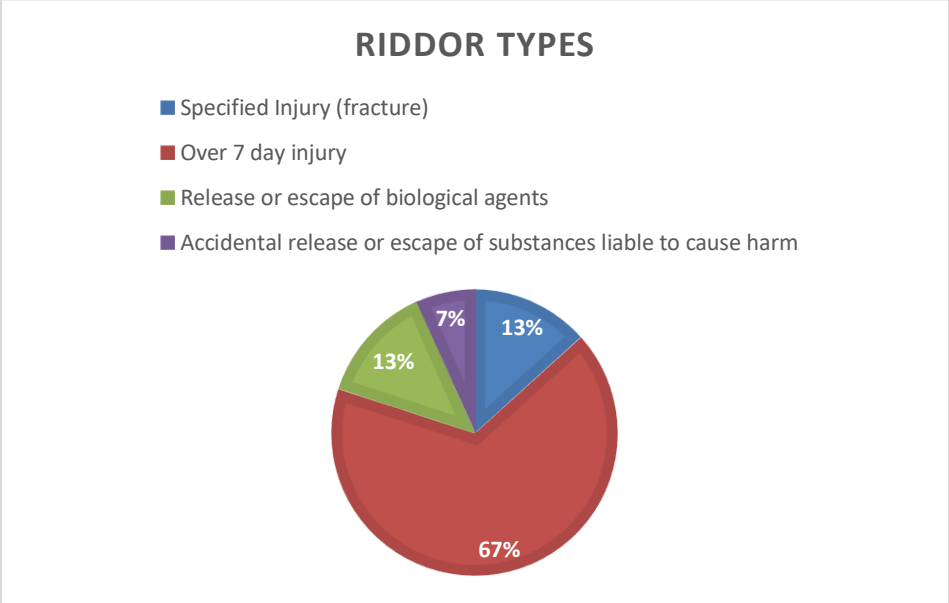
	Accidents and Injuries (NOT slips, trips, falls)	Exposure to harmful agent - radiation / biological / substance	Moving and Handling	Needlestick / Sharps Incident	Slips, Trips and Falls	Violence (including assault, abuse or harassment)	Total
Public , contractors, visitors	15	2	2	2	29	3	53
Staff (Including Agency Staff)	143	98	53	175	89	330	888
Total	158	100	55	157	118	333	941

There has been a slight reduction in the number of incidents reported from 2024/2025 (1019).

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

During the period April 2025 to March 2026 the Health and Safety team reported a total of 15 incidents to the Health and Safety Executive as they met the schedule of RIDDOR. All related to Trust colleagues.





This is a decrease in reporting compared to 2024/2025 which had a total of 23 incidents being reported for the period. The number of RIDDOR incidents is reflected as an incidence rate against the national average. The Trust's overall RIDDOR incidence rate is 174 per 100,000 employees based on a staffing level of 8,634. The national incidence rate in 2024/2025 was 209.

NHS Oversight Framework

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

NHS organisations are allocated to one of five 'segments'.

Segmentation indicates performance and whether improvement is required, from high-performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

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

1. Its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)
2. considering financial override which may limit a segment to be no better than 3
3. contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and
4. capability assessments which consider the organisation's leadership and governance.

NNUH is in segment 3 of the NHS Oversight Framework following publication of quarter 3 performance on 18 March 2026.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website at https://www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/.

The trust is included on the acute trust dashboard.

Approval of the Accountability Report

I confirm my approval of the Accountability Report.

Professor Lesley Dwyer

Chief Executive Date: 25 June 2026

Statement of the Chief Executive's responsibilities

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 our 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.

Prof Lesley Dwyer, Chief Executive

Date: 25 June 2026

Annual Governance Statement 2025/26

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of 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 2026 and up to the date of approval of the annual report and accounts.

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

Capacity to handle risk

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

Leadership of risk management during 2025/26 was exercised through the Trust Board and, within management, through the Executive Managing Director, the Hospital Management Group, and its specialist management groups for quality, people and culture, and finance and performance. The Board's Audit Committee (from November 2025 constituted as a Group Audit Committees in Common) scrutinised the adequacy and effectiveness of the Trust's risk management and internal control arrangements.

Operational responsibility for risk management rested with care groups and corporate departments, each of which was required to identify, assess, manage, and escalate risks in line with the risk management framework. Local risk leadership was supported by the Head of Risk Management, who provided reports, recommendations, and shared learning through the Trust's management structure.

Staff were supported through policy guidance, role-specific training, targeted improvement work arising from incidents, inspections, audit, and external review, and focused organisational learning through the Learning from Insight and Outcomes Group.

Specialist practitioners were also employed to provide targeted staff training and implement service improvements responding to previous incidents involving patient falls, nutrition, and hydration. These arrangements provided active first-line controls and learning routes, but the Trust recognised that recurrent harm themes required sustained evidence of embedded practice change during 2026/27.

The risk and control framework

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

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

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

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

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

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

Quality arrangements formed a central part of the risk and control framework. Group Aim A1 defined Quality as patient safety, patient experience, and clinical effectiveness. Associated principal risks included variation in quality standards, maternity services improvement, Electronic Patient Record dependent change, and new hospital programme transformation risk. Controls and review routes recorded in the March 2026 Group Board Assurance Framework Report included Trust-level Quality Management Groups, Hospital Management Groups, monthly Executive Performance Reviews,

management escalation through ERAG, Board-level scrutiny through GRAC, and external review through NHS England oversight, Care Quality Commission inspection, General Medical Council Enhanced Monitoring, and accreditation visits. Assurance was active but incomplete: controls provided structured oversight and escalation, but did not yet demonstrate that quality variation, recurrent harm themes, training supervision conditions, data quality limitations, and all improvement trajectories had reduced to target. Identified gaps included the need for a Group-wide quality framework, a Group-wide quality improvement programme, more consistent real-time quality data, and enhanced Board-level oversight of quality and outcomes. These actions will continue during 2026/27, with progress monitored through Trust management structures, ERAG, GRAC and the Group Board.

Group Aim A4 and Principal Risk 4 established the strategic framework for financial sustainability and value. The March 2026 Board Assurance Framework recorded limited assurance over financial sustainability, with key controls including the Board-approved Medium-term Plan, Cost Improvement Programme (CIP) development, bank and agency controls, capital planning, Financial Recovery Group oversight, and monthly financial performance reporting. Assurance sources included monthly Executive Performance Reviews, escalation through ERAG and GRAC, monthly reporting to NHS England, internal audit opinion, and external audit value for money findings once completed. The controls were operating and supported stronger grip, including the Trust's exit from NHS England's triple lock expenditure controls in March 2026, but had not yet reduced the financial sustainability risk to target. Gaps remained in relation to finalisation and achievement of 2026/27 CIP programmes, recurrent deficit reduction, run-rate improvement, and deeper assurance over the recurrent effect of savings.

Access, flow, and productivity remained a material operational risk during 2025/26, including urgent and emergency care pressures, elective waiting list management, diagnostic capacity, cancer pathways, and long-wait pathways. Controls included integrated performance reporting, Patient Tracking List review, elective and diagnostic validation, cancer and long-wait oversight, specialty recovery planning, Executive Performance Reviews, and escalation through the Hospital Management Group, ERAG, GRAC and Board reporting. Assurance was available over the existence and operation of these controls, and elective waiting list validation was strengthened through participation in national Elective Sprints. However, the controls had not yet secured the sustained recovery required against all access and waiting-list standards. Further assurance will be provided through continued Board and management scrutiny, 2026/27 recovery planning, and the planned Group-wide Internal Audit review of Waiting List Management.

During 2025/26, the Group identified digital capability and data readiness as a principal risk because insufficient digital maturity, data quality assurance, and analytics capability could inhibit modern clinical practice, transformation, and confident decision-making. Risks to data security were managed through digital and cyber controls including Data Protection and Security Toolkit improvement planning, cyber action plans, layered technical controls, user education, internal audit coverage, Cyber Assessment Framework work, and business case development for cyber and infrastructure investment. These controls provided an operating control environment, but assurance remained limited by legacy infrastructure, variable data maturity, and the need to align information management, cyber security, analytics, and data quality assurance capability across the Group. Further work is planned in 2026/27 on resources, infrastructure refresh, governance alignment, and compliance capability.

The Trust's principal risks to compliance with the NHS provider licence section 4 on governance during the year related to the effectiveness and completeness of the evolving Group governance

arrangements, clarity of responsibilities between the Trust Board, the Group Board, Committees in Common, and executive management structures, the sufficiency of Non-Executive Director scrutiny within the new model, the evidential standards required for lawful and informed decision-making, and the need to complete and embed the aligned governance instrument set. These matters were reflected in the Group principal risk relating to corporate governance and were subject to external legal review, NHS England follow-up review, Audit Committee scrutiny, GRAC oversight and Board reporting.

Risk management was embedded in the activity of the organisation through integrated performance reporting, incident reporting, escalation processes, finance and performance review, quality review mechanisms, workforce planning, management group oversight, committee scrutiny, and use of the BAF Report. Equality, diversity, human rights, and wider regulatory obligations were addressed through the Trust's established policies, operational controls, and decision-making processes.

Public stakeholders remained engaged through the continuing constitutional role of the Trust's Council of Governors, patient and public involvement arrangements, patient feedback and complaints systems, and the Group's stated intention to strengthen stakeholder engagement and confidence through transparent communication and visible leadership. Group Aim A6 explicitly required proactive public and stakeholder engagement to build and maintain confidence in Group services.

The Trust continued to ensure that short, medium, and long-term workforce strategies and staffing systems were in place to support safe, sustainable, and effective staffing. The Group Aims and BAF Report identified workforce capacity, capability, retention, safe staffing, wellbeing, engagement, inclusion, and workforce pipeline as central priorities. The March 2026 Board Assurance Framework recorded controls including Trust-level workforce plans, establishment control, acuity-based rostering, temporary staffing controls, sickness absence plans, and staff survey improvement planning, while also identifying gaps in relation to shortage specialties, sickness rates, and staff engagement.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. The Trust retains an overall CQC rating of Requires Improvement, with Safe, Responsive, and Well-led rated Requires Improvement and Effective, Caring, and Maternity rated Good. The rating remained a material context for the Board's assessment of the internal control environment, particularly in relation to quality variation, responsiveness, leadership systems, and the need for sustained improvement evidence.

The Board considered Well-led requirements through the NHS England and Care Quality Commission Well-led Framework, the NHS Provider Licence governance condition, CQC inspection evidence, internal and external audit, Board and committee reporting, and development of the Group Governance Framework. Assurance was strengthened by completion of the Group statutory governance instrument set and NHS England follow-up review, but the Board recognised that the Group model, Board assurance cycle, risk appetite, BAF Report, and NED scrutiny arrangements required further embedding during 2026/27.

While no CQC enforcement notices or special measures apply, the Trust remains subject to General Medical Council Enhanced Monitoring for Medicine and Surgery, managing specific conditions regarding supervision and handovers for doctors in training. Controls included specialty-level action plans, educational supervision oversight, handover improvement work, reporting through medical education and management routes, and escalation to executive and Board-level structures where required. During 2026/27, assurance will focus on whether the conditions have been addressed sustainably and whether evidence supports exit from enhanced monitoring.

A significant regulatory milestone was achieved in March 2026 when the Trust successfully exited NHS England's triple lock expenditure controls. The Trust also maintained arrangements consistent with Developing Workforce Safeguards. Safe staffing and red-flag processes were overseen locally by the People and Culture Management Group, using evidence-based establishment review, acuity-based rostering, professional judgement, quality and outcome indicators, incident themes, sickness and vacancy data, temporary staffing controls, and escalation where staffing risks moved outside tolerance. Mandatory training and appraisal compliance remained strong, but the Board recognised continuing workforce risks in relation to sickness absence, staff survey engagement, shortage specialties, and sustained capacity.

Local workforce risks, including sickness absence, staff survey engagement declines, capacity pressure, and shortage specialties, were addressed through targeted interventions, leadership visibility programmes, establishment review, temporary staffing controls, and alignment with Group-wide actions. Assurance was provided through workforce reporting, management group review, executive oversight, and Board-level reporting, with further work planned during 2026/27 to evidence sustained improvement.

Local estates risks continued to be managed through the Trust's estates governance and risk management arrangements, with escalation through executive and Board reporting where required. Controls included estates risk review, statutory compliance monitoring, capital prioritisation, business continuity arrangements, health and safety controls, and escalation of material infrastructure risks through local and Group routes. Assurance was available over operating controls, but the estate remained a material constraint on productivity, resilience, and patient environment improvement, with residual risk dependent on capital prioritisation and Group estate planning.

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

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

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

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

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

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

The Trust's exit from triple lock controls provided evidence of strengthened expenditure control, but the Board recognised that recurrent financial sustainability, productivity recovery, and achievement of 2026/27 CIP plans remained subject to limited assurance pending further evidence and final external audit value for money findings.

Information governance

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

No material personal data breaches or Data Security Incident Reporting Tool escalations were reported in 2025/26. Controls are delivered locally through Inphase and Caldicott processes and reported via the People and Culture Management Group and Quality Management Group, with Group-level DSPT oversight.

Data quality and governance

The Trust maintained arrangements to provide the Board with confidence that appropriate controls were in place to support the accuracy of performance, quality, operational, waiting list, mortality, and clinical coding data. The Board recognised, however, that data quality assurance remained an area requiring strengthened controls, especially where coding, pathway recording, or validation weaknesses could affect reported performance, mortality indicators, or confidence in recovery trajectories.

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

The Trust ensured the quality and accuracy of elective waiting time data through a dedicated Data Quality Manager working with the Access, Commissioning, and Clinical Coding teams. Controls included Patient Tracking List review, validation of waiting list status, pathway checks, long-wait oversight, and cross-team review where data anomalies were identified.

The Chief Operating Officer oversaw elective performance through automated reporting and standard operating procedures. Validation controls included contacting all patients waiting over 12 weeks to confirm ongoing clinical need, with further targeted validation through national Elective Sprint work. These controls strengthened visibility and correction of waiting list data, but the Trust recognised that operational recovery and the accuracy of pathway recording required continued scrutiny during 2026/27.

During 2025/26, elective waiting time validation was strengthened through participation in national Elective Sprints, overseen by the Finance and Performance Management Group. The Board and management groups used the resulting intelligence to support pathway validation, recovery planning, and escalation of long-wait risks.

A known local data risk, Risk 80, related to clinical coding and pathway weaknesses which historically contributed to the Trust's status as a national mortality outlier. The risk was managed through a mortality improvement plan focused on improving coding of frailty, comorbidities, case mix, and pathway documentation, with oversight through mortality review, clinical coding improvement work, quality reporting, and executive review. The control issue was not confined to coding accuracy: inaccurate or incomplete coding could affect mortality indicators, Board interpretation of clinical effectiveness, external perception of quality, and confidence in whether variation reflected actual clinical outcomes or data artefact. During 2026/27, assurance will need to demonstrate timely coding, sustained correction of mortality indicator anomalies, clear linkage between mortality review and coding improvement, and reliable escalation where data quality affects Board interpretation of quality or performance.

Audit coverage will be further supported by a Group-wide Internal Audit review of Waiting List Management in 2026/27. The review should be used to assess whether controls over waiting list governance, pathway validation, escalation, reporting accuracy, and recovery oversight are operating effectively and whether any findings require further disclosure in the 2026/27 governance cycle.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within Norfolk and Norwich University Hospitals NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

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

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

The review identified material areas requiring continued management action, most notably financial sustainability, achievement of the Cost Improvement Programme, access and waiting list recovery, mortality and clinical coding data quality assurance, recurrent harm themes, General Medical Council Enhanced Monitoring, workforce capacity and engagement, and embedding of the Group governance framework. These matters were recorded through the Trust's and Group's risk and assurance arrangements and were subject to enhanced scrutiny through executive review, Financial Recovery

Group oversight, management group reporting, Audit Committee review, GRAC scrutiny, Board reporting, and external oversight where applicable.

The Board considered whether these matters represented significant internal control issues. The Board's judgement was that they did not amount, individually or collectively, to a breakdown of the overall system of internal control. Rather, they represented material areas where controls were present and operating, but where application, consistency, and evidence of sustained effect were not yet sufficient to provide the required level of assurance in all respects. These matters therefore require tighter control application, continued scrutiny, and demonstrable improvement during 2026/27.

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

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

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

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

Significant internal control issues

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

The Board nevertheless recognised material risks and assurance limitations in relation to financial sustainability, delivery of the Cost Improvement Programme, access and waiting list recovery, mortality and clinical coding data quality assurance, recurrent quality themes, General Medical Council Enhanced Monitoring, workforce capacity and engagement, and embedding of the Group governance framework. These matters required strengthened management action, tighter application of controls, and continued assurance during 2026/27, but were not assessed as evidencing a breakdown of the overall system of internal control.

Conclusion

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

Lesley Dwyer

Chief Executive

Norfolk and Norwich University Hospitals NHS Foundation Trust

Date: 25 June 2026

Remuneration Report

1. Annual Statement on Remuneration

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

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

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

Major decisions on senior managers' remuneration

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

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

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

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

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

Senior managers are employed on contracts of service and are substantive employees of the Trust. Their contracts are open-ended employment contracts which can be terminated by either party with six months' notice. All executive directors are subject to periodic appraisal and are accountable to the Board of Directors for performance in those areas to which they

provide executive leadership. The Trust's normal disciplinary policies apply to senior managers, including the sanction of summary dismissal without notice for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff.

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

During 2025/26, two directors received part of their remuneration via a bonus scheme. No other substantial changes to senior managers' remuneration were made during 2025/26.

Signed by the Chair of the Remuneration Committee on 25 June 2026:

Sally Collier
Non-Executive Director
Chair of the Remuneration Committee

2. Senior Managers' Remuneration Policy

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

Remuneration component	Applicable to	Jurisdiction	Relevance to Trust's long- and short-term objectives	Amount payable
Basic salary	All senior managers	Nominations and Remuneration Committee	Recommendations in respect of basic salary are made to the Nominations and Remuneration Committee by the Chief Executive (for executive directors) and the Chairman (for the Chief Executive) on the basis of assessment of performance at annual appraisal, and specifically achievement of agreed personal objectives that reflect the long- and short-term objectives of the Trust.	Any increases are agreed with reference to the NHS VSM Pay Framework and advice as required.
Pension	All senior managers	Terms of membership as specified by the NHS Pension Scheme administered by the NHS Pensions Agency	N/A	Determined by the NHS Pensions Agency.
NNUH Pension Contributions Alternative Rewards Policy	Senior managers who opt in (who are not making pension contributions)	Nominations and Remuneration Committee	A separate cash payment of up to 12.5% of an employee's basic salary where they have opted out of the NHS Pension Scheme.	Payment is made at up to 12.5% of gross basic pay.
Clinical Impact Award (formerly Clinical Excellence Award) Scheme	Group Chief Medical Director only	Determined by Local Awards Committee in accordance with medical and dental employment contract; not awarded by Nominations and Remuneration Committee. The Scheme ended on 1st April 2024. Existing awards granted prior to 1st April 2018 remain in place.	Awards are determined by the Local Awards Committee in accordance with an agreed scheme that recognises clinical excellence across five domains. Analysis of the scheme demonstrates a linkage to the Trust's strategic objectives including the leadership and delivery of clinical services, teaching, training and research.	Level nine award is the maximum that can be awarded locally.
10% Bonus	Group Chief Medical Director and Executive Managing Director	Nominations and Remuneration Committee & Regional Medical Director	A separate cash payment of 10% of an employee's basic salary where a bonus payment has been agreed.	Payment is made at 10% of gross basic pay.

Accompanying notes:

(1) In 2025/26 a 10% bonus payment has been introduced for the Group Chief Medical Director and Executive Managing Director. This is to attract the appropriate talent to senior roles.

(2) With the exception of the end of the Local Clinical Impact Awards (formerly Clinical Excellence Awards) scheme and bonus scheme, there have been no additions or changes to the components of the remuneration package during 2025/26.

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

3. Annual Report on Remuneration

Service Contracts

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

Name & Title	Date of Commencement	End Date	Unexpired Term at 31st March 2026	Notice Period
Group Executive Directors:				
L Dwyer, Group Chief Executive Officer	01/11/2025	Ongoing	N/A	6 Months
J Segasby, Group Chief Delivery Officer	01/11/2025	Ongoing	N/A	6 Months
J Segasby, Acting Group Chief Nurse	01/11/2025	14/12/2025	N/A	6 Months
M Thorman, Group Chief Finance Officer	01/11/2025	Ongoing	N/A	6 Months
M Thorman, Interim Executive Managing Director	13/11/2025	07/12/2025	N/A	6 Months
T Bleakley, Interim Executive Managing Director [2]	01/11/2025	12/11/2025	N/A	6 Months
S Gordon, Executive Managing Director	08/12/2025	Ongoing	N/A	6 Months
J Sherwin, Group Chief Medical Director	01/12/2025	Ongoing	N/A	6 Months
B Brett, Acting Group Chief Medical Director (NNUH) [1]	01/11/2025	30/11/2025	N/A	6 Months
V Chitre, Acting Group Chief Medical Director (JPUH) [1]	01/11/2025	30/11/2025	N/A	6 Months
R Martin, Acting Group Chief Medical Director (QEHKL) [1]	01/11/2025	30/11/2025	N/A	6 Months
R Cocker, Interim Group Chief Nurse	15/12/2025	15/12/2026	N/A	6 Months
NNUH Trust Executive Directors prior to Group:				
L Dwyer, Trust Chief Executive Officer	04/03/2024	31/10/2025	N/A	6 Months
M Thorman, Interim Trust Chief Finance Officer	24/03/2025	31/10/2025	N/A	6 Months
C Cobb, Trust Chief Operating Officer	17/04/2019	31/10/2025	N/A	6 Months
T Bleakley, Interim Executive Managing Director	12/05/2025	31/10/2025	N/A	6 Months
B Brett, Trust Medical Director (Appointed 10 October 2024, Interim Medical Director from 14 September 2023)	14/09/2023	31/10/2025	N/A	6 Months
R Cocker, Chief Nurse (Appointed 4 September 2024, Interim Chief Nurse from 29 February 2024)	29/02/2024	31/10/2025	N/A	6 Months

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

[2] – T Bleakley was employed by the Norfolk and Waveney ICB with the cost to the Trust being recharged.

Group Non-Executive Directors:	Date of Commencement	End Date	Unexpired Term at 31st March 2026	Notice Period
D Roberts, Interim Group Chairman	01/11/2025	31/10/2026	6 Months	3 Months
W Van't Hoff, Group Non-Executive Director	10/12/2025	09/12/2027	20 Months	3 Months
S Collier, Group Non-Executive Director	10/12/2025	09/12/2028	32 Months	3 Months
P Baker, Group Non-Executive Director	10/12/2025	09/12/2028	32 Months	3 Months
J Bowman, Group Non-Executive Director	10/12/2025	09/12/2028	32 Months	3 Months
J Churchill, Group Non-Executive Director	10/12/2025	09/12/2028	32 Months	3 Months
N Gray, Group Non-Executive Director	22/12/2025	21/12/2028	32 Months	3 Months
S Javes, Group Non-Executive Director	22/12/2025	21/12/2027	20 Months	3 Months
Trust Non-Executive Directors:				
M Friend, Interim Trust Chairman	07/04/2025	31/10/2025	N/A	3 Months
T Spink, Trust Chairman	22/03/2023	06/04/2025	N/A	3 Months
T Spink, Trust Non-Executive Director	07/04/2025	31/10/2025	N/A	3 Months
J Foster, Trust Non-Executive Director	01/06/2019	09/12/2025	N/A	3 Months
S Dinneen, Trust Non-Executive Director	01/01/2020	09/12/2025	N/A	3 Months
J Hannam, Trust Non-Executive Director	01/01/2020	09/12/2025	N/A	3 Months
U Sarkar, Trust Non-Executive Director	05/09/2022	09/12/2025	N/A	3 Months
P Baker, Trust Non-Executive Director	03/03/2025	09/12/2025	N/A	3 Months
N Gray, Trust Non-Executive Director	02/01/2024	21/12/2025	N/A	3 Months
P Chrispin, Trust Non-Executive Director	01/01/2020	30/04/2025	N/A	3 Months
C Fernandez, Trust Non-Executive Director	01/04/2025	09/12/2025	N/A	3 Months

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

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

Nominations and Remuneration Committee

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

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

The Committee met two times during 2025/26, on 4 July and 21 October 2025. The meetings were quorate.

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

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

Disclosures required by the Health and Social Care Act

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

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

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

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

Executive Managing Director - The remuneration for this post represents a departure from the NHS VSM pay framework, reflecting the scale and complexity of the role and the organisation's operational and improvement challenges. Approval remains outstanding by DHSC but has been supported and submitted by NHS England.

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

The Governor role is unpaid. When the Council of Governors was established, it was agreed

that governors were entitled to claim travel expenses for attending meetings. In 2025/26 there were 21 governors (14 public governors, six staff governors and one partner governor). In 2024/25 there were 25 governors (16 public governors, six staff governors and three partner governors).

Table of disclosure	2025/26	2024/25
Governors		
The total number of governors in office	21	25
The number of governors receiving expenses in the reporting period	4	5
The aggregate sum of expenses paid to governors in the reporting period	£ 1,831	£ 1,326
Directors		
The total number of directors in office	27	16
The number of directors receiving expenses in the reporting period	3	4
The aggregate sum of expenses paid to directors in the reporting period	£ 8,253	£ 2,275

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

	12 months ended 31st March 2026					12 months ended 31st March 2025				
	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)
Name and title (Chairman and Executive Directors)	£'000	£	£'000	£'000	£'000	£'000	£	£'000	£'000	£'000
D Roberts, Interim Group Chair (Appointed 1 November 2025)	35 – 40	0	0	0	35 – 40	0	0	0	0	0
T Spink, NNUH Chair (NED from 7 April 2025 until 31 October 2025, NNUH Chair from 22 March 2023)	25 – 30	100	0	0	25 – 30	50 - 55	100	0	0	55 - 60
M Friend, Interim NNUH Chair (Appointed 7 April 2025 until 31 October 2025)	35 – 40	0	0	0	35 – 40	0	0	0	0	0
L Dwyer, Group Chief Executive (Appointed 1 November 2025, NNUH Chief Executive from 4th March 2024)	260 – 265	0	0	62.5 – 65	325 - 330	260 - 265	0	0	0	260 - 265
M Thorman, Group Chief Financial Officer (Appointed 1 November 2025, also Interim NNUH EMD between 13 November 2025 and 7 December 2025, NNUH Interim Chief Financial Officer from 24 March 2025) **	255 – 260	0	0	102.5 – 105	360 - 365	5 - 10	0	0	0	5 - 10
E Sanford, Interim Chief Finance Officer (Appointed 11 March 2024 until 23 March 2025)	0	0	0	0	0	180 - 185	0	0	55 - 57.5	235 - 240
J Segasby, Group Delivery Officer (Appointed 1 November 2025, also Acting Group Chief Nurse between 1 Nov 2025 to 14 Dec 2025)	95 – 100	0	0	147.5 – 150	245 – 250	0	0	0	0	0
T Bleakley, Interim Executive Managing Director of the Norfolk and Norwich University Hospital (Appointed 12 May 2025 to 12 November 2025)	110 – 115	0	0	37.5 – 40	145 – 150	0	0	0	0	0
S Gordon, Executive Managing Director of NNUH (Appointed 08 December 2025, Interim Executive Managing Director of JPUH Appointed 12 May 2025 until 7 December 2025)	90 – 95	0	0	0	90 – 95	0	0	0	0	0
C Cobb, NNUH Chief Operating Officer (Appointed 17 April 2019 until 31 October 2025)	110 – 115	0	0	0	110 – 115	190 - 195	0	0	0	190 - 195
J Sherwin, Group Chief Medical Director (Appointed 1 December 2025)	65 – 70	0	5 – 10	62.5 – 65	135 – 140	0	0	0	0	0
B Brett, NNUH Medical Director (Acting Group Medical Director 1 November 2025 to 30 November 2025)	160 – 165	0	20 - 25	112.5 – 115	295 – 300	230 - 235	0	30 - 35	507.5 - 510	770 - 775
V Chitre, Acting Group Chief Medical Director (JPUH) (Appointed 1 November 2025 to 30 November 2025)	10 – 15	0	0	20 – 22.5	35 – 40	0	0	0	0	0
R Martin, Acting Group Chief Medical Director (QEHKL) (Appointed 1 November 2025 to 30 November 2025)	15 – 20	100	0	5 – 7.5	25 – 30	0	0	0	0	0

R Cocker, Interim Group Chief Nurse (Appointed 15 December 2025, NNUH Chief Nurse from 29 February 2024 to 31 October 2025)	150 – 155	0	0	27.5 – 30	180 – 185	165 - 170	0	0	517.5 - 520	685 - 690
P Jones, Chief People Officer (Until 31 December 2024) *	0	0	0	0	0	210 - 215	0	0	22.5 - 25	235 - 240

* P 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 for the period ending 31 March 2025. In addition, P Jones received a £33k redundancy payment. This is not included in the salary figure above.

** Due to the appointment date of M Thorman the Greenbury Submission Window had already closed resulting in the Pension Related Benefits for 2024/25 not being supplied. Therefore £nil has been detailed. This will have an immaterial impact on the table above.

	12 months ended 31st March 2026					12 months ended 31st March 2025				
	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)
Name and title (Non-Executive Directors)	£'000	£	£'000	£'000	£'000	£'000	£	£'000	£'000	£'000
P Baker, Group Non-Executive Director (Appointed 10 Dec 2025, NNUH Non-Executive Director from 03 Mar 2025)	10 - 15	0	0	0	10 – 15	0 – 5	0	0	0	0 – 5
J Bowman, Group Non-Executive Director (Appointed 10 Dec 2025)	5 – 10	0	0	0	5 – 10	0	0	0	0	0
J Churchill, Group Non-Executive Director (Appointed 10 Dec 2025)	5 – 10	0	0	0	5 – 10	0	0	0	0	0
S Collier, Group Non-Executive Director (Appointed 10 Dec 2025)	5 – 10	0	0	0	5 – 10	0	0	0	0	0
N Gray, Group Non-Executive Director (Appointed 22 Dec 2025, NNUH Non-Executive Director from 02 Jan 2024)	10 – 15	0	0	0	10 – 15	10 – 15	0	0	0	10 – 15
S Javes, Group Non-Executive Director (Appointed 22 Dec 2025)	0 – 5	0	0	0	0 – 5	0	0	0	0	0
W Van't Hoff, Group Non-Executive Director (Appointed 10 Dec 2025)	5 – 10	0	0	0	5 – 10	0	0	0	0	0
P Chrispin, NNUH Non-Executive Director (Until 30 Apr 2025)	0 – 5	0	0	0	0 – 5	10 – 15	0	0	0	10 - 15
S Dinneen, NNUH Non-Executive Director (Until 09 Dec 2025)	5 - 10	0	0	0	5 – 10	10 – 15	0	0	0	10 - 15
J Foster, NNUH Non-Executive Director (Until 09 Dec 2025)	5 – 10	0	0	0	5 – 10	10 – 15	0	0	0	10 - 15
C Fernandez, NNUH Non-Executive Director (Appointed 01 Apr 2025, until 09 Dec 2025)	5 – 10	0	0	0	5 – 10	0	0	0	0	0
JM Hannam, NNUH Non-Executive Director (Until 09 Dec 2025)	5 – 10	0	0	0	5 – 10	10 – 15	0	0	0	10 - 15
U Sarkar, NNUH Non-Executive Director (Until 09 Dec 2025)	5 – 10	0	0	0	5 – 10	10 – 15	0	0	0	10 - 15
C ffrench-Constant, NNUH Non-Executive Director (UEA NED Post until 31 January 2025)	0	0	0	0	0	10 – 15	0	0	0	10 – 15

Definitions:

Senior Managers

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

Salary

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

Expense Payments

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

Pension related benefits

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

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

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

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

Benefits in Kind

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

Bonus

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

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

Remuneration Split

				Total Earnings	Pension Related Benefits	Earning Less Pension Adjustment	NNUH Contribution (Based on Earnings less Pension)	JPUH Contribution (Based on Earnings less Pension)	QEHKL Contribution (Based on Earnings less Pension)
		Dates		(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)
Name	Position	Appointed	End	£'000	£'000	£'000	£'000	£'000	£'000
D Roberts	Interim Group Chair	01/11/2025	Ongoing	35 – 40	0	35 – 40	10 – 15	10 – 15	10 – 15
L Dwyer	Group Chief Executive Officer (NNUH Chief Executive Officer until 31 Oct 2025)	04/03/2024	Ongoing	325 – 330	62.5 – 65	260 – 265	105 – 110	75 – 80	75 – 80
M Thorman	Group Chief Financial Officer (NNUH Interim Chief Financial Officer from 24 Mar 25 to 31 Oct 25)	24/03/2025	Ongoing	360 – 365	102.5 – 105	255 – 260	185 – 190	35 – 40	35 – 40
J Segasby	Group Delivery Officer	01/11/2025	Ongoing	245 – 250	147.5 – 150	95 – 100	30 – 35	30 – 35	30 – 35
T Bleakley	Interim Executive Managing Director of NNUH	12/05/2025	12/11/2025	145 – 150	37.5 – 40	110 – 115	110 – 115	0	0
S Gordon	Executive Managing Director of NNUH	08/12/2025	Ongoing	90 – 95	0	90 – 95	90 – 95	0	0
C Cobb	Chief Operating Officer	17/04/2019	31/10/2025	110 – 115	0	110 – 115	110 – 115	0	0
J Sherwin	Group Chief Medical Director	01/12/2025	Ongoing	135 – 140	62.5 – 65	75 – 80	25 – 30	25 – 30	25 – 30
B Brett	Acting Group Medical Director (NNUH) (Prev. NNUH Medical Director)	14/09/2023	30/11/2025	295 – 300	112.5 – 115	180 – 185	165 – 170	5 – 10	5 – 10
V Chitre	Acting Group Chief Medical Director (JPUH)	01/11/2025	30/11/2025	35 – 40	20 – 22.5	10 – 15	0 – 5	0 – 5	0 – 5
R Martin	Acting Group Chief Medical Director (QEHKL)	01/11/2025	30/11/2025	25 – 30	5 – 7.5	15 – 20	5 – 10	5 – 10	5 – 10
R Cocker	Interim Group Chief Nurse (from 15 Dec 25, previously NNUH Chief Nurse between 29 Feb 24 to 31 Oct 25)	29/02/2024	Ongoing	180 – 185	27.5 – 30	150 – 155	115 – 120	15 – 20	15 – 20
P Baker	Group Non-Executive Director (NNUH NED from 03 Mar 25 to 09 Dec 25)	03/03/2025	Ongoing	10 – 15	0	10 – 15	10 – 15	0 – 5	0 – 5
J Bowman	Group Non-Executive Director	10/12/2025	Ongoing	5 – 10	0	5 – 10	0 - 5	0 - 5	0 - 5

J Churchill	Group Non-Executive Director	10/12/2025	Ongoing	5 – 10	0	5 – 10	0 - 5	0 - 5	0 - 5
S Collier	Group Non-Executive Director	10/12/2025	Ongoing	5 – 10	0	5 – 10	0 - 5	0 - 5	0 - 5
N Gray	Group Non-Executive Director (NNUH NED from 02 Jan 24 to 22 Dec 25)	02/01/2024	Ongoing	10 – 15	0	10 – 15	10 – 15	0 – 5	0 – 5
S Javes	Group Non-Executive Director	22/12/2025	Ongoing	0 – 5	0	0 – 5	0 – 5	0 – 5	0 – 5
W Van't Hoff	Group Non-Executive Director	10/12/2025	Ongoing	5 – 10	0	5 – 10	0 - 5	0 - 5	0 - 5
T Spink	Non-Executive Director (Trust Chair until 05/04/2025)	22/03/2023	31/10/2025	25 – 30	0	25 – 30	25 – 30	0	0
M Friend	Interim Trust Chair	07/04/2025	31/10/2025	35 – 40	0	35 – 40	35 – 40	0	0
P Chrispin	Non-Executive Director	01/01/2020	30/04/2025	0 - 5	0	0 - 5	0 - 5	0	0
S Dinneen	Non-Executive Director	01/01/2020	09/12/2025	5 – 10	0	5 – 10	5 – 10	0	0
C Fernandez	Non-Executive Director	01/04/2025	09/12/2025	5 – 10	0	5 – 10	5 – 10	0	0
J Foster	Non-Executive Director	01/06/2019	09/12/2025	5 - 10	0	5 - 10	5 - 10	0	0
J Hannam	Non-Executive Director	01/01/2020	09/12/2025	5 – 10	0	5 – 10	5 – 10	0	0
U Sarkar	Non-Executive Director	05/09/2022	09/12/2025	5 - 10	0	5 - 10	5 - 10	0	0

Notes:

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

Pensions entitlement table

2025/26 Name and title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2026 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pensions at 31 March 2026 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2025 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2026 £'000
L Dwyer, Group Chief Executive [2]	2.5 – 5	0	10 – 15	0 – 5	99	0	0
M Thorman, Group Chief Financial Officer	5 – 7.5	2.5 – 5	85 – 90	225 – 230	1,816	109	1,988
J Segasby, Group Delivery Officer	15 – 17.5	37.5 – 40	95 – 100	265 – 270	1,831	381	2,271
T Bleakley, Interim Executive Managing Director of NNUH	2.5 – 5	0	15 – 20	0 – 5	193	25	272
C Cobb, NNUH Chief Operating Officer [1]	N/A	N/A	N/A	N/A	N/A	N/A	N/A
S Gordon, Executive Managing Director of NNUH [1]	N/A	N/A	N/A	N/A	N/A	N/A	N/A
J Sherwin, Group Chief Medical Director	2.5 – 5	5 – 7.5	60 – 65	150 – 155	1,225	71	1,487
B Brett, NNUH Medical Director	5 – 7.5	7.5 – 10	100 – 105	265 – 270	2,246	135	2,516
V Chitre, Acting Group Chief Medical Director (JPUH)	7.5 – 10	10 – 12.5	90 – 95	215 – 220	200	53	301
R Martin, Acting Group Chief Medical Director (QEHKL)	2.5 – 5	2.5 – 5	70 – 75	175 – 180	1,579	60	1,719
R Cocker, Interim Group Chief Nurse	2.5 – 5	0	70 – 75	180 – 185	1,555	42	1,645

Notes:

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

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

2024/25 Name and title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2025 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pensions at 31 March 2025 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2024 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2025 £'000
L Dwyer, Chief Executive	0 – 2.5	0	5 – 10	0 – 5	85	0	99
C Cobb, Chief Operating Officer [1]	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
P 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 [2]	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Notes:

1. C Cobb chose not to be covered by the pension arrangements during the reporting year.
2. M 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.
3. 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.

Lump Sum

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

Cash Equivalent Transfer Values

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

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

Real Increase in CETV

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

Compensation on early retirement or for loss of office

There were no directors paid for early retirement or loss of office in 2025/26. In 2024/25, one director received a redundancy payment of £33k.

Payments to past directors

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

Fair pay disclosure

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

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

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

The banded remuneration of the highest paid director in the organisation in the financial year 2025-26 was £260k-£265k (2024/25: £260k-£265k). The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

Pay ratio information table

2025/26	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	31,158	40,823	53,274
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	31,158	40,823	53,274
'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 (£)	8.42	6.43	4.93
2024/25	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	31,890	42,003	52,651
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	31,890	42,003	52,651
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff): mid-point of band of highest paid director (£)	8.23	6.25	4.99

Percentage change in remuneration of highest paid director

The Group Chief Executive was the highest paid director for the Norfolk and Norwich University Hospitals NHS Foundation Trust in the financial year 2025/26 at £260k-£265k. In 2024/25 the Chief Medical Director was the highest paid director at £260k-£265k. The 2025/26 cost is the full salary and does not reflect the shared cost arrangement with N&WUHG agreed as part of the Group.

2025/26	**% Change from previous financial year in salary and allowances**	**% Change from previous financial year in performance pay and bonuses**
Highest paid director (midpoint of band)	12.90	-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)	4.49	-0.49

2024/25	% Change from previous financial year in salary and allowances	% Change from previous financial year in performance pay and bonuses
Highest paid director (midpoint of band)	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

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

	2025/26	2024/25
Band of highest paid director's total remuneration (£'000)	260 – 265	260 – 265
Midpoint of band	262,500	262,500
25th percentile (£)	31,158	31,890
Median total (£)	40,823	42,003
75th percentile (£)	53,274	52,651
Remuneration ratio	6.43	6.25

Employee Remuneration Range

	2025/26	2024/25
Band of highest paid employee (£'000)	365 - 370	380 – 385
Band of lowest paid employee (£'000)	10 – 15	10 – 15

In 2025/26, eleven (2024/25: six) employees received remuneration in excess of the highest paid director. Remuneration ranged from £12.5k to £367.5k (2024/25: £12.5k to £382.5k).

The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full-time equivalent number of employees) between years was 4.49%.

The highest paid director's remuneration was 6.43 times (2024/25: 6.25 times) the median remuneration of the workforce which was £40,823 (2024/25: £42,003).

Signed on behalf of the Board on 25 June 2026 Group Chief Executive Officer – Lesley Dwyer

Norfolk and Norwich University Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2026

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

In our opinion the financial statements:

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

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

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

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

- Enquiring of management, the Audit Committee, Group Audit Committees In Common 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 Trust Board, Group Board, Audit Committee and Group Audit Committees in Common minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the Trust's accounting policies.

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

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls 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 the variable element of the contacted income was consistent in value on a monthly basis. 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.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journal entries with unusual characteristics compared to the total journal population.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- 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-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 2025/26.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 97 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.

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

Reliance on non-recurrent funding to deliver CIP requirement

We inspected the financial planning return for 2025-26 noting a CIP requirement of £43.7m. As at the year end, the Trust had delivered CIP of £43.7m which was in line with the budgeted plan. However, this had a full year effect of £26.9m which is £16.8m adverse to plan. The achievement of the CIP performance in the current year was largely the result of non-recurrent additional funding receipts rather than through the effective delivery of recurrent improvements in cost.

Whilst there is a robust governance process in relation to CIP, there continues to be challenges for the Trust in relation to the delivery of recurrent CIP.

As a result of the work that the Trust still needs to do to drive recurrent cost saving efficiencies 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 deliver recurrent cost savings with a large reliance on additional funding receipts.

Recommendation:

The Trust needs to work with budget holders to perform a detailed review of spending of spending across the organisation, to identify areas and opportunities for the delivery of cost savings for the full year budget. This should cover the full-year effect of the CIP programme with the level of non-recurrent delivery being aligned to the plan with limited reliance on additional funding being received.

Assurance will need to be provided to the Group Board throughout the year that sufficient cost improvement schemes are in place to achieve the full £52.2m of CIP.

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

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

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

operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

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

Statutory reporting matters

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

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

We have nothing to report in these respects.

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

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

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

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

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

Emma Larcombe

Emma Larcombe

for and on behalf of KPMG LLP

Chartered Accountants

20 Station Road

Cambridge

CB1 2JD

25 June 2026

Foreword to the accounts

Norfolk and Norwich University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2026, 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 **Group Chief Executive**
Date **25 June 2026**

Statement of Comprehensive Income

	Note	2025/26 £000	2024/25 £000
Operating income from patient care activities	2	991,843	942,368
Other operating income	3	152,550	140,804
Operating expenses	6.1,8.1	(1,089,447)	(1,059,319)
Operating surplus from continuing operations		**54,946**	**23,853**
Finance income	10	4,856	6,263
Finance expenses	11	(50,000)	(43,594)
Net finance costs		**(45,144)**	**(37,331)**
Other (losses) / gains	12	(128)	315
Surplus / (deficit) for the year		**9,674**	**(13,163)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(215)	-
Revaluations	14.1	9,520	326
Total comprehensive income / (expense) for the period		**18,979**	**(12,837)**

Statement of Financial Position

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Intangible assets	13	32,794	-
Property, plant and equipment	14	411,883	413,816
Right of use assets	17	44,521	43,683
Receivables	19	56,095	57,554
Total non-current assets		**545,293**	**515,053**
Current assets			
Inventories	18	20,202	15,793
Receivables	19	60,928	54,914
Cash and cash equivalents	20	96,368	93,418
Total current assets		**177,498**	**164,125**
Current liabilities			
Trade and other payables	21	(148,337)	(143,146)
Borrowings	23	(28,514)	(26,170)
Provisions	24	(3,848)	(4,024)
Other liabilities	22	(28,289)	(23,419)
Total current liabilities		**(208,988)**	**(196,759)**
Total assets less current liabilities		**513,803**	**482,419**
Non-current liabilities			
Borrowings	23	(375,098)	(383,203)
Provisions	24	(3,416)	(3,945)
Other liabilities	22	(987)	(1,155)
Total non-current liabilities		**(379,501)**	**(388,303)**
Total assets employed		**134,302**	**94,116**
Financed by			
Public dividend capital		412,057	390,850
Revaluation reserve		34,842	26,328
Income and expenditure reserve		(312,597)	(323,062)
Total taxpayers' equity		**134,302**	**94,116**

The notes on pages 138 to 181 form part of these accounts.

Name Lesley Dwyer
Position Group Chief Executive
Date 25 June 2026

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2025 - brought forward	**390,850**	**26,328**	**(323,062)**	**94,116**
Surplus for the year	-	-	9,674	**9,674**
Other transfers between reserves	-	(791)	791	**-**
Impairments	-	(215)	-	**(215)**
Revaluations	-	9,520	-	**9,520**
Public dividend capital received	21,207	-	-	**21,207**
Taxpayers' equity at 31 March 2026	**412,057**	**34,842**	**(312,597)**	**134,302**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024 - brought forward	**345,033**	**26,366**	**(310,263)**	**61,136**
(Deficit) for the year	-	-	(13,163)	**(13,163)**
Other transfers between reserves	-	(364)	364	**-**
Revaluations	-	326	-	**326**
Public dividend capital received	45,817	-	-	**45,817**
Taxpayers' equity at 31 March 2025	**390,850**	**26,328**	**(323,062)**	**94,116**

Information on reserves

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

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

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

Statement of Cash Flows

	Note	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating surplus		54,946	23,853
Non-cash income and expense:			
Depreciation and amortisation	6.1	33,781	32,855
Net impairments	7	-	24,295
Income recognised in respect of capital donations	3	(3,548)	(5,899)
(Increase) in receivables and other assets		(4,986)	(10,805)
(Increase) / decrease in inventories		(4,409)	344
Increase / (decrease) in payables and other liabilities		3,456	(5,028)
(Decrease) in provisions		(807)	(2,124)
Net cash flows from operating activities		**78,433**	**57,491**
Cash flows from investing activities			
Interest received		4,891	6,308
Purchase of intangible assets		(11,627)	-
Purchase of PPE and investment property		(31,737)	(60,686)
Sales of PPE and investment property		96	109
Receipt of cash donations to purchase assets		2,182	-
Net cash flows (used in) investing activities		**(36,195)**	**(54,269)**
Cash flows from financing activities			
Public dividend capital received		21,207	45,817
Capital element of lease rental payments		(8,686)	(10,672)
Capital element of PFI, LIFT and other service concession payments		(18,248)	(16,116)
Interest paid on lease liability repayments		(724)	(481)
Interest paid on PFI, LIFT and other service concession obligations		(32,837)	(33,057)
Net cash flows (used in) financing activities		**(39,288)**	**(14,509)**
Increase / (decrease) in cash and cash equivalents		**2,950**	**(11,287)**
Cash and cash equivalents at 1 April - brought forward		**93,418**	**104,705**
Cash and cash equivalents at 31 March	20.1	**96,368**	**93,418**

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 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the 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 Trust is the corporate trustee to Norfolk and Norwich Hospitals Charity. The Trust has assessed its relationship to the charity and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the 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 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 the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such 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 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.
Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

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

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 for 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 (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use 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. 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. The valuation was accounted for in the 2024/25 accounts.

For 2025/26, the valuation has been subject to an indexation valuation by Montagu Evans, to assess the valuation movement over the year to 31 March 2026. This movement has been reflected in the 2025/26 accounts, along with capital additions in the financial year.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, 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 Financial Reporting Manual (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 1.14).

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.

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:

	Min life Years	Max life Years
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 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as ‘deemed cost’ and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

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

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

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

Useful lives of intangible assets

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:

	Min life Years	**Max life Years**
Information technology	-	-
Development expenditure	-	-
Websites	-	-
Software licences	-	-
Licences & trademarks	-	-
Patents	-	-
Other (purchased)	-	-

Note 1.11 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.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through 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.

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 1.14 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 term 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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

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 1.15 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 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

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

	Inflation rate	Prior year rate
Year 1	2.50%	2.60%
Year 2	2.00%	2.30%
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 2.95% in real terms (prior year: 2.40%).

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 1.16 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 1.17 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 1.18 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 1.19 Corporation tax

The Trust does not fall within the scope of Corporation Tax for the year ended 31 March 26, neither did it for the year ended 31 March 25.

Note 1.20 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 1.21 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 1.22 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 1.23 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 1.24 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 1.25 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted
The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

Note 1.27 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. The valuation was accounted for in the 2024/25 accounts.

For 2025/26, the valuation has been subject to an indexation valuation by Montagu Evans, to assess the valuation movement over the year to 31 March 2026. This movement has been reflected in the 2025/26 accounts, along with capital additions in the financial year.

Note 1.28 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 23, 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 2026 or 31 March 2025, 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 the 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 2026 was £60.1m. If 5% of the expected works were not to be undertaken the prepayment would be overstated by £3m

Note 2 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 2.1 Income from patient care activities (by nature)	2025/26 £000	2024/25 £000
Acute services		
Income from commissioners under API contracts - variable element*	221,352	217,992
Income from commissioners under API contracts - fixed element*	631,992	594,131
High cost drugs income from commissioners	79,170	74,758
Other NHS clinical income	15,289	11,053
All services		
Private patient income	3,549	3,231
National pay award central funding***	-	2,085
Additional pension contribution central funding**	37,078	35,017
Other clinical income	3,413	4,101
Total income from activities	**991,843**	**942,368**

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

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

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

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

Income from patient care activities has increased by c. £52.4m in 2025/26, primarily driven by higher income from commissioners under Aligned Payment and Incentive (API) contracts, particularly the fixed element. C. £25.1m reflects increased funding allocations to support service delivery and activity levels during the year, of which £11.9m is due to the CDC which opened Feb-25, and c. £19.3m relates to inflationary pressures including Pay Award.

The increase also includes additional central funding, including pension contribution support (£2.1m), and growth in high cost drugs income (£4.4m). A proportion of this funding relates to national allocations and is non-recurrent in nature.

Note 2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2025/26 £000	2024/25 £000
NHS England	154,170	161,026
Integrated care boards	830,709	773,998
Department of Health and Social Care	-	-
Other NHS providers	-	12
NHS other	-	-
Local authorities	36	336
Non-NHS: private patients	3,550	3,231
Non-NHS: overseas patients (chargeable to patient)	580	584
Injury cost recovery scheme	1,690	1,677
Non NHS: other	1,108	1,504
Total income from activities	**991,843**	**942,368**
Of which:		
Related to continuing operations	991,843	942,368
Related to discontinued operations	-	-

Note 2.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26	2024/25
	£000	£000
Income recognised this year	580	584
Cash payments received in-year	312	194
Amounts added to provision for impairment of receivables	322	199
Amounts written off in-year	190	365

Note 3 Other operating income

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	9,998	-	**9,998**	8,620	-	**8,620**
Education and training	40,148	2,304	**42,452**	37,703	2,051	**39,754**
Income in respect of employee benefits accounted on a gross basis	14,811	-	**14,811**	15,914	-	**15,914**
Receipt of capital grants and donations and peppercorn leases	-	3,548	**3,548**	-	5,899	**5,899**
Revenue from operating leases	-	318	**318**	-	359	**359**
Other income	81,423	-	**81,423**	70,258	-	**70,258**
Total other operating income	**146,380**	**6,170**	**152,550**	**132,495**	**8,309**	**140,804**
Of which:						
Related to continuing operations			152,550			140,804
Related to discontinued operations			-			-

Note 4.1 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:

	2025/26	2024/25
	£000	£000
Income from services designated as commissioner requested services	985,496	935,957
Income from services not designated as commissioner requested services	6,347	6,411
Total	**991,843**	**942,368**

Note 4.2 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 5 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 5.1 Operating lease income

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	87	87
Variable lease receipts / contingent rents	231	272
Total in-year operating lease income	**318**	**359**

Note 5.2 Future lease receipts

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due in:		
- 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	87	175
Total	**522**	**610**

Note 6.1 Operating expenses

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,128	5,638
Purchase of healthcare from non-NHS and non-DHSC bodies	8,570	15,875
Staff and executive directors costs	634,062	600,503
Remuneration of non-executive directors	223	152
Supplies and services - clinical (excluding drugs costs)	104,934	104,223
Supplies and services - general	10,474	10,750
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	115,121	113,097
Inventories written down	89	88
Consultancy costs	4,118	698
Establishment	5,353	5,057
Premises	36,672	34,120
Transport (including patient travel)	4,748	4,654
Depreciation on property, plant and equipment	33,781	32,855
Net impairments	-	24,295
Movement in credit loss allowance: contract receivables / contract assets	1,455	2,561
Movement in credit loss allowance: all other receivables and investments	235	167
Change in provisions discount rate(s)	(64)	7
Fees payable to the external auditor		
audit services- statutory audit	220	233
Internal audit costs	124	136
Clinical negligence	21,693	19,773
Legal fees	1,679	36
Insurance (as a policy holder)	470	464
Research and development	9,362	8,658
Education and training	4,430	4,889
Expenditure on short term leases	175	229
Redundancy	12,445	1,715
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	37,164	34,707
Hospitality	174	101
Losses, ex gratia & special payments	4	10
Grossing up consortium arrangements	33,050	29,665
Other services, eg external payroll	1,934	2,330
Other	1,624	1,633
Total	**1,089,447**	**1,059,319**
Of which:		
Related to continuing operations	1,089,447	1,059,319
Related to discontinued operations	-	-

Note 6.2 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 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £5,000k (2024/25: £5,000k).

Note 7 Impairment of assets

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	-	24,295
Total net impairments charged to operating surplus / deficit	**-**	**24,295**
Impairments charged to the revaluation reserve	215	-
Total net impairments	**215**	**24,295**

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 8.1 Employee benefits

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	485,950	460,436
Social security costs	61,077	47,545
Apprenticeship levy	2,356	2,288
Employer's contributions to NHS pensions	93,683	88,683
Pension cost - other	81	115
Termination benefits	12,445	1,715
Temporary staff (including agency)	5,465	11,862
Total gross staff costs	**661,057**	**612,644**
Of which		
Costs capitalised as part of assets	7,121	3,729

Note 8.2 Retirements due to ill-health

During 2025/26 there was 1 early retirement from the trust agreed on the grounds of ill-health (9 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £62k (£1,081k in 2024/25).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2023, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

Note 10 Finance income

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

	2025/26	2024/25
	£000	£000
Interest on bank accounts	4,856	6,263
Total finance income	**4,856**	**6,263**

Note 11.1 Finance expenditure

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

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on lease obligations	724	481
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	32,837	33,057
Remeasurement of the liability resulting from change in index or rate	16,378	10,005
Total interest expense	**49,939**	**43,543**
Unwinding of discount on provisions	61	51
Total finance costs	**50,000**	**43,594**

Note 11.2 The late payment of commercial debts (interest) Act 1998

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

Note 12 Other (losses) / gains

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	97	458
Losses on disposal of assets	(225)	(143)
Total (losses) / gains on disposal of assets	**(128)**	**315**

Note 13.1 Intangible assets - 2025/26

	Intangible assets under construction	Total
	£000	£000
Cost at 1 April 2025 - brought forward *	**-**	**-**
Additions	12,305	**12,305**
Reclassifications	20,826	**20,826**
Cost at 31 March 2026	**33,131**	**33,131**
Amortisation at 1 April 2025 - brought forward	**-**	**-**
Reclassifications	337	**337**
Amortisation at 31 March 2026	**337**	**337**
Net book value at 31 March 2026	**32,794**	**32,794**
Net book value at 1 April 2025	**-**	**-**

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

The intangible asset balance at 31 March 2026 primarily relates to capitalised software and system development costs. The additions during the year reflects continued investment in the Electronic Patient Records project.

During the year, certain assets previously classified within property, plant and equipment have been reclassified to intangible assets. This reclassification reflects a review of the nature of these assets and confirmation that they meet the definition of intangible assets, primarily relating to software and system development costs. The reclassification has no impact on the overall net asset position but has increased the intangible asset balance at 31 March 2026.

Note 13.2 Intangible assets - 2024/25

	Intangible assets under construction	Total
	£000	£000
Valuation / gross cost at 1 April 2024	**-**	**-**
Additions	-	**-**
Reclassifications	-	**-**
Valuation / gross cost at 31 March 2025	**-**	**-**
Amortisation at 1 April 2024	**-**	**-**
Reclassifications	-	**-**
Amortisation at 31 March 2025	**-**	**-**
Net book value at 31 March 2025	**-**	**-**
Net book value at 1 April 2024	**-**	**-**

Note 14.1 Property, plant and equipment - 2025/26

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**15,147**	**323,449**	**25,420**	**91,498**	**108**	**51,445**	**1,747**	**508,814**
Additions	-	18,608	1,264	15,853	-	2,189	31	**37,945**
Impairments	(118)	(97)	-	-	-	-	-	**(215)**
Revaluations	-	9,520	-	-	-	-	-	**9,520**
Reclassifications	-	(7,477)	(20,826)	-	-	2	-	**(28,301)**
Disposals / derecognition	-	(44)	-	(5,278)	-	(12)	-	**(5,334)**
Valuation/gross cost at 31 March 2026	**15,029**	**343,959**	**5,858**	**102,073**	**108**	**53,624**	**1,778**	**522,429**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**5,205**	**-**	**48,232**	**80**	**40,526**	**955**	**94,998**
Provided during the year	-	10,449	-	7,954	6	4,653	184	**23,246**
Reclassifications	-	(2,251)	-	-	-	(337)	-	**(2,588)**
Disposals / derecognition	-	(45)	-	(5,053)	-	(12)	-	**(5,110)**
Accumulated depreciation at 31 March 2026	**-**	**13,358**	**-**	**51,133**	**86**	**44,830**	**1,139**	**110,546**
Net book value at 31 March 2026	**15,029**	**330,601**	**5,858**	**50,940**	**22**	**8,794**	**639**	**411,883**
Net book value at 1 April 2025	**15,147**	**318,244**	**25,420**	**43,266**	**28**	**10,919**	**792**	**413,816**

Note 14.2 Property, plant and equipment - 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**17,014**	**287,997**	**43,636**	**78,340**	**108**	**51,179**	**1,715**	**479,989**
Additions	-	31,791	18,473	16,023	-	3,888	469	**70,644**
Impairments	(2,001)	(22,622)	-	-	-	-	-	**(24,623)**
Revaluations	134	(9,688)	-	-	-	-	-	**(9,554)**
Reclassifications	-	36,690	(36,689)	(7)	-	7	(1)	**-**
Disposals / derecognition	-	(719)	-	(2,858)	-	(3,629)	(436)	**(7,642)**
Valuation/gross cost at 31 March 2025	**15,147**	**323,449**	**25,420**	**91,498**	**108**	**51,445**	**1,747**	**508,814**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**5,475**	**-**	**44,984**	**74**	**39,375**	**1,215**	**91,123**
Provided during the year	-	10,656	-	5,982	6	4,769	169	**21,582**
Impairments	-	(328)	-	-	-	-	-	**(328)**
Revaluations	-	(9,880)	-	-	-	-	-	**(9,880)**
Reclassifications	-	1	-	(1)	-	-	-	**-**
Disposals / derecognition	-	(719)	-	(2,733)	-	(3,618)	(429)	**(7,499)**
Accumulated depreciation at 31 March 2025	**-**	**5,205**	**-**	**48,232**	**80**	**40,526**	**955**	**94,998**
Net book value at 31 March 2025	**15,147**	**318,244**	**25,420**	**43,266**	**28**	**10,919**	**792**	**413,816**
Net book value at 1 April 2024	**17,014**	**282,522**	**43,636**	**33,356**	**34**	**11,804**	**500**	**388,866**

Note 14.3 Property, plant and equipment financing - 31 March 2026

	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	15,029	131,415	5,858	42,485	22	8,753	590	**204,152**
On-SoFP PFI contracts and other service concession arrangements	-	185,997	-	-	-	-	-	**185,997**
Owned - donated/granted	-	13,189	-	8,455	-	41	49	**21,734**
Total net book value at 31 March 2026	**15,029**	**330,601**	**5,858**	**50,940**	**22**	**8,794**	**639**	**411,883**

Note 14.4 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	**211,798**
On-SoFP PFI contracts and other service concession arrangements	-	180,842	-	-	-	-	-	**180,842**
Owned - donated/granted	-	13,232	-	7,830	-	56	58	**21,176**
Total net book value at 31 March 2025	**15,147**	**318,244**	**25,420**	**43,266**	**28**	**10,919**	**792**	**413,816**

Note 15 Donations of property, plant and equipment

During the year assets to the value of £3,216k (2024/25: £4,699k) were purchased using charitable support. No conditions were imposed by the donor.

Note 16 Revaluations of property, plant and equipment

A full valuation of the Trust owned land and buildings 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. The valuation was accounted for in the 2024/25 accounts.

For 2025/26, the valuation has been subject to an indexation valuation by Montagu Evans, to assess the valuation movement over the year to 31 March 2026. This movement has been reflected in the 2025/26 accounts, along with capital additions in the financial year.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Note 17 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 17.1 Right of use assets - 2025/26

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**26,040**	**41,551**	**334**	**2,576**	**70,501**	**566**
Additions	93	4,423	112	934	**5,562**	-
Remeasurements of the lease liability	892	(399)	-	52	**545**	-
Movements in provisions for restoration / removal costs	41	-	-	-	**41**	27
Reclassifications	7,475	-	-	-	**7,475**	7,475
Disposals / derecognition	(89)	(1,148)	(27)	-	**(1,264)**	-
Valuation/gross cost at 31 March 2026	**34,452**	**44,427**	**419**	**3,562**	**82,860**	**8,068**
Accumulated depreciation at 1 April 2025 - brought forward	**3,260**	**21,583**	**146**	**1,828**	**26,817**	**75**
Provided during the year	1,724	7,879	126	806	**10,535**	340
Reclassifications	2,251	-	-	-	**2,251**	2,251
Disposals / derecognition	(89)	(1,148)	(27)	-	**(1,264)**	-
Accumulated depreciation at 31 March 2026	**7,146**	**28,314**	**245**	**2,634**	**38,339**	**2,666**
Net book value at 31 March 2026	**27,306**	**16,113**	**174**	**928**	**44,521**	**5,402**
Net book value at 1 April 2025	**22,780**	**19,968**	**188**	**748**	**43,684**	**491**

Net book value of right of use assets leased from other NHS providers	77
Net book value of right of use assets leased from other DHSC group bodies	5,325

Note 17.2 Right of use assets - 2024/25

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**25,891**	**44,003**	**204**	**2,576**	**72,674**	**499**
Additions	326	3,048	195	-	**3,569**	236
Remeasurements of the lease liability	1,628	907	-	-	**2,535**	-
Movements in provisions for restoration / removal costs	(8)	-	-	-	**(8)**	-
Disposals / derecognition	(1,797)	(6,407)	(65)	-	**(8,269)**	(169)
Valuation/gross cost at 31 March 2025	**26,040**	**41,551**	**334**	**2,576**	**70,501**	**566**
Accumulated depreciation at 1 April 2024 - brought forward	**4,534**	**18,138**	**103**	**1,028**	**23,803**	**130**
Provided during the year	523	9,842	108	800	**11,273**	114
Disposals / derecognition	(1,797)	(6,397)	(65)	-	**(8,259)**	(169)
Accumulated depreciation at 31 March 2025	**3,260**	**21,583**	**146**	**1,828**	**26,817**	**75**
Net book value at 31 March 2025	**22,780**	**19,968**	**188**	**748**	**43,684**	**491**
Net book value at 1 April 2024	**21,357**	**25,865**	**101**	**1,548**	**48,871**	**369**

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 17.3 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 17.4 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 23.1.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April	**40,366**	**46,487**
Lease additions	4,249	2,377
Lease liability remeasurements	546	2,536
Interest charge arising in year	724	481
Early terminations	-	(362)
Lease payments (cash outflows)	(9,409)	(11,153)
Carrying value at 31 March	**36,476**	**40,366**

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 6.1. 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 3.

Note 17.5 Maturity analysis of future lease payments

	Total 31 March 2026	Of which leased from DHSC group bodies: 31 March 2026	Total 31 March 2025	Of which leased from DHSC group bodies: 31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	8,358	75	8,501	114
- later than one year and not later than five years;	18,456	166	20,907	210
- later than five years.	11,992	187	12,996	219
Total gross future lease payments	**38,806**	**428**	**42,404**	**543**
Finance charges allocated to future periods	(2,330)	(37)	(2,038)	(48)
Net lease liabilities at 31 March 2026	**36,476**	**391**	**40,366**	**495**
Of which:				
Leased from other NHS providers		79		156
Leased from other DHSC group bodies		312		339

Note 18 Inventories

	31 March 2026	31 March 2025
	£000	£000
Drugs	5,301	5,405
Consumables	14,845	10,388
Energy	56	-
Total inventories	**20,202**	**15,793**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £218,785k (2024/25: £186,697k). Write-down of inventories recognised as expenses for the year were £89k (2024/25: £88k).

Note 19.1 Receivables

	31 March 2026	31 March 2025
	£000	£000
Current		
Contract receivables	44,596	41,092
Allowance for impaired contract receivables / assets	(6,197)	(5,482)
Allowance for other impaired receivables	(2,648)	(2,435)
Prepayments (non-PFI)	9,320	7,334
PFI lifecycle prepayments	7,121	6,198
Interest receivable	252	287
VAT receivable	5,790	5,394
Other receivables	2,694	2,526
Total current receivables	**60,928**	**54,914**
Non-current		
Contract receivables	1,724	1,664
PFI lifecycle prepayments	53,017	54,336
Other receivables	1,354	1,554
Total non-current receivables	**56,095**	**57,554**
Of which receivable from NHS and DHSC group bodies:		
Current	29,717	24,764
Non-current	1,354	1,554

Note 19.2 Allowances for credit losses

	2025/26		2024/25	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**5,482**	**2,435**	**4,843**	**2,308**
New allowances arising	2,445	424	2,561	407
Reversals of allowances	(990)	(189)	-	(240)
Utilisation of allowances (write offs)	(740)	(22)	(1,922)	(40)
Allowances as at 31 Mar 2026	**6,197**	**2,648**	**5,482**	**2,435**

Note 20.1 Cash and cash equivalents movements

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

	2025/26	2024/25
	£000	£000
At 1 April	**93,418**	**104,705**
Net change in year	2,950	(11,287)
At 31 March	**96,368**	**93,418**
Broken down into:		
Cash at commercial banks and in hand	195	165
Cash with the Government Banking Service	96,173	93,253
Total cash and cash equivalents as in SoFP	**96,368**	**93,418**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**96,368**	**93,418**

Note 20.2 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 2026	31 March 2025
	£000	£000
Bank balances	1	3
Total third party assets	**1**	**3**

Note 21 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	19,007	29,658
Capital payables	23,030	16,593
Accruals	84,284	76,694
Social security costs	14,137	12,679
Pension contributions payable	7,879	7,522
Total current trade and other payables	**148,337**	**143,146**
Of which payables from NHS and DHSC group bodies:		
Current	11,071	9,554
Non-current	-	-

Note 22 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities	28,289	23,419
Total other current liabilities	**28,289**	**23,419**
Non-current		
Deferred income: contract liabilities	987	1,155
Total other non-current liabilities	**987**	**1,155**

Note 23.1 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Lease liabilities	8,358	8,492
concession contracts	20,156	17,678
Total current borrowings	**28,514**	**26,170**
Non-current		
Lease liabilities	28,118	31,875
concession contracts	346,980	351,328
Total non-current borrowings	**375,098**	**383,203**

Note 23.2 Reconciliation of liabilities arising from financing activities

	Lease Liabilities	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2025	**40,366**	**369,005**	**409,371**
Cash movements:			
Financing cash flows - payments and receipts of principal	(8,685)	(18,246)	**(26,931)**
Financing cash flows - payments of interest	(724)	(32,837)	**(33,561)**
Non-cash movements:			
Additions	4,249	-	**4,249**
Lease liability remeasurements	546	-	**546**
Remeasurement of PFI / other service concession liability resulting from change in index or rate		16,378	**16,378**
Application of effective interest rate	724	32,837	**33,561**
Carrying value at 31 March 2026	**36,476**	**367,137**	**403,613**

	Lease Liabilities	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2024	**46,487**	**375,116**	**421,603**
Cash movements:			
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)**
Non-cash movements:			
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)**
Carrying value at 31 March 2025	**40,366**	**369,005**	**409,371**

Note 24.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2025	**470**	**1,834**	**120**	**690**	**4,854**	**7,968**
Change in the discount rate	(6)	(58)	-	-	(109)	**(173)**
Arising during the year	50	56	34	-	899	**1,039**
Utilised during the year	(85)	(159)	(34)	(690)	(641)	**(1,609)**
Reversed unused	-	-	-	-	(112)	**(112)**
Unwinding of discount	11	49	-	-	91	**151**
At 31 March 2026	**440**	**1,722**	**120**	**-**	**4,982**	**7,264**
Expected timing of cash flows:						
- not later than one year;	84	159	120	-	3,485	**3,848**
- later than one year and not later than five years;	276	591	-	-	233	**1,100**
- later than five years.	80	972	-	-	1,264	**2,316**
Total	**440**	**1,722**	**120**	**-**	**4,982**	**7,264**

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 2026, £251,839k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Norfolk and Norwich University Hospitals NHS Foundation Trust (31 March 2025: £265,591k).

Note 25 Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	2,850	16,743
Intangible assets	2,223	-
Total	**5,073**	**16,743**

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 £37,164k (2024/25: £34,700k).

The estimated value of the scheme at inception was £222,600k. Payments under the scheme commenced on 15 August 2001. In 2003/04 the Trust entered into and concluded a refinancing arrangement with Octagon Healthcare Ltd on the investment in the hospital. This resulted in an extension of the minimum term of the scheme from 30 to 35 years and a reduction in the annual charge by £3,500k per annum.

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 2026 £000	31 March 2025 £000
Gross PFI, LIFT or other service concession liabilities	**578,515**	**603,154**
Of which liabilities are due		
- not later than one year;	51,790	49,529
- later than one year and not later than five years;	207,012	198,117
- later than five years.	319,713	355,508
Finance charges allocated to future periods	(211,379)	(234,149)
Net PFI, LIFT or other service concession arrangement obligation	**367,136**	**369,005**
- not later than one year;	20,156	17,678
- later than one year and not later than five years;	100,116	87,963
- later than five years.	246,864	263,364

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 2026 £000	31 March 2025 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,040,006**	**1,100,374**
Of which payments are due:		
- not later than one year;	89,638	86,365
- later than one year and not later than five years;	368,105	354,904
- later than five years.	582,263	659,105

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:

	2025/26 £000	2024/25 £000
Unitary payment payable to service concession operator	**94,051**	**89,465**
Consisting of:		
- Interest charge	32,837	33,057
- Repayment of balance sheet obligation	18,248	16,116
- Service element and other charges to operating expenditure	37,164	34,707
- Addition to lifecycle prepayment	5,802	5,585
Total amount paid to service concession operator	**94,051**	**89,465**

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 2026 are in receivables from customers, as disclosed in the Trade and Other Receivables note.

The Trust's Treasury Management Policy has clear criteria, is updated regularly and 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 2026	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	40,349	**40,349**
Cash and cash equivalents	96,368	**96,368**
Total at 31 March 2026	**136,717**	**136,717**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	37,580	**37,580**
Cash and cash equivalents	93,418	**93,418**
Total at 31 March 2025	**130,998**	**130,998**

Note 27.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	-	**-**
Obligations under leases	36,476	**36,476**
Obligations under PFI, LIFT and other service concession contracts	367,136	**367,136**
Other borrowings	-	**-**
Trade and other payables excluding non financial liabilities	116,734	**116,734**
Other financial liabilities	-	**-**
Provisions under contract	7,122	**7,122**
Total at 31 March 2026	**527,468**	**527,468**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£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**
Total at 31 March 2025	**530,461**	**530,461**

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 2026	31 March 2025
	£000	£000
In one year or less	180,730	175,503
In more than one year but not more than five years	226,568	220,125
In more than five years	333,879	371,018
Total	**741,177**	**766,646**

Note 28 Losses and special payments

	2025/26		2024/25	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	121	240	4,405	1,251
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	540	501	693	671
Stores losses and damage to property	2	89	4	97
Total losses	**663**	**830**	**5,102**	**2,019**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	18	4	50	10
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**18**	**4**	**50**	**10**
Total losses and special payments	**681**	**834**	**5,152**	**2,029**

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.

The Trust entered into a Provider Collaborative Agreement with James Paget University Hospitals NHS Foundation Trust and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust on 1st November 2025 for the purpose of establishing Norfolk and Waveney University Joint Working Arrangements and appointment of a General Purpose Joint Committee to exercise joint functions. The Trusts remain independent, sovereign organisations constituted in accordance with the NHS Act and their respective constitutions.

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 deminimus of £5m income or expenditure has been used.

Related Party Transactions	Total income 2025/26	Total expenditure 2025/26	Total income 2024/25	Total expenditure 2024/25
	£000	£000	£000	£000
Value of transactions with board members	-	-	-	-
Value of transactions with key staff members	-	-	-	-
Cambridge University Hospitals NHS Foundation Trust	1,536	11,903	1,257	9,773
Department of Health and Social Care	40,639	-	35,477	-
HM Revenue & Customs	-	63,433	-	49,833
James Paget University Hospitals NHS Foundation Trust	13,851	6,063	13,172	7,424
NHS England	158,546	30	154,109	65
NHS Norfolk and Waveney ICB	823,351	1,780	780,282	1,306
NHS Pension Scheme	-	93,990	-	88,938
NHS Resolution	-	21,965	-	20,891
NHS Suffolk and North East Essex ICB	14,774	5	14,151	32
Norfolk Community Health and Care NHS Trust	3,384	6,031	2,961	5,797
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	11,504	5,214	10,232	4,015
Total	**1,067,585**	**210,414**	**1,011,641**	**188,074**

Related Party Balances	Total receivables 2025/26	Total payables 2025/26	Total receivables 2024/25	Total payables 2024/25
	£000	£000	£000	£000
Value of balances (other than salary) with related parties in relation to doubtful debt	(2,648)	-	(2,435)	-
Value of balances (other than salary) with related parties in respect of doubtful debts written off in year	-	-	-	-
Cambridge University Hospitals NHS Foundation Trust	486	1,460	558	2,008
Department of Health and Social Care	1,830	-	1,913	-
HM Revenue & Customs	5,790	14,136	5,394	12,678
James Paget University Hospitals NHS Foundation Trust	2,929	1,385	7,055	1,114
NHS England	978	1,096	2,259	1,760
NHS Norfolk and Waveney ICB	9,453	197	6,072	27
NHS Pension Scheme	-	7,859	-	7,590
NHS Resolution	-	-	-	-
NHS Suffolk and North East Essex ICB	39	-	303	-
Norfolk Community Health and Care NHS Trust	625	4,799	489	142
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	10,057	650	4,784	413
Total	**29,539**	**31,582**	**26,392**	**25,732**

Note 29 Related parties (continued)

Other non DHSC group related parties

Related Party Transactions	Total income 2025/26	Total expenditure 2025/26	Total income 2024/25	Total expenditure 2024/25
	£000	£000	£000	£000
Bullen Development Ltd - note 1	-	634	-	599
Anglia Innovation Partners LLP - note 2	-	710	-	485
QI Partners Ltd - note 2	-	1,840	-	1,755
University of East Anglia - note 3	2,293	1,678	3,126	2,358
NHS Shared Business Services - note 4	-	1,870	-	2,622
Macmillan Cancer Support - note 5	287	-	364	-
Norfolk County Council - note 6	51	477	35	6
Eastern Diagnostic Imaging Network - note 7	9	-	36	-
Medacs Healthcare - note 8	-	857	-	5,684
Total	**2,640**	**8,066**	**3,561**	**13,509**

Related Party Balances	Total receivables 2025/26	Total payables 2025/26	Total receivables 2024/25	Total payables 2024/25
	£000	£000	£000	£000
Bullen Development Ltd - note 1	-	-	-	-
Anglia Innovation Partners LLP - note 2	-	-	-	-
QI Partners Ltd - note 2	-	-	-	-
University of East Anglia - note 3	778	249	1,469	241
NHS Shared Business Services - note 4	-	-	-	362
Macmillan Cancer Support - note 5	-	-	-	-
Norfolk County Council - note 6	20	-	-	-
Eastern Diagnostic Imaging Network - note 7	-	-	-	-
Medacs Healthcare - note 8	-	-	-	-
Total	**798**	**249**	**1,469**	**603**

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
Note 6 - Non-Executive director spouse has a role for this organisation.
Note 7 - An Executive director is a member of the board of this organisation
Note 8 - An Executive director has a role for this organisation

Remuneration of Key Management Personnel

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

	Year ended 31 March 2026	Year ended 31 March 2025
	£000	£000
Short term employee benefits (pay)	1,554	1,400
Post-employment benefits (employers pension contribution)	145	135

The highest paid Director in 2025/26 received remuneration of £265k, excluding pension related benefits and exit packages, for their services as Chief Executive Officer for the Norfolk and Waveney University Hospitals Group. The Trust recharged part of their remuneration to other Trusts. In 2024/25 the highest paid Director received remuneration of £264k, not including pension related benefits and exit packages, for their services as Medical Director including an element relating to their non-managerial role.

Further details on remuneration of the Board of Directors can be found in the Remuneration Report.

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 £819k for enhancement of patient environment, investment in staff, additional equipment, and research (2024/25: £774k) from the Norfolk and Norwich Hospitals Charity.

During the year net assets to the value of £3,216k (2024/25: £4,699k) were donated to the Foundation Trust, of which £2,572k (2024/25: £170k) came from the Norfolk and Norwich Hospitals Charity.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has recharged the sum of £429k (2024/25: £376k) 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 £2,639k (2024/25: £2,304k).

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.

Our Vision
The best care
for every patient

NHS
Norfolk and Norwich
University Hospitals
NHS Foundation Trust

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