NHS

Norfolk Community Health and Care NHS Trust

Annual Report & Accounts

2024/25

Introduction

The Annual Report and Accounts is set out as follows:

Norfolk Community Health and Care NHS Trust (NCH&C) is defined as a Department of Health and Social Care (DHSC) group body and as such is required to publish, as a single document, a three-part annual report and accounts:

1. Performance Report

The Performance Report, which includes:

- An Overview
- A Performance Analysis

2. Accountability Report

The Accountability Report, which includes:

- Corporate Governance Report
- Remuneration and Staff Report
- Parliamentary Accountability and Audit Report

3. The Financial Statements

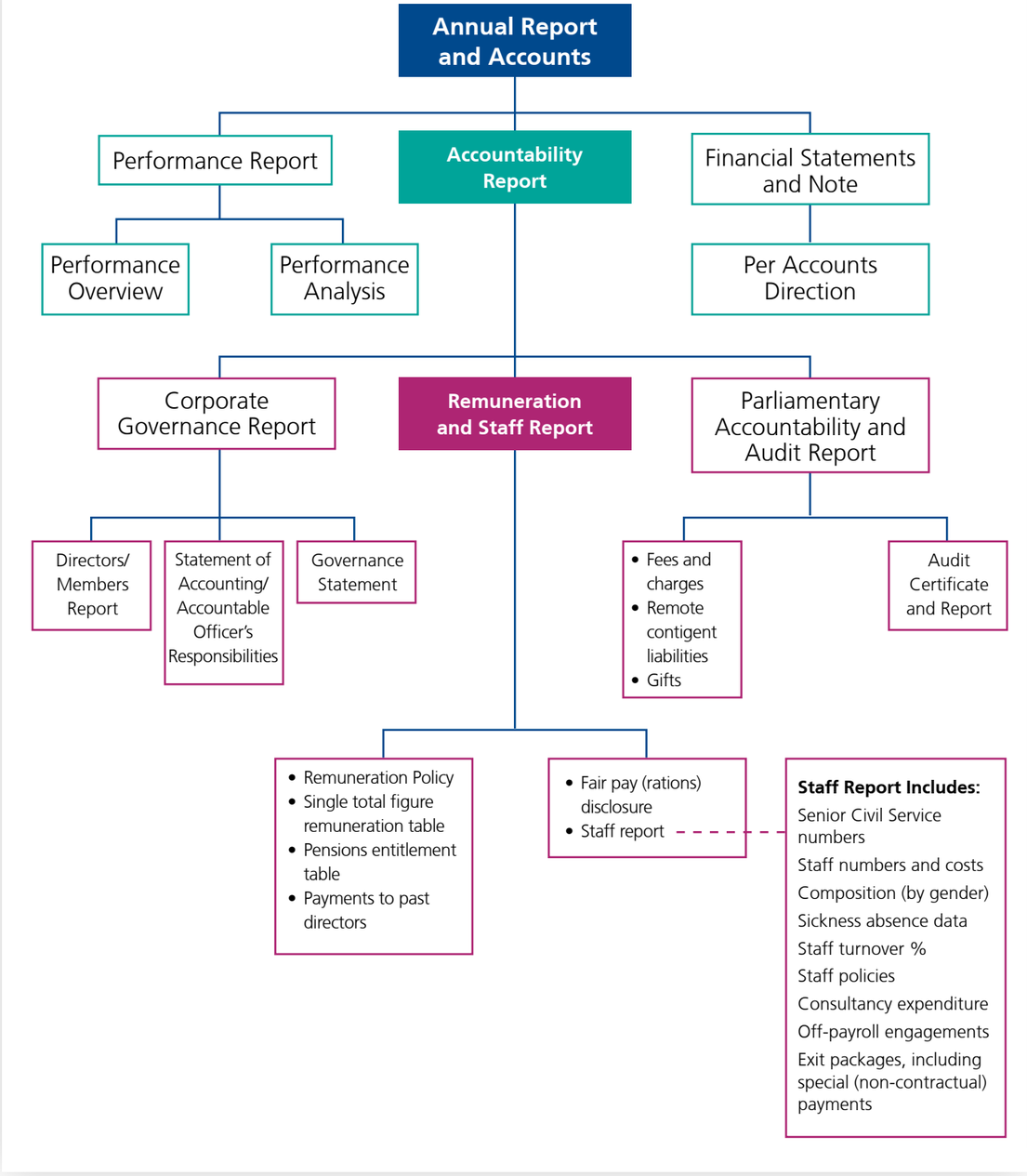
The structure of the annual report and accounts is described in the government Financial Reporting Manual (FReM). DHSC group bodies may omit headings or sections where they consider that these are not relevant, but the structure of the three-part annual report and accounts outlined in the Group Accounting Manual (GAM) must be adhered to.

Abbreviations used in this report

NCH&C	Norfolk Community Health and Care NHS Trust
NHSE	NHS England
NHSI	NHS Improvement
CCGs	Clinical Commissioning Groups
NCC	Norfolk County Council
CQC	Care Quality Commission
NED	Non-Executive Director
PCN	Primary Care Networks

Structure

The structure of the annual report and accounts



General Principles

GAM guidance sets out the minimum content of the annual report and accounts. Beyond this however, NCH&C has ensured that additional information is included where necessary to reflect the position of the Trust within the community and give sufficient information to meet the requirements of public accountability. Part A of the Financial Reporting Manual (FReM) sets out the purposes, principles and best practice in financial reporting. In establishing these, the FReM makes a number of references to the Financial Reporting Council's July 2018 publication of Guidance on the Strategic Report. Reporting requirements expressed in the FReM and GAM apply these principles to the preparation of annual report and accounts.

Specific reference is made to the application of the concept of materiality to the Performance Report and Accountability Report. Unless explicitly permitted, the concept of materiality cannot be applied to disclosures required:

By the GAM and consequently the FReM

By law or by regulation

Promulgated by HM Treasury through Public Expenditure System papers.

Where additional information is provided, NCH&C has ensured that the disclosure of information meets the principles and practices as detailed in the FReM in force for the financial year.

Accountable Officer Responsibilities

The Accountable Officer has taken personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable. NHS bodies are not required to comply with the UK Code of Corporate Governance. However, NCH&C complies with the NHS England "Code of governance for NHS provider trusts", which came into force from 1 April 2023. As a DHSC body NCH&C has included a Statement of the Accountable Officer's Responsibilities within the Accountability Report. Additionally, as an NHS trust, NCH&C has included a Statement of Directors' Responsibilities.

The Chief Executive as the Accountable Officer has signed and dated the following within the annual report and accounts to confirm adherence to the reporting framework:

- Performance Report
- Accountability Report, which incorporates the Corporate Governance Report/Statement and the Remuneration and Staff Report.
- Statement of Financial Position.

Contents

1. Performance Report

The purpose of the performance section of the annual report is to provide information on NCH&C, its main objectives and strategies and the principal risks that it faces.

The requirements of the performance report are based on the matters required to be dealt with in a Strategic Report as set out in Chapter 4A of Part 15 of the Companies Act 2006, as amended by SI 2013 No.1970, The Companies Act 2006 (Strategic Report and Directors' Report) Regulations 2013.

NCH&C complies with the Act as adapted in that it treats itself as if it were a quoted company. The performance report is required to have two sections: a 'performance overview' and a 'performance analysis'. The report is fair, balanced and understandable. Infographics and visual aids are used where they can enhance users understanding of the report. For NHS trusts, performance of the organisation in both the overview and performance analysis covers all aspects of performance and not only financial.

The performance report has been signed and dated by the Chief Executive as the Accountable Officer. Auditors have reviewed the Performance Report for consistency with other information in the financial statements. Auditors have read the information in the annual report and refer to this in their audit report.

The performance report comprises:

1.1 Performance overview

This section includes:

- A short summary explaining the purpose of the overview section.
- A statement from the chief executive providing their perspective on the performance of the organisation over the period.
- A statement of the purpose and activities of the organisation, including a brief description of the business model and environment, organisational structure, objectives and strategies.
- A performance appraisal which provides a synopsis of the performance analysis and an assessment of the NCH&C's progress towards delivering its objectives.

Purpose of the performance overview

The purpose of the performance overview is to give the user a short summary that provides them with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year. The overview is enough for the lay user to have no need to look further into the rest of the annual report and accounts unless they were interested in further detail or had specific accountability or decision-making needs to be met.

Chief Executive's Statement

In an organisation as diverse as Norfolk Community Health and Care NHS Trust (NCH&C), and in a year marked by significant events, it can be challenging to know where to begin. Ultimately, it all comes down to the impact we have on people's lives. Reflecting on the past year, we must acknowledge the tough financial situation faced by the NHS in England. Financial pressures have meant making difficult decisions but have also driven us to innovate and find new ways to deliver high-quality care. The UK general election of 2024 brought about changes that will shape the future of healthcare, and we are committed to implementing these changes with enthusiasm.

This year we have opened a brand-new therapy-led rehabilitation centre in Norwich. The Willow Therapy Unit is a state-of-the-art facility designed to provide much-needed services to our patients, helping them recover and regain their independence. You can read more about this state-of-the-art unit on page 13. Our commitment to service user feedback remains strong. In the 2024/25 Friends and Family Test, we received feedback from thousands of people, with an overwhelming majority rating our services as very good or good. This positive feedback is a testament to the hard work and dedication of our staff.

Some of our services still have waiting times that are too long. We are pleased that we have made changes in our Wheelchair services and are already seeing waiting times reduce. We also have joint approaches with Norfolk County Council to support children and young people with neuro-developmental issues sooner.

Similarly, our NHS staff survey results continue to reflect our commitment to being an excellent employer. We have made significant strides in areas such as compassion, inclusivity, flexible working, and staff engagement but know there is much more to do in some areas of the organisation. These improvements not only benefit our staff but also translate into better, safer, and kinder care for our patients.

As we look ahead to 2025/26, we are excited about the opportunities and challenges that lie ahead. Our commitment to our values remains unwavering, guiding us in everything we do.

Community is at the heart of our organisation. We believe that by working together as one, we can enhance the lives of our patients. Our dedication to providing integrated quality services with our partner organisations allows us to serve our local community with pride. We deeply respect and value the trust our patients place in us when we enter their homes and lives, and we strive to honour that trust every day.

Compassion drives our approach to care. We are committed to providing compassionate, coordinated, and personalised, quality care that is both safe and effective. Empowering and educating our patients and their carers is central to our mission, helping them manage their own independence, health, and wellbeing. Our dedication to holistic, compassionate care is reflected in our commitment to personal and professional development, ensuring that we continue to grow and improve.

Creativity fuels our innovation. Our expertise, commitment, and creativity are key to the successful delivery of our services. We are always open to new ideas that support us in delivering effective, compassionate care to our patients. By continuously innovating and implementing efficient delivery of care, we strive to meet the evolving needs of our community.

One of the most significant developments this year was the announcement that NCH&C will form a group with neighbouring community trust, Cambridgeshire Community Services NHS Trust (CCS). This collaboration is the first of its kind in the country and brings together two high performing Trusts. It will enable us to share our resources, expertise, and best practices. This aims to further enhance the care we provide to our communities.

Work as a Group began earlier in the year with the appointment of our new Group Board, putting our new governance arrangements in place, and creating opportunities for our people to start getting to know each other. Becoming a specialist community health and care Group on 1 April 2025 will make things better for our patients and our staff, while also making our services stronger and more resilient. We're excited about the opportunities this brings, and we look forward to an even brighter future together. Read more about this on page 33.

We are incredibly proud of our team at NCH&C. Their dedication makes NCH&C what it is, and we cannot thank them enough for their hard work and unwavering support. Thank you for taking the time to read our annual report. We look forward to continuing our journey together, improving the health and wellbeing of our communities.

Warm regards,

Lynda Thomas
Chair, Norfolk Community Health and Care NHS Trust

Matthew Winn
Chief Executive Officer, Norfolk Community Health and Care NHS Trust

Purpose and activities of NCH&C

This overview provides a summary of the Trust's background, service portfolio, income, aims and aspirations, as well as our approach to risk management.

NCH&C was established on 1 November 2010 to provide community-based health and care services. NHS trusts were established under the National Health Service and Community Care Act 1990, with each NHS trust individually being established by Statutory Instrument (NCH&C reference: 2010 no. 2466). Services are commissioned by the Integrated Care Board (ICB), Norfolk County Council (NCC) and NHS England (NHSE).

We report under the Accounts Direction determined by the Department of Health (Secretary of State) and approved by the Treasury. The Accounts Direction is made under the following legislation: National Health Service Act 2006 Chapter 41 Schedule 15: Preparation of annual accounts. The Trust Board is accountable to NHS England.

We are Community Health and Social Care Specialists for Norfolk and Waveney delivering more than 70 services to a population of over 900,000 people. We believe that you are better served within your own community, and we work hard to bring our expert care to people, close to where they live and work, in our community hospitals, within GP surgeries and in people's homes.

We work with our communities to improve and manage their health and medical conditions and minimise the need for them to be in hospital. We work collaboratively with patients and partners to offer a safe, personalised experience, delivered with expertise and care.
In line with the NHS Long Term Plan, the work we undertake will become more important as the NHS seeks to prevent ill health, support an ever-growing older population, deal with the increasing level of obesity (in children and adults) and manage the complexity of care required to support people to live independently in community settings. This report sets out our many achievements over the last 12 months, focusing on how we have successfully improved existing services and introduced innovation.

In line with our aim to deliver services that:

- Are locally accessible - provided close to or in people's own homes
- Are provided to the highest standard by skilled and compassionate staff
- Promote good health and the prevention of ill health
- Reduce inequalities and ensure equity of access
- Are integrated across health and social care 'boundaries'
- Are focused on maximising an individual's potential and independence.

The Trust will continue to work with integrated care systems and local authorities to redesign services to support the achievement of local plans and joint forward plans. These plans will ensure that, where it is clinically appropriate, services will move from the acute hospital setting to the community, making the services more accessible for patients and cost effective for the system as a whole.

NCH&C works with system partners to identify inequalities using an integrated and collaborative approach to ensure access for all. Our clinical directors lead on clinical pathways within the Trust, such as diabetes, wound care, and end of life, to ensure our service offer is fit for purpose, meets the needs of our population, and provides high quality care for all.

We use business intelligence and data to truly understand our population needs and focus areas to target health inequalities.

The Trust can be affected by a variety of financial, clinical, operational and regulatory risks and uncertainties. The organisation's risk management strategy clarifies responsibility for the identification, assessment and management of risk throughout the Trust. The Board retains ultimate responsibility for the Trust's risk management framework and a formal risk management system is in place, to identify and evaluate both internal and external risks.

The Board's audit committee regularly reviews strategic risks. Component risks of the risk register are reviewed by other Board subcommittees. Further information on risk management procedures is provided within the annual governance statement on page 102.

The narrative in the following performance report meets all the requirements and disclosures of strategic reports as required by the Companies Act 2006.

Strategic and Annual Priorities

Outstanding health and care at the heart of the community

NHS
Norfolk Community Health and Care
NHS Trust

Bringing thoughtful, expert health and social care into the homes and daily lives of our local communities.

Who we are

We're Community Health and Social Care Specialists for Norfolk and Waveney. We work with our communities to improve and manage their health and medical conditions in, or near their homes, and minimise the need for them to be in hospital.

What we do

We work collaboratively with patients and partners to offer a safe, personalised experience, delivered with heart.

Our vision

Providing seamless health and social care that creates healthier futures for everyone across Norfolk and Waveney.

To help us achieve our vision, we'll work to five new strategic priorities:

- Deepening our integration with partners
- Attracting and developing brilliant and fulfilled teams
- Continually improving standards of excellence
- Advancing our use of data and technology
- Being a future-focused organisation

And we'll remain guided by our values:

- Community
- Compassion
- Creativity

The NCH&C Trust Strategy 2023-27 was developed by the Trust Board, working in close consultation with our leadership teams. We also undertook engagement with our external stakeholders.

In determining the Trust's commitments for each of the five strategic priorities for 2023-27, we have ensured alignment with other key strategies, policies, and guidance, including the objectives of the Integrated Care Board, Care Quality Commission, and national and regional requirements.

Our priorities are:

- **Deepening our integration with partners**
- **Attracting and developing brilliant teams**
- **Continually improving standards of excellence**
- **Advancing our use of data and technology**
- **Being a future-focused organisation**

In the following section we outline our progress against our five strategic priorities. Included are examples of activity that has been considered by individual strategic priority leads when assessing their assurance of progress in delivering that priority. This is by no means a comprehensive list of all initiatives being delivered across NCH&C but demonstrates some of the ways that we are delivering real change 'on the ground' and working with partners across Norfolk and Waveney to support the delivery of the strategy.

Each strategic priority has been given a red, amber or green rating. In summary, progress in all five areas is good, and we are generally on track for year three of our four-year plan, with some areas needing further focus and others ahead of schedule.

As we move into a Group model, and recognising the changes taking place within the NHS announced by the government, we will be reviewing our Trust Strategy and agreeing Group-wide priorities and outcomes.

This section provides brief overview of our progress against our strategic aims through delivery of our operational focus areas.

Deepening our integration with partners

Executive Lead	Progress Assurance
Laura Clear Director of Strategy and Transformation	

Our delivery focus:

- Preventing health conditions from developing
- Responding quickly to urgent needs
- Delivering more joined-up treatment experiences
- Empowering patients and caregivers to manage conditions at home

Three key operational focus areas have been progressed through the year:

- Consistent community offer
- Urgent care services
- Discharges into the community

Significant progress has been made with embedding consistent models of operation across Places.

Boosting integrated urgent care provision through the Unscheduled Care Coordination Hub (UCCH)

Based at Reed House in Norwich, the UCCH team has been instrumental in transforming urgent and emergency care services in Norfolk and Waveney since its launch. By integrating multidisciplinary teams and providing timely, appropriate responses, the UCCH has significantly improved patient outcomes.

NCH&C, East Coast Community Healthcare (ECCH), Integrated Care 24 (IC24), Norfolk and Waveney Integrated Care Board (ICB), Norfolk County Council (NCC), and East of England Ambulance Service NHS Trust (EEAST) work together to provide a collaborative approach to assessing patients waiting on the 999 and 111 call lists. Many patients seen and assessed by the UCCH require a community response, and the ability to move patients to community services increases the likelihood of patients receiving appropriate care that enables them to stay at home.

Willow Therapy Unit (WTU)

The opening of the Willow Therapy Unit in March 2025 was a significant milestone for the health and care system in Norfolk and Waveney. The approach to patient care at the WTU is helping to reduce the amount of care and support people need when they are discharged.

Designed to facilitate the seamless transition of patients from acute hospitals back into the community Willow Therapy Unit utilises the latest therapy and rehabilitation technology and practices to prevent further deconditioning of patients and enable them to return home. Our focus is on providing active, out-of-bed care to support patient recovery and wellbeing and reduce the risk of hospital readmission. You can read more about the positive impact of Birch Ward (the ward where we began this approach before completion of WTU) and WTU in the performance section of this report.

Patients benefit from using the cutting-edge NIRVANA system from Gait and Motion Technology Ltd. This innovative system, which has never been used by the NHS in England before, projects different scenes onto walls or floors for the patient to interact with. A device tracks the patient's movements and changes the scene based on their actions. The immersive approach enhances rehabilitation by fully involving the body.

As well as utilising the latest technology, our focus is on delivering rehabilitation around the clock, not just during therapy sessions. For example, patients might be encouraged to brush their own hair or reach for their slippers instead of staff doing it for them. Simple movements like this throughout the day help patients progress, improving their strength, confidence, and mobility.

Willow has significantly contributed to an increase in Intermediate Care discharges since it opened. In its first month, Willow Therapy Unit had an ALOS of 18.3 days, compared to the Intermediate Care Beds average length of stay of 24.7 days. Patients discharged from the unit are 10% more likely to be returned to their usual place of residence than those discharged from other units.

Alongside its modern facilities, the unit also boasts unique artwork, designed and installed by local artist Carl Rowe. To develop the designs, Carl held a series of art workshops with patients, staff, and volunteers. The artwork encourages patients to move around the unit, integrating rehabilitation into the building's design while providing a visually engaging backdrop for therapy.

Community Virtual Ward: keeping patients well at home

The NHS Community Virtual Ward service for Norfolk and Waveney launched on 18 September 2023. This innovative service allows patients to receive hospital-level monitoring and treatment at home, preventing avoidable hospital admissions.

In its first year, the service:

Admitted and discharged 1,315 patients

Helped 79% of patients discharged from the service avoid admission to acute or community hospitals

Saved over 4,500 bed days in acute and community hospitals

The service, which is provided by NCH&C for patients registered with a GP in Norwich or West or North Norfolk, and by East Coast Community Healthcare in East Norfolk, has made a substantial impact on keeping patients out of hospital.

Many hospital services can be provided safely at home, and research shows recovery is faster in familiar and comfortable surroundings where patients can maintain their independence. Staying out of hospital also eliminates the risk of hospital-related complications.

Virtual ward care is managed by an Advanced Care Practitioner (ACP), working with other professionals such as doctors, nurses, and therapists. The service is appropriate for patients over 18 with conditions including respiratory disease, frailty, and heart failure.

Patients in any community setting, including community hospitals, residential care homes, and nursing homes, can also be referred.

Patients suitable for virtual ward care are trained to use a device that sends continuous or intermittent observations. This includes breathing, heart rate, and skin temperature readings. These are sent directly to the Community Virtual Ward team. If there is a sign of health deterioration, such as a rise in blood pressure, the team receives an immediate alert. Staff can then call the patient over the phone or via video call to discuss any health changes and decide on the most appropriate next steps.

Patients are typically under the Community Virtual Ward's care for up to 14 days, depending on their treatment plans and recovery.

Over 600 patients benefit from innovative community physiotherapy events

Norfolk and Waveney Community Musculoskeletal Services (NoW MSK) launched in April 2024 in a ground-breaking collaboration between NCH&C and East Coast Community Health (ECCH) aimed at providing a unified approach to musculoskeletal (MSK) services across Norfolk and Waveney.

The joint initiative has helped improve access to services for users and has enabled the alignment of clinical pathways across the region. The new service provides a single 'front door' for patients, who are directed to the most appropriate team based on their location and clinical needs.

Patients now have greater control over their MSK care. They can self-refer to MSK services via the NoW MSK website without seeing their GP first and have the flexibility to schedule and rebook their own appointments through a patient communications app called Airmid.

In February and March 2025, a series of five Community Assessment Days (CADs) took place across Norfolk and Waveney, providing more than 600 patients with access to MSK and physiotherapy care. The events were part of a wider £100,000 initiative funded by NHS England through the Norfolk and Waveney Integrated Care Board (ICB). The funding supports a range of targeted actions to reduce waiting times, improve access to community MSK services, and optimise care.

Held in Thetford, Lowestoft, Norwich, Long Stratton, and Fakenham, the events offered patients the opportunity to meet MSK clinicians in accessible community venues for a flexible and tailored assessment.

One of the key benefits of this initiative was that many patients were able to attend an appointment sooner than if they had opted for a regular MSK clinic. In addition to speeding up access to care, the CADs aimed to provide personalised advice and treatment, including physiotherapy and rehabilitation, and to support patients in managing their conditions at home where appropriate.

Support was also provided by a range of local organisations offering health and lifestyle guidance on topics including exercise and activity, finance, mental health and wellbeing, and diet and nutrition. Local GPs were also available at some events to offer general health advice. Having access to experts from these services at the CADs meant that patients received holistic advice to support them in managing their condition.

The initiative was well received by patients, with many sharing positive feedback. One patient summed up their experience: "Everything needed under one roof", "Friendly, informative, I appreciate being able to ask questions."

Elinor McDowall, MSK Services Lead for NCH&C, said: "This new way of working allowed greater blending of expertise and patient care options together than in a traditional clinic setting. Because we had flexibility to adjust how long we spent with each patient, we could really focus on everyone's personal goals and needs to provide a truly tailored approach. This was reflected in the overwhelmingly positive feedback from patients on the clinical care they received".

The events also proved valuable in strengthening cross-team relationships, both within NoW MSK and across the wider community of organisations that attended the CADs.

Emma Beard, MSK Operational Lead for ECCH, said: "We're incredibly proud of what our teams achieved through these events. It was a fantastic example of collaborative working between ECCH and NCH&C, focused on doing what's best for patients. Staff went above and beyond to support these days, and the positive feedback speaks volumes about their dedication and the impact of working together."

Social care partnership working

NCH&C and Norfolk County Council (NCC) have been working in an integrated way to deliver adult health and social care across Norfolk and Waveney as part of a Section 75 (S75) agreement since October 2014. This partnership is crucial for meeting the health and care needs of our communities. Over the past five years significant work has taken place to build effective relationships across health and social care. 2025 will bring a new S75 agreement with clear objectives and to further help integration at the Place and neighbourhood level, we are introducing a new Integrated Senior Leadership Structure.

This includes a new, integrated directorate for Intermediate Care and Urgent Community Response (UCR), and the delivery of reablement into Place. Changes to role titles will reflect strategic roles across Place/directorate on behalf of NCC and NCH&C, reinforcing both organisations' commitment to place-based partnerships.

The new structure was in place for the end of this reporting period and has been created to embed Place leadership of specialist pathways and services and simplify line management structures. It will also allow for greater operational and quality integration. Support services will align to operational delivery models to optimise effectiveness and efficiency.

From NCC's perspective the new structure will put greater emphasis on Place delivery and increase place led-prevention focus.

We look forward to working collaboratively to achieve these goals and make a positive impact on the lives of those we serve.

Attracting and developing brilliant and fulfilled teams

Executive Lead	Progress Assurance
Liz Cooke Director of HR & OD	

Our delivery focus:

- Looking after our people
- Ensuring everyone feels they belong
- Encouraging personal growth
- Enabling new ways of working

Significant progress has been made with embedding consistent models of operation across Places.

Staff survey results

Last year 67% of our substantive staff and 34% of our bank-only workers responded to the survey which represents our highest response rates yet:

- We are at, or above average, for community trusts in six of the People Promises and the two sub-themes of Staff Engagement and Morale
- We are below average, for community trusts, for the People Promise: We are safe and healthy
- The theme of Staff Engagement has seen a statistically significant deterioration
- 7 in 10 people would recommend NCH&C as a place to work
- 7 in 10 people would be happy with the standard of care provided by this organisation for a friend or relative
- 8 in 10 people are reporting that their immediate manager values their work
- 8 in 10 people enjoy working with the colleagues in their team
- 8 in 10 people report that patient care is the Trust's top priority
- 9 in 10 people feel trusted to do their job

Bank workers receive a slightly different questionnaire, but results are provided on the same basis of People Promises and themes:

- In comparison to substantive staff, bank workers have scored higher in all seven of the People Promises and in the theme of Staff Engagement
- NCH&C has been rated as a top employer, with 89% of bank staff recommending the Trust as a place to work.
- 8 in 10 people would be happy with the standard of care provided by this organisation for a friend or relative

Overall, while we were pleased to see an improvement in areas relating to flexible working, we were disappointed to see deterioration in all other themes. The results highlight that attention needs to be given to staff experience, including providing more opportunities for staff to make improvements in their area of work. Deterioration in the People Promise: We are safe and healthy, has highlighted burnout and work-related stress to be key areas of concern.

The survey results have also identified that the Trust needs to focus on addressing the experiences of violence and aggression within our working environment, with a high percentage of respondents stating that they have experienced harassment and bullying from the public. Staff have also reported that they have been the target of unwanted behaviour of a sexual nature in the workplace.

We take this information very seriously and there are programmes of work currently in progress that will support addressing these concerns, including the introduction of the Reporting Roadmap, and signing the NHS Sexual Safety in Healthcare Organisational Charter, which supports the creation of a safe and respectful organisational culture.

From these results, we will be focussing on supporting inpatient areas and addressing the negative experiences of violence and aggression in the workplace.

NHS Staff Survey 2024:
The results

NHS
Norfolk Community Health and Care
NHS Trust

67% of staff took the opportunity to feedback their experience

77% of staff would be happy with the standard of care provided if their friend or relative needed treatment

74% of staff would recommend the trust as a place to work

Our top trust priorities

From these results, our two key trust priorities will be supporting inpatient areas, and addressing the negative experiences of violence and aggression in the workplace.

Staff experience

In 2024/25, NCH&C was recognised nationally in the following awards:

- Employers Network for Equality and Inclusion's Talent, Inclusion and Diversity Evaluation Gold Award
- NHS England Work Experience Quality Standard Bronze Award
- Outstanding for Carers Friendly Tick Employers Award
- Defence Employer Recognition Scheme Silver Award

31 new Mental Health First Aiders have been trained, 16 existing Mental Health First Aiders have attended their three-year refresher course, and the trust's 140 Mental Health First Aiders have been supported through group supervision.

Growing our future workforce

Growing our own talent to deliver high quality patient care in the community is crucial. This has been taken back to the grass roots, and a full review of our work experience opportunities was completed. This included an NHS benchmarking of our offer to receive external input and advice for which we received the NHS England Work Experience Standard Bronze Award.

The first pilot cohort ran in Summer 2024, with 13 students attending a week-long programme. The attendees were provided with a variety of sessions from different clinicians and teams, as well as a day in clinical services and practical support with applying for roles in the NHS.

In 2024, NCH&C welcomed its first T Level students on placement. These are young people, (typically aged 16-18 years) who are undertaking an academic programme equivalent to three A Levels, who attend a work-based placement.

- 51 started new apprenticeships at NCH&C, 10 were recruited externally.
- 46 apprentices successfully completed their programme.
- 13 attended a new work experience programme in the Summer.
- 38 staff have received 121 sessions on interview skills.
- Career Development team attended 34 events and interacted with 854 students and parents about careers in at NCH&C and the wider NHS.
- Three Non-Clinical T Level students on placement in January 2024 and 3 Clinical T Level students on placement in September 2024.
- £17,800 invested on CPD for staff since April 2024.

Recognising our people

The NHS People Promise sets out the ambition for NHS staff experience, and one of the promises is "We are recognised and rewarded". Our employee recognition programme was reviewed against the ambition in this NHS People Promise and the NHS Employer's guidance for recognition. In early 2025 we launched our STAR Programme, which rewards outstanding achievements by staff; from shout-outs on our STAR Community board, to badges, certificates, and the annual REACH Awards

Building a compassionate and inclusive culture

This year we launched a revised Behaviour Framework and the new Our Leadership Way. These are the foundation of our employment lifecycle from recruitment and selection, induction, through to appraisals and development conversations. Setting out the expectations of us all at NCH&C, the aim is to make NCH&C the best healthcare employer in Norfolk and Waveney.

- 1847 staff have had a career conversation with their manager recorded, and their agreed development and succession plans have been captured to support the Trust's talent and succession plans.
- Over 240 leaders have attended the one-day Leaders Workshop with a focus on inclusion and compassionate workplaces.
- 30 leaders have attended REAL First Line Leader programme.

Continually improving standards of excellence

Executive Lead	Progress Assurance
Carolyn Fowler Director of Nursing	

Our delivery focus:

- Supporting people to advance their clinical capability
- Creating a quality improvement culture
- Keeping patient experience and safety a top priority
- Prioritising action in our most challenged services

The two primary operational focus areas in the year were Palliative Care Transformation, and support to our most challenged services.

Palliative and End of Life Care (PEOLC)

The PEOLC project group working has focused on key developments to improve the way we support patients living with life limiting illness at home. These were identified from feedback and discussions that took place at three workshops arranged to bring together key staff working in different teams across all four Places, as well as patient feedback provided in bereavement calls, and via compliments and complaints.

The Better For All work has also dovetailed with service development work happening at Priscilla Bacon Lodge (PBL) following the move into the new hospice and a new collaborative relationship with Priscilla Bacon Hospice Charity (PBHC).

Bank workers receive a slightly different questionnaire, but results are provided on the same basis of People Promises and themes:

The two areas of focus were:

- Improving the ways community and specialist teams communicate and coordinate care together
- Providing more support 'upstream' when patients are still in the Gold Standard Framework green phase and more opportunities for advance care planning, what to expect, and how to access the right services at the right time.

Actions taken during the year include:

- Specialist Palliative Care Nurses (SPCNs) joining daily operational meetings in each Place
- A pilot in the West Place which involves SPCN and community nursing teams being able to put patients directly onto each other's triage waiting lists rather than going through formal referral processes to avoid long delays. The aim is to test and finesse the processes prior to the teams being on the same SystmOne unit, and then implement the process out across all Places.

We continue to work with system partners across the acute and voluntary sectors to deliver a patient focused palliative service and have continued to deliver additional community healthcare beds.

Wheelchair Service

The Wheelchair Service has faced significant challenges over the years. This year we developed a business case to address critical issues affecting the service.

Key drivers for this included:

Patient safety: Mitigating risks associated with delays in equipment provision.	**Staff retention:** High turnover rates impacting service continuity.	**Budgetary pressures:** Escalating costs and inefficiencies.	**High levels of complaints:** Indicating patient dissatisfaction and service shortfalls.

In January 2024, the service had a caseload of 1,313 patients. Through targeted transformation efforts, this has been reduced to 948 as of January 2025. This progress has been achieved through a series of strategic initiatives:

1. **Smarter working:** Issuing basic equipment through a direct issue model to low-risk patients, enabling quicker resolutions and reducing backlog.
2. **Team development:** Expanding the team's skill mix to ensure more efficient use of expertise and improved staff retention.
3. **Process review:** Streamlining workflows and processes to eliminate inefficiencies.
4. **Supplier collaboration: P**artnering with suppliers to run independent clinics, improving service delivery and accessibility.
5. **Administrative upskilling:** Training administrative staff to better support the patient pathway and alleviate clinical burdens.

Building on the success of 2024, the service aims to:

- Continue expanding direct issue provision, ensuring more patients receive timely support.
- Further embed smarter processes to sustain efficiency and productivity.
- Leverage the asset database to optimise the management of stores, ensuring better resource utilisation and reduced waste.
- Transition to electronic referrals, to facilitate easier, faster and more appropriate referrals and reduce administrative inefficiencies.

These ongoing efforts will strengthen the Wheelchair Service, improving outcomes for patients while addressing systemic challenges.

We held patient engagement events designed to talk to the public about improvements to the service and gain more understanding of ways they could continue to progress.

Open to all adult wheelchair users, prosthetics patients, or patients that had recently received rehab, the events took place at The Re-Enablement Services Centre, Julian Hospital.

Patients were invited to attend and meet our re-enablement service teams and find out more about the support available to them, as well as talk to other organisations about additional help, advice and support. The Build Charity, Limbless Association, MND Association, Limb Power, Steel Bones, and Opcare were all represented at the event.

Neurodevelopmental Service (NDS)

Our NDS assesses children and young people up to the age of 18 years where there are concerns regarding possible neurodevelopmental disorders such as Autism Spectrum Disorder (ASD) and/or Attention Deficit Hyperactivity Disorder (ADHD).

There are over 7,000 children waiting for an assessment and this number has continued to rise. Significant system and referral pathway transformation is urgently needed to address this.

2024/25 saw a renewed focus on Children's Services within NCH&C to slow the growth of the caseload. Actions to ensure we could do this include launching a new operating model and changes to leadership that have brought new perspectives and approaches to how we deliver these services.

The team from NCH&C has joined with the team from our new Group partner, Cambridgeshire Community Services NHS Trust (CCS) to renew relationships and enable a blended approach to transforming this service.

A key part of this joint working means that NCH&C is now represented in the wider Norfolk children's system through the Children's System Collaborative and has a single joint representation for Children and Young People's community health at children's system boards and forums. By sharing co-production resources and approaches and using shared established links and groups to better engage with parents, the service has been able to identify ways to make efficient changes.

The key achievements of this transformation project to date are:

- Launch of a digital referral form to reduce admin time and to ensure that all referrals have all the required supporting evidence in place prior to being sent. This has improved the efficiency of our service.
- Development of a co-produced digital resource library for families and professionals to support families while they are waiting for an assessment appointment.
- Roll out of new one-day assessment clinics for children under the age of five. In May 2025 we will also launch a one-day assessment clinic for children and young people over the age of five.
- A joint Norfolk and Waveney NDS transformation group has been launched where our leadership teams and services have begun to work on joint service improvements such as improving continence pathway for children
- Focusing on improved integration in delivery of review health assessments for looked after children (0-18) where CCS delivers reviews for 0-5s and NCH&C delivers reviews for 5-18s.

Next steps

We will be reviewing the systems and processes for our assessment and diagnostic process for complex presentations that aren't suitable for the one-day assessment clinics. Waiting list initiatives will be developed with the system.

As part of the wider system transformation, we will focus on three key areas:

Development of an early needs assessment tool

Development of a universal training offer

Development of an ND Community Support Pathway

Advancing our use of data and technology

Executive Lead	Progress Assurance
Andrew Hopkins Director of Finance and Performance	

Our delivery focus:

- Developing digital solutions that enable more services at home
- Providing high-quality data analysis and reporting
- Enabling joined-up systems and data with colleagues and partners
- Optimising our digital capabilities to drive efficiencies

Our operational focus for the year was to optimise our digital capabilities to drive efficiencies that will free up time for patient care. We have rolled out the use of PowerBI across Trust leaders, with revised service dashboards and continued evolution of Trust reporting.

Our demand and capacity modelling for inpatient beds has been shared with, and adopted by, system colleagues.

We have appointed a digital development and transformation lead to support optimisation and cross-system working and have identified efficiency opportunities for SystmOne development.

Digital

A new digital strategy has been agreed and a Group Chief Information Officer has been appointed to the Group Board. On the following page is a summary of the Digital Strategy.

What does it mean for me?

NHS
Norfolk Community Health and Care
NHS Trust

A new 10-year NHS plan for England is underway and will highlight a shift towards increased community care, making better use of technology, and focusing on preventative care.

This digital strategy will deliver the following benefits:

Staff

- Timely provision of the appropriate kit to do your job
- Greater visibility of patient records within the electronic patient record, (SystmOne), and the Norfolk & Waveney Shared Care Record
- Improved, seamless Microsoft Teams experience between partner organisations
- The right digital tools, supporting more clinical time to care
- Data insights to aid future planning and move toward preventative care

Patients

- Your care and experience will improve, by aiding clinicians with supporting technology
- By improving our communications, you will be informed when visits are scheduled or changed
- By being more digitally inclusive, you will be provided the ability to book appointments via app and online services
- Access to your community health data via the NHS app
- Care provided within your own home through an expansion of virtual wards and remote monitoring technology

Partners

- Standardised and faster digitised referral process
- Working closely together with Norfolk County Council and other organisations to identify digitally inclusive and integrated service opportunities in areas such as, Neuro Developmental Service and Children's and Young People's mental health services
- Providing services to Norfolk and Waveney partners, for example seamless connectivity and support to Primary Care
- Improve patient pathways and shared digital solutions emerging from the new Acute hospital electronic patient record system

Being a future focussed organisation

Executive Lead	Progress Assurance
Andrew Hopkins Director of Finance and Performance	

our delivery focus:

- Ensuring we have the resources for current and future needs
- Minimising our impact on the environment
- Using evidence to continually evolve how we work
- Nurturing proactive leaders at all levels

NCH&C has delivered its financial plan for 2024/25. Detailed information on this can be found in the Financial Performance section of this report.

Our key operational focus was to maximise Place based engagement and opportunities, and estate optimisation. We have agreed an Estates Plan and are looking at the new opportunities afforded by the wider Group structure.

A Greener NCH&C

As an NHS organisation, and as a spender of public funds, we continue to have an obligation contractually (NHS Standard Service Conditions) to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. You can read more about our Green Plan on page 65.

New services join NCH&C

The West Norfolk Pulmonary Rehabilitation Service, previously provided by BOC Healthcare, transferred to NCH&C on 1 October.

Pulmonary rehabilitation programmes are designed for people with a diagnosed respiratory condition such as COPD, bronchiectasis, interstitial lung diseases and asthma who are beginning to experience limitations in everyday activities because of breathlessness. Pulmonary rehabilitation concentrates on improving physical fitness, quality of life and confidence for those living with long-term lung disease.

The West Norfolk Service joins our existing Pulmonary Rehab Service, who offer courses in North Norfolk, South Norfolk, and Norwich. The service is run by a multi-disciplinary team including respiratory physiotherapists, respiratory nurses, occupational therapists, and community assistant practitioners.

The Environmental Controls Service in Suffolk also transferred to NCH&C from West Suffolk NHS Foundation Trust in April 2025. The service provides assessment for electronic assistive technology equipment to enable people with complex physical disabilities to live with a degree of independence in the community. NCH&C already provides an Environmental Controls Service in Norfolk and the model for Suffolk will be similar to this existing service.

Strengthening care across our communities by Building Trust

NCH&C and CCS announced in July 2024 that we were coming together to create a new Group structure. The term ‘Group model’ within the NHS can mean a range of different organisational forms. In our case it means that from April 2025 our two organisations remain in place but will have a single Board and executive leadership team.

Each organisation will keep its own CQC registration, NHS Provider Licence, ICO Registration, and annual reports and accounts approval while we are a Group.

Despite legally existing as two separate organisations, in every other aspect we will try to work as a Group. We will still have different systems, processes, policies, and ways of working, but over the coming months we will begin to unify these across the Group.

It’s the first time two high performing organisations have joined up in this way. We believe that by doing so, we can offer the best community care in the NHS.

NCH&C and CCS have much in common as organisations. We both offer great care. We both focus on community services. We both work with adults and children. We both serve the wider East of England region, including Norfolk for both of us.

We have similar objectives and similar values including a laser focus on doing the right thing in working with and supporting our communities. We also complement each other and have strengths in different areas.

Forming a Group will make us stronger and more resilient, better able to cope with challenges and continue our focus on the needs of patients and service users. Meanwhile cost efficiencies – such as better buying power – will give us more funds to spend on care.

There are three key reasons for choosing to come together in this way:

1. Increasing demand and complexity in our health and care services means that the NHS and Local Authorities need specialist community health and care providers to flourish. By operating at a larger scale, from a combined organisation, we will be better placed to design and provide the best community health and care.
2. To deliver the radical approach needed to improve equitable health outcomes for everyone, we will need the combined skills, talents, and infrastructure of both organisations to succeed.
3. While we are both successful providers of community health and care, we are both relatively small organisations. Ongoing public finance challenges mean we need to be increasingly efficient. By operating together, we will be able to reduce duplication and streamline systems and process. We will be better able to provide tailored services to those who need them.

Having a stronger unified voice will also ensure that patient interests are heard and well represented in policy discussions and service planning.

You can find out more about our Group model on our Building Trust website and read more about how we are already working together in our ND Service for the benefit of our local communities on page 25.

Key risks

The key strategic risks facing NCH&C are described in the Board Assurance Framework and include risks to:

- Partner Relations
- Quality of Care
- Staff Experience
- Recruitment and Retention
- Digital First
- Cybersecurity
- Annual Financial Plan
- Community Capacity
- Bed Capacity and Flow
- Financial Sustainability

Two new risks were added during the year:

- Group Model
- Group Model conflicts of interests

These risks are described in more detail in the Accountability Report.

Addressing Health Inequalities

Health inequalities are avoidable, unfair, and systematic differences in health between different groups of people, which impact on longer term health outcomes and a person's ability to access healthcare. This work is fundamental to the delivery of the Trust's strategic priorities around being a future focussed organisation, where there is an ambition in relation to prevention and addressing health inequalities.

NCH&C is part of the Integrated Care System (ICS) working group to enable a shared approach and collaboration around implementation of this ambition. NCH&C will align the NHSE statement requirements with the developing Norfolk and Waveney Health Inequalities Strategic Framework for Action, as part the wider picture to include the wider determinants of health and care enable a whole system approach.

Clinical directors are now leading on clinical pathways within the Trust, such as diabetes, wound care, and end of life, to ensure our service offer is fit for purpose, meets the needs of our population, and provides high-quality care for all.

We use business intelligence and data to truly understand our population needs and focus areas to target health inequalities:

High Intensity User service (HIU) and Pulmonary Rehabilitation

Our Business Intelligence team is working with our HIU service to look at links between their client base and areas of health and social deprivation. In particular, work has been undertaken in helping to address the feeling of isolation that result in health inequalities, and understanding the link between lack of access to public transport and those requiring support from the HIU service.

We've also been looking at how we can reduce patient rejected referrals to the Pulmonary Rehabilitation (PR) service and identifying patients who have not completed the PR course they have been referred to in order to find out why. Clusters have been detected in areas with higher levels of deprivation via analysis using geographic information systems combined with socio-demographic/socio-economic data.

In terms of research, we've also matched indices of multiple deprivation with the Townsend Deprivation Scale (TDS) of inequalities for patients in our Community Nursing and Therapy (CNT) service. TDS is a metric of material deprivation.

The Trust will support production of an ICS dashboard to enable the integrated care system to provide oversight and drive action on improvements aligned to the Norfolk and Waveney Health Inequalities Strategic Framework for Action.
https://improvinglivesnw.org.uk/our-work/working-better-together/health-inequalities/

NCH&C has performed well against targets and standards set nationally and those agreed locally with commissioners. The Board reviews a detailed integrated analysis report covering people, finance, operational performance, and quality of care. A report on the mitigation of strategic risks is presented to Board through the Board Assurance Framework. NCH&C has been assessed by CQC and NHSI.

CQC rating

NCH&C's CQC rating was published on 22 June 2018 and is summarised in the table below:

Overall rating for this trust	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Outstanding ☆

The chart below shows the CQC's rating in more detail with a comparison of the current to previous ratings:

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good →← Jun 2018	Good →← Jun 2018	Outstanding ↑ Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good →← Jun 2018
Community health services for children and young people	Good ↑ Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Requires improvement ↓ Jun 2018	Good →← Jun 2018	Good →← Jun 2018
Community health inpatient services	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Outstanding ↑ Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018
Community end of life care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Community dental services	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Overall*	Good ↑ Jun 2018	Good →← Jun 2018	Outstanding ↑ Jun 2018	Good →← Jun 2018	Outstanding ↑ Jun 2018	Outstanding ↑ Jun 2018

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

NHS System Oversight Framework segmentation

The NHS oversight framework replaces the NHS system oversight framework for 2021/22, which described NHS England's approach to oversight of integrated care boards (ICBs) and trusts.

This framework outlines NHS England's approach to NHS oversight and is aligned with the ambitions set out in the NHS Long Term Plan and the NHS operational planning and contracting guidance. It also reflects the significant changes enabled by the Health and Care Act 2022 including the formal establishment of integrated care boards and the merging of NHS Improvement (comprising of Monitor and the NHS Trust Development Authority) into NHS England.

The framework describes how the oversight of NHS Trusts, foundation trusts and integrated care boards will operate. This supports our ambition for system-led delivery of integrated care in line with the direction of travel set out in the NHS Long Term Plan, integrating care: next steps to building strong and effective integrated care systems across England and the government's white paper on integration – Joining up care for people, places and populations.

NCH&C has been placed in segment one, described as: "consistently high performing across the oversight themes. Capability and capacity required to deliver the ICS four fundamental purposes is well developed." No specific support needs have been identified and the Trust is offering peer support to other Trusts in the system. The graphic below outlines the scope of the framework:

1.2 Performance analysis

This section will show how NCH&C measures its performance, with a more detailed integrated performance analysis and long-term expenditure trend analysis.

The performance analysis section includes performance across the following domains:

- Strategic Performance
- Operational Performance
- Patient and Carer Experience
- Sustainability (Green Plan) Performance
- Financial Performance

Strategic Performance

To support delivery of the strategic objectives the Trust identifies, on an annual basis, 'Operational Focus' areas to aid Place and service planning which form the basis of the Trust's Annual Plan. The Trust's Annual Plan is not intended as a project plan, nor as a comprehensive list of all initiatives being delivered across operational services but seeks to be a guide to the key themes of delivery for the year.

For 2024/25 the Trust's operational Focus areas were:

- Consistent community offer
- Palliative care service transformation
- Urgent care services
- Discharges into the community
- Workforce resilience
- Supporting our most challenged services
- Sustainable intermediated bedded care provision
- Maximising place-based engagement and opportunities
- Digital Services
- Estates

During the year the Trust has progressed its plans against all its Operational Focus areas and, consistent with the review of strategic priorities, no revisions to the Operational Priority areas are proposed for 2025/26.

Operational Priority	Trust Strategic Priority	Success component
Consistent community offer	Deepening our integration with Partners	We will develop and deliver a consistent community offer in all places. This will enable easier and faster urgent access to services where required; prioritise earlier access into prevention focused services and improve the efficiency of planned care.
Palliative care service transformation	Deepening our integration with Partners	We will offer leading end of life care to patients, families, and carers following the opening of the 'new' PBH inpatient unit and reviewing community palliative care pathways.
Urgent care services	Deepening our integration with Partners	We will work with partners and patients to increase access when people need community urgent care services and develop ways of preventing people from requiring urgent care where possible.
Discharges into the community	Deepening our integration with Partners	We will improve our discharge pathways from acute into inpatient and community care.
Workforce Resilience	Attracting and developing brilliant and fulfilled teams	We will ensure the development and sustainability of our workforce to meet future demand.
Supporting our most challenged services	Continually improving standards of excellence	We will have targeted recovery and improvement plans for services experiencing unsustainable operational, financial and workforce challenges.
Sustainable intermediated bedded care provision	Being a future focussed organisation	We will work with the ICB to identify a preferred model for intermediate bedded care and develop improved use of existing bedded facilities – Recognising the impact of the Willow Therapy Unit.
Maximising place-based engagement and opportunities	Being a future focussed organisation	We will establish NCH&C as a key leader in places and develop local priorities and projects to deliver improved outcomes for communities and individuals.
Digital Services	Advancing our use of data and technology	We will optimise our digital capabilities to drive efficiencies to free up time for patient care.
Estates	Being a future focussed organisation	We will optimise our estate to deliver our existing services, with ICB support for the cost of estate for future system developments.

Operational Performance

NCH&C continues to face four underlying system drivers which contribute to performance challenges: population growth, an ageing population, health inequalities, and significant financial constraints.

To support the Trust in meeting some of these challenges, the Business Intelligence and Reporting function has designed and delivered self-serve dashboards that provide a visually engaging and interactive way to view complex service and patient level data.

Demand and activity

In 2024, our total referral rates were 6% higher than 2023. Services with the largest increases in referral rates include Specialist and Enhanced Palliative Care (13%), Dietetics (10%), and Adult Speech and Language Central (3%). Clinical activity has also risen (9%), with the Community Nursing and Therapy service seeing a 10% rise in contacts.

These increases in contacts can also be attributed to changes in service provision, for example: the increase in capacity in our Community Virtual Ward, and the collaboration between NCH&C and East Coast Community Healthcare (ECCH) to create a new Community MSK service from April 2024.

NCH&C Community Nursing and Therapy teams are facing mounting pressure from increasing complexity of patient needs and rises in referrals (3% increase between 2023 and 2024). These challenges have contributed to increased waiting times and a higher number of unallocated visits and deferrals across all our Places.

To mitigate this, the Better For All programme has focused on introducing consistency of pathway and process. This has been underpinned by a data-driven approach which included a 'Community Triage Demand and Capacity Model' that evidenced the increased capacity of a standardised triage model. The programme also included a 'Community Nursing Demand and Capacity Model' which is helping to evidence the required capacity to build a sustainable model to reduce unallocated visits and enhance the quality of care provided.

In addition to the Better For All Programme, NCH&C has invested in additional capacity from HomeLink (February 2024 to June 2024 and September 2024 to February 2025) targeting phlebotomy and wound care interventions. This has helped alleviate pressure on the Places during this period, as evidenced by two periods of special cause variation improvement in the Unallocated Total Chart below.

Inpatient beds

The Trust provides a range of inpatient beds, the majority delivering intermediate care and rehabilitation to patients to provide admission avoidance and supported discharge across six geographical sites.

The wards provide an integrated approach to care and rehabilitation through close multi-disciplinary working including physiotherapy and occupational therapy which aims to maximise the rehabilitation potential and care for all its users. Capacity has increased over the last year with an additional unit, Birch Ward, opening 20 beds for a temporary period while the new Willow Therapy Unit was being built.

The Willow Therapy Unit is a new 48-bedded inpatient unit at Norwich Community Hospital, commissioned as a fast track, therapy-led, rehabilitation centre. It will support patient discharges from the Norfolk and Norwich University Hospital, allowing patients to continue their journey home in a more appropriate and effective setting. The Willow Therapy Unit opened in March 2025 and will increase intermediate care bed capacity to 183 beds across the NCH&C inpatient wards. NCH&C also supports and facilitates patient flow within seven ICB care homes across the county.

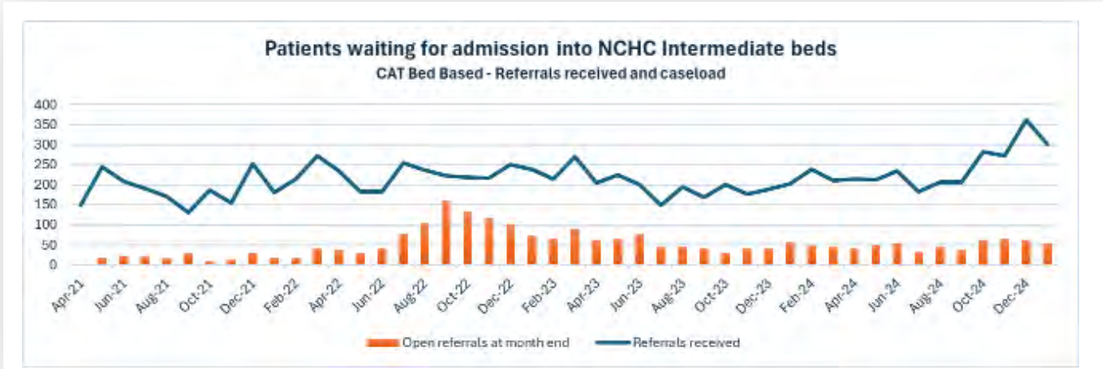
The Trust provides specialist inpatient palliative and end of life care at Priscilla Bacon Lodge (PBL). The unit provides 16 beds with further capacity for eight additional beds currently being used to provide support for patients requiring a Continuing Heath Care resource. We provide 24 specialist beds supporting stroke patients in Beech Ward and amputee care in the nine bedded Pine Cottage facility. Caroline House provides highly, specialist rehabilitation for people with very complex needs following an acquired brain injury and has 20 beds.

The number of beds the Trust manages continues to be temporarily increased at points during the year to support surge pressures within the system. These additional beds help improve flow from acute hospitals using the Discharge to Assess (D2A) Pathway.

This year NCH&C has worked closely with the ICB and the rest of the system, leading on future bed modelling, collaborating on the beds plan and facilitating the system's SPRINT group.

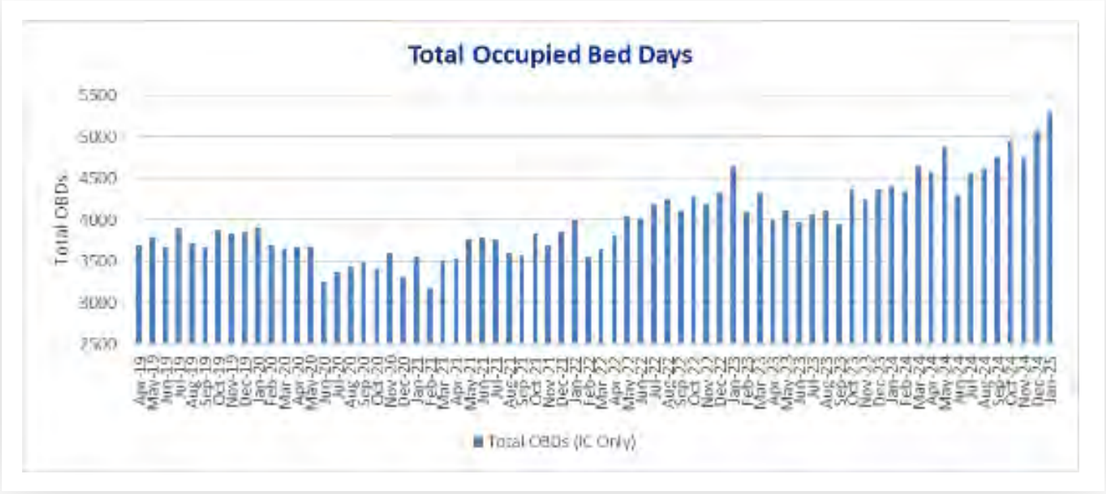
Discharge to Assess (D2A) Pathway Two

As the country moved out of the COVID-19 pandemic, the measures that had been put in place to support the discharge of patients from acute hospitals – those who no longer needed acute care but were not yet well enough to return home – were scaled back. This was known as Pathway Two. It resulted in a backlog in patients waiting to access NCH&C's intermediate care and rehabilitation beds. While this peaked at 165 patients in late 2022, the graph below shows the largely static trend over the last two years. It is expected that increasing bed capacity with the Willow Therapy Unit in 2025 will have a positive effect on the waiting times for a bed.



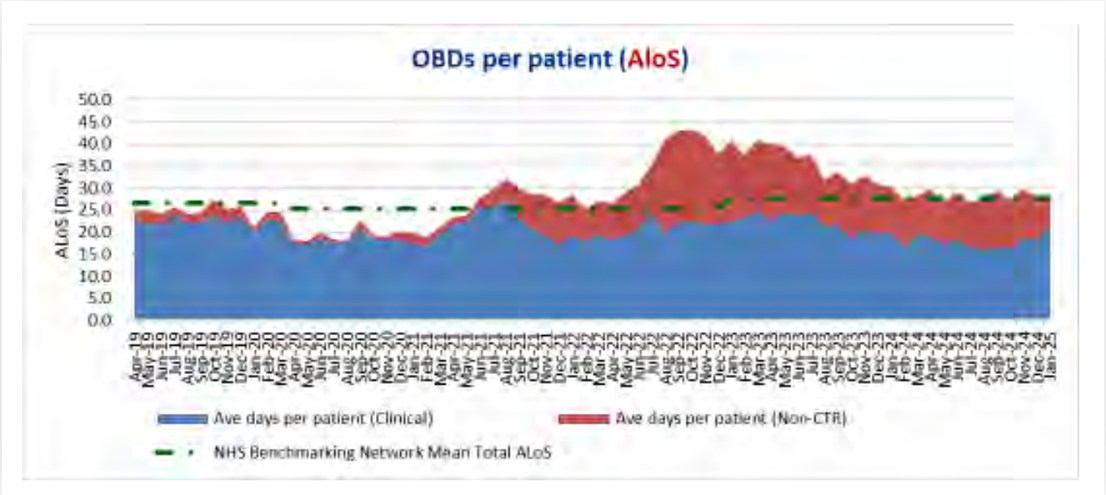
Although there was a slight rise due to seasonal winter pressures at the end of the year, in 2024 the average inpatient waiting list had 49 patients on it. Working with partners in the system, a range of measures, including opening additional bed capacity and Birch Ward in April 2024, has managed the waiting list. The measures put in place to increase activity to meet these pressures resulted in a significant increase in delivered Occupied Beds Days (OBD) when compared to previous years.

In December 2024 over 5,000 Occupied Bed Days (OBDs) were delivered. This is a 22% increase compared to an average of 4,100 in 2023 and pre-covid average of 3,700 (35% increase).
The volume of OBDs will further increase with the opening of the Willow Therapy Unit.



Challenges within the wider system because of the pandemic had resulted in reduced capacity in the care sector. This created an increase in average patient length of stay for patients who were clinically fit for discharge i.e. no longer having a 'Criteria to Reside (CTR) but still required non-clinical support to allow them to leave hospital.

The chart below demonstrates how NCH&C has been able to reduce the average length of stay for patients in our units once they were ready for discharge. This has been through close working with system partners and has contributed to a lower number of people waiting for admission to our units.



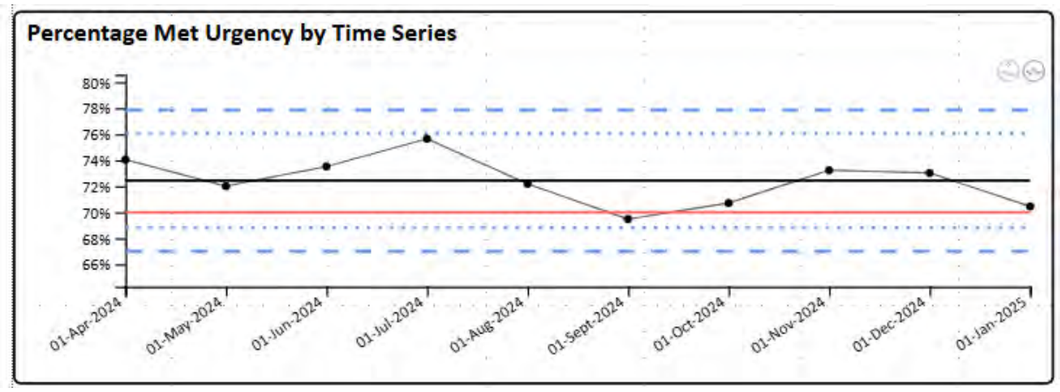
The average length of stay for a patient in one of our inpatient units averaged 28.2 days in 2024. This has remained consistent over the last 12 months and far improved from 40-day plus length of stay in 2022.

NCH&C is a member of the NHS England Benchmarking Network. Using the most recent benchmarking data, out of 15 comparable Trusts, we sit around the average of most measures nationally. Some key comparable benchmarking include:

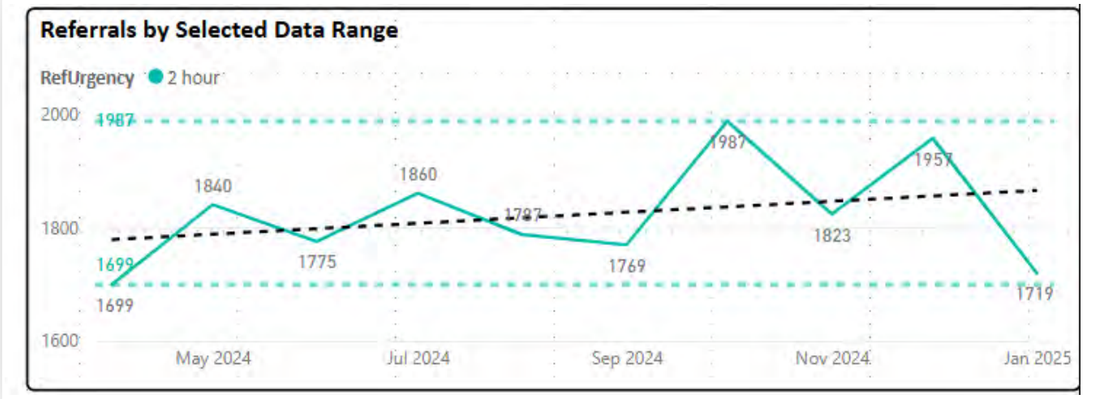
	NHS Benchmarking average	NCH&C
Average Length of Stay (days)	27.8	28.2
Non-Criteria to Reside (%)	29.5%	30%
Discharge to own home (%)	63.5%	62.2%

Urgent Care Response (UCR)

The past year demonstrated stability in both UCR demand and performance across the Trust. Overall performance for two-hour urgent UCR referrals reached 72%, exceeding the national target of 70% and improving upon the 70.9% achieved in 2023/24.



While overall demand increased marginally by 1.18%, this masks significant fluctuations with a high of 1,987 and a low of 1,699 referrals observed. Notably, UCR (all urgencies) comprises approximately 5% of all activity within NCH&C.



As the second largest provider of UCR care in England, NCH&C averaged 1,812 referrals per month, significantly exceeding the national average of 491 (Top 10 average is 1,501).

The Out-of-Hours team continues to face significant challenges, achieving an average of 68% compliance with two-hour referral targets.

Both West and South Places have now recruited sufficiently to enable an 8am to 8pm service, aligning with Norwich Place. An ongoing redesign project aims to enhance standardisation, centralise certain functions, and integrate UCR services with the Unscheduled Care Coordination Hub (UCCH) to improve performance towards our Trust target of 80%.

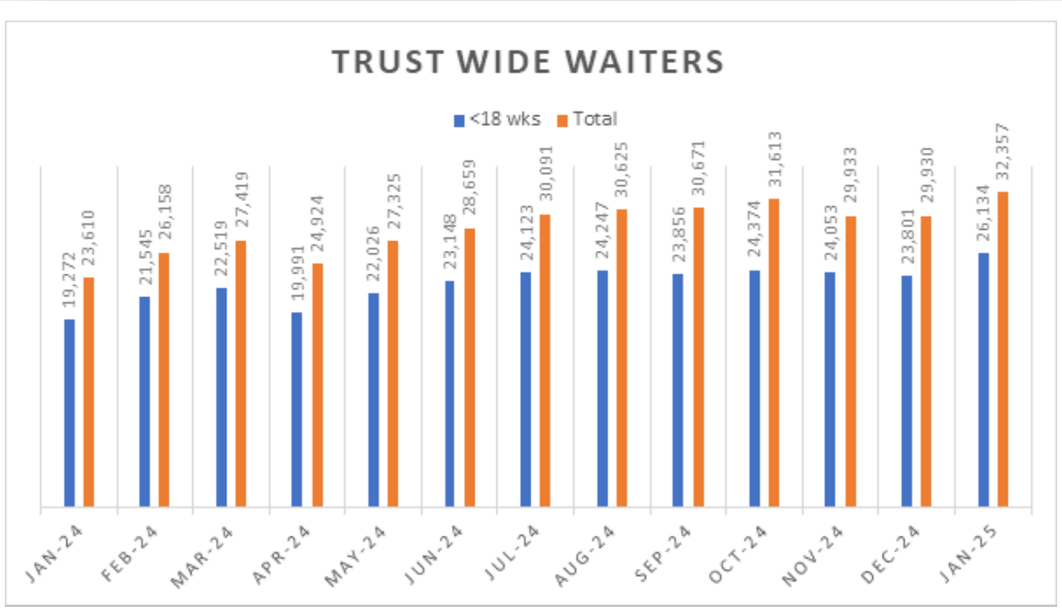
Acute catheter and end-of-life care remain the most frequent reasons for referral, accounting for 43.9% and 32.3% of demand respectively.

Waiting times

In January 2024, 19,272 patients were waiting less than 18 weeks, which made up 81.7% of the total waiting list of 23,610. As the year progressed there was noticeable fluctuation in this percentage, which mirrored the ongoing shifts in the overall waiting list size.

The summer months of July and August 2024 saw a peak in demand, with the total waiting list climbing to 30,091 and 30,625 patients, respectively. Despite this surge in total numbers, the percentage of patients waiting under 18 weeks remained relatively steady at around 80%—specifically 80.3% in July and 79.2% in August. This stability indicated the Trust's success in maintaining a consistent proportion of patients within the 18 week target, despite significant growth in demand.

While the total waiting list increased by approximately 37% over the course of the year, the percentage of patients waiting 18 weeks or less fluctuated between 79.2% and 82.3%. This reflects the increased demand for services, and the Trust's ability to keep a substantial portion of patients within the 18-week target, which validates our ongoing efforts to manage and stabilise waiting times in the face of continued high demand.



While the Trust is doing all it can to reduce waiting lists there has also been a focus on the actions that can be taken to mitigate the impact of waiting for care.

Our 'Waiting Well' agenda centres around three principles:

- Clinical reviews to ensure the safety of all patients waiting for care
- Ensuring patients who are waiting are managed properly under the Trust's 'Patient Access Policy' which has been revised to fully meet the NHS Referral To Treatment (RTT) guidance
- A renewed focus on using waiting time data to support service level decision making to deliver targeted productivity gains.

Patient and Carer Experience

Patient and Carer Experience and Involvement Strategy

Feedback from our patients and their carers about our services and organisation helps us improve the care we give.

To support us to gather a range of feedback and to inform our understanding we use a range of methods. This includes compliments, complaints, the Friends and Family Test, Care Opinion, Healthwatch, patient and carer surveys, focus groups and patient stories as well as staff surveys, local working groups, our staff networks and engagement avenues.

The key goals of the PCEI have helped to shape and improve patient and carer experience and involvement. In 2025 the strategy will be reviewed, building on previous and existing initiatives as well as looking ahead to enhance our patient and carer experience and involvement.

The overarching workplan for the PCEI was designed at Place level to ensure Trust-wide engagement and involvement. Activity is aligned to what matters most to our patients and carers.

Objectives:

1. Actively engage with and understand what matters most to patients, families, and carers, and improve the experiences for all
2. Strengthen and enhance personalised care to ensure people are treated with dignity, respect and receive safe, effective care for their needs
3. Empower our staff and volunteers with the tools, techniques and confidence to effectively capture an act upon and improve the experiences of patients, carers, and families

Progress

Over the past twelve months, the Lived Experience Team has worked to deliver the three key objectives of the strategy.

Some examples of that work include:

- Roll-out of the "hello my name is…" also known as "yellow badges" to all our staff and volunteers, with progress made for provision of these at Trust Induction
- Participation in system wide networks across health, social care, and the voluntary sector to contribute to best practice and sharing of knowledge.
- Active lead NHS Trust, in collaboration with Carers Voice, on a system-wide Carers Booklet for discharge
- 15 Steps Challenge follow up visits to ensure recommendations were followed up.
- A Patient, Carer, and Partner Advisory Group was set up.

Looking forward to 2025/26

A co-production methodology was used to navigate through the process of refreshing the strategy in 2022, ensuring that patients, carers, staff, and key partner organisations contributed equally to shaping the strategy objectives and workplan. We will follow the same collaborative process again during the strategy review in 2025 with the aim of having clear objectives about what matters most to those who currently use or may use our services in the future.

Patient Voice to Board

Each NCH&C board meeting commences with a patient story. This gives an opportunity for the Board to directly hear examples of patient experience. These stories can be a chance to recognise positive experiences and also to gain an insight into, and understanding of, the areas that require improvement. Stories are followed up with recommendations and for updates.

Places have continued to invite patients, carers and family members to share their stories using a range of formats to accommodate individual needs such as pre-recorded video, teams meeting or face to face in person. This approach has enabled the voices of harder to reach patients and communities to be heard.

Friends and Family Test (FFT)

The FFT is a national feedback programme for all NHS Trusts that enables NHS users to feedback on their experience. It allows both good and poor patient experiences to be identified.

FFT feedback and bespoke patient surveys are analysed to ensure that issues that are important to patients are recognised and actions are taken in areas requiring improvements.

During 2024/25, NCH&C received 4,107 responses to the FFT. A comparison with 2023/24 data showed a 10% decrease in response rate.

This decrease in performance could be attributed to a number of factors such as:

- Staff having to print their own FFTs to give out rather than having it managed centrally
- Time constraints within the services

Following changes to the team in August 2024 we have brought the printing of FFTs back to the Lived Experience Team to see whether this increases the response rate.

The overall percentage of patients that said the service was 'very good' or 'good' during 2024/25 was over 97%. In comparison to the national community trust average recommend scores, NCH&C have remained consistently above this.

The best monthly community trust performance was 100% and although NCH&C has not reached this, several months have seen a performance of 99%. The national community trust average for 2023 was 93%.

Care Opinion – Digital Feedback Platform

The Care Opinion platform www.careopinion.org enables patients, carers and their families to tell us about their experience via a web-based tool. The tool provides a feedback loop whereby staff can interact with patients and carers online to understand concerns and to recognise good practice to help improve patient experience and the provision of care going forwards.

During 2024/25, there were nine stories posted on the Care Opinion platform under the umbrella of NCH&C services which is a small increase to previous 12 months.

Three of the nine stories were wrongly attributed to NCH&C and originated from NHS ratings online for GP Practices and Surgeries. One was positive and two were negative.

Of the remaining stories for NCH&C, five were positive and included Ogden Court Inpatient Unit, Leg Ulcer Clinic, MSK Physiotherapy at Long Stratton Health Centre, and Phlebotomy Service at Norwich Community Hospital.

The Ogden Court story mentioned outstanding care for a family member where they felt the patient's skin care could not be better and that the patient felt he was treated very much with care and dignity.

Stories entered on Care Opinion and NHS Digital Feedback are responded to online by the Patient Safety and Experience Team as soon as is possible. Where the stories are more complex, they are shared with the clinical area they relate in order to explore the concern in more detail and to fully understand how to improve the communication and outcome for that individual. Learning is always taken and shared to improve services for other patients, families and carers.

Patient Advice and Liaison Service (PALS)

The PALS forms part of our commitment to provide high standards of care and support to patients, carers and the public. It provides an informal way for resolving concerns that our service users may have. PALS manages concerns, comments, and enquiries effectively and seeks to reduce the number of issues that may escalate to a formal complaint.

During 2024/25 PALS improved its responsiveness with dedicated staff assigned to telephone calls Monday to Friday 9am to 4pm, with voicemail services only used outside of working hours. This has improved our response rate and enabled conversations with patients, carers and families to be acted on in a timely manner.

PALS saw a year-on-year increase of enquires received. 907 enquiries were received during 2024/25, which is a decrease when compared to the 909 enquiries received during 2023/24. These enquiries have included appointment queries, guidance and information, and queries relating to other trusts and are detailed in the table below:

Type of Enquiry	Total no. Received 01/04/2024 - 31/03/2025
Appointment change / cancellation	51
Complaint	4
Comment	20
Concern / Informal complaint	68
Guidance / Information	462
Locally raised concern	89
Medical examiner query	3
Non NCH&C Related Query	143
Non PALS but NCH&C	66
TOTAL	**907**

Across all the categories relating to NCH&C services, the following themes were identified:

- Requesting an update on a referral to, and the waiting time for, the Neurodevelopmental service
- Norfolk and Waveney Musculoskeletal Services (NoW MSK) including making referrals and booking appointments
- Community nursing visiting times
- NCH&C has seen a decrease in non-NCH&C enquiries many relating to the Norfolk and Norwich University Hospital (NNUH), GP and dental services.

Volunteers

Volunteers have been recruited, trained and supported to make a valued and valuable contribution to a number of key areas of NCH&C over 2024/25, including:

- Support for the new Willow Therapy Unit team at the Birch Unit
- Support for our inpatient services
- Support for outpatient services and community teams

There remains a high level of interest in volunteering with NCH&C. Between April and December 2024, 203 new volunteer applications were received, which represents an increase of 70% compared to the equivalent period of the previous year. This reflects the efforts made by the NCH&C Volunteer Service delivered by Voluntary Norfolk, to engage with the community and promote volunteering.

An example of how volunteers are used across the Trust is in the table below, which details the number of volunteers active in each type of role during 2024/25 quarter three:
PALS saw a year-on-year increase of enquires received. 907 enquiries were received during 2024/25, which is a decrease when compared to the 909 enquiries received during 2023/24. These enquiries have included appointment queries, guidance and information, and queries relating to other trusts and are detailed in the table below:

Activity support	16
Patient support (including Therapy Dogs)	29
Visitor and team support	6
Stockroom support / other practical	17
Meet and greet	3
Patient contact and feedback	7
Gardening	8
Admin	6
TOTAL	**92**

Volunteer case study

Sarah joined the Volunteer Service in late 2021 and volunteers at Caroline House at our Colman Hospital. Sarah's role is focused primarily on patient and visitor engagement, but she also supports housekeeping by helping to serve meals and helping with the laundry cupboards. Patients and their families and carers benefit greatly from the companionship that Sarah provides with families often needing the opportunity to chat as much as the patients do. Sarah has said that even the tiniest moments in a patient's recovery can be amazing to witness and to be involved with.

When Sarah is not directly supporting patients and their families she is always helping with the smooth running of the ward and helping with various tasks that greatly reduce the workload of staff, thereby freeing them for increased patient contact and care. Sarah's role on the ward does not go unnoticed and her time and dedication to supporting both patients, their families and staff is greatly appreciated.

Complaints

Our aim is to always provide high quality services but occasionally things can go wrong. Our complaints procedure is one way that our patients, their carers or family can tell us if they feel we have not got things right. All complaints are investigated with transparency. The Trust learns as much as it can from both individual complaints in real time and from the trend analysis that we undertake on a regular basis to ensure wherever possible to prevent further harm arising.

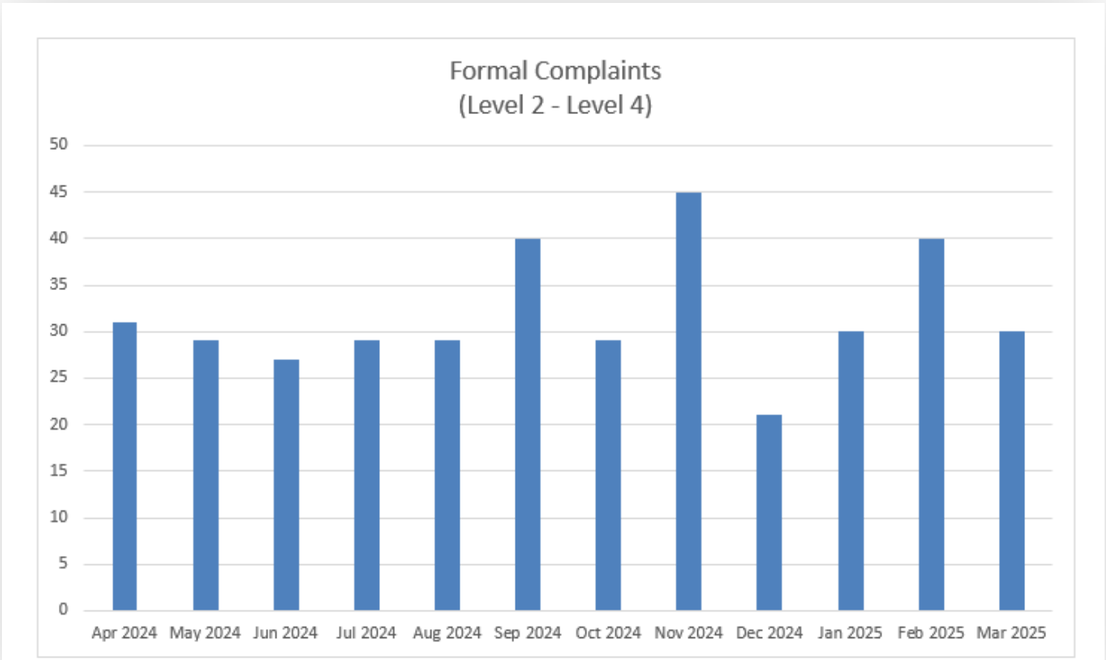
During 2024/25 NCH&C received 139 formal complaints showing an increase from the 134 that were received during the year 2023/24.

Of the 139 complaints received, 74 were upheld (63%), 36 were partially upheld (30%), and 7 were not upheld (6%).

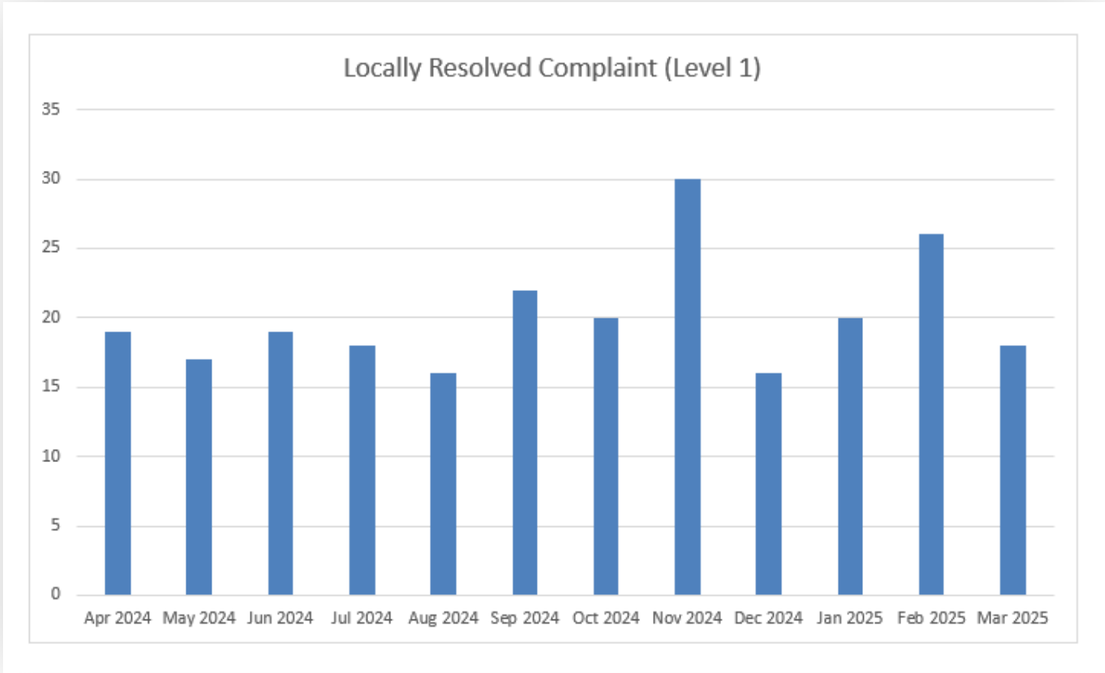
Undertaking regular thematic analysis of the complaints received and triangulation with inquests and incidences helps us to identify opportunities for learning which we disseminate across NCH&C. Themes and outcomes from complaints have been discussed at relevant committees and at Trust Board meetings throughout the year.

The following themes have been identified over the past year:

- Complaints about waiting times for the neurodevelopmental service (NDS) remains high. NDS continues to work closely with colleagues at the Norfolk and Waveney Integrated Care Board to address these timescales.
- Complaints about appointment scheduling for musculoskeletal services (MSK) increased n 2024-25. We are working with East Coast Community Healthcare (ECCH) to review services and improve patient experience at the point of referral.
- Complaints regarding communication with community nursing and therapy patients about changes to visits without discussion have become more prominent.



The graph below shows the number of local resolution level one complaints received on a month-by-month basis from April 2024 to March 2025:



Assurance around the complaints process, themes and trends, and learning continues to be provided in the following ways:

- The Trust submits an annual KO41a return to the Health and Social Care Information Centre which details the number of formal complaints received, and the type of complaint relating to set subjects that we are required to report against
- "Deep Dives" by Non-Executive Directors take place on a quarterly basis
- The Governance and Quality lead in each Place has access to the complaints Datix module, with themes discussed in Place and at the Patient and Carer Experience Working Group
- Learning from complaints and patient feedback is used to develop and update learning hub sessions and clinical education. Themes and learning are also shared at the relevant specialist group, including Nutrition and Quality Improvement Group, Medicines Optimisation and Deteriorating Patient Group
- Where an incident is identified within a complaint, a Datix is raised, discussion at learning huddle takes place, and a full investigation is completed.

The Trust continues to encourage early resolution of complaints where possible, and Quality Teams review learning in Place, demonstrating ongoing compliance with the Parliamentary and Health Service Ombudsman (PHSO).

Compliments and thanks

We recorded 1,280 compliments during 2024/25. The Patient Experience team continued to support and encourage Places or Specialist, System Operations and Children's Services (SSOCS) to record compliments on Datix. The Datix patient feedback form is available on all computer desktops and is accessible to those with Datix accounts. This ensures a timely capture, report and utilisation of this data alongside other quality indicators.

Patient-Led Assessments of the Care Environment (PLACE)

PLACE is a self-assessment tool designed to measure standards of:

- Cleanliness
- Food
- Privacy, Dignity & Wellbeing
- Building Condition, Appearance & Maintenance
- Dementia friendly environment
- Disability access

This non-clinical assessment focuses on in-patient facilities and the surrounding patient accessed environment. Staff areas are excluded from the assessment.

PLACE assessments at NCH&C's eight inpatient sites were undertaken between 5 September and 5 November 2024.

The assessments were managed by the Estates and Facilities Service Quality Team and led by good support from existing and new patient assessors. All assessments achieved at least the minimum required ratio of 50:50 patient/staff assessors to enable assessments to be validated by NHS Digital as compliant.

The results of the 2024 PLACE collection was published nationally by NHS Digital on 20th February 2025 at NHS Digital PLACE 2024

Comparison of NCH&C scores with National Average Scores

	Cleanliness	Combined food	Privacy, Dignity & Wellbeing	Condition, Appearance & Maintenance	Dementia	Disability Access
NCH&C % score	99.42	92.34	86.61	93.01	85.75	85.09
National average % score	98.31	91.32	88.22	96.36	83.66	85.27
Variance +/-	1.11	1.02	-1.61	-3.35	2.09	-0.18

The Trust performed above the national average in three domains of Cleanliness, Food and Dementia with the scores for the Privacy, Dignity & Wellbeing and Condition, Appearance & Maintenance and Disability Access domains fell just under just under the national average (<3.5%).

Comparison of NCH&C 2024 scores with previous year

With the exception of a small increase in the Privacy, Dignity & Wellbeing score, there was a very minor decrease (<1%) in all domains from the 2023 collection. This reflects a consistency of approach and the fact that the assessments took place before the impact of the planned PLACE capital programme for 2024/25 could be assessed.

	Cleanliness	Combined food	Privacy, Dignity & Wellbeing	Condition, Appearance & Maintenance	Dementia	Disability Access
NCH&C % score 2023	99.72	93.14	85.83	93.08	85.87	85.27
NCH&C % score 2024	99.41	92.34	86.61	93.01	85.75	85.09
Variance +/-	-0.30	-0.80	0.78	-0.07	-0.12	-0.18

Summary report

Cleanliness

Exceptional standards of cleanliness were observed at all assessments and resulted in the high score achieved for this domain.

Food Services

A Trust-wide project to review and enhance the current catering model through the implementation of NHS England's National Standards for healthcare food and drink has been concluded. The food provided by our suppliers continues to produce many positive comments from patients and patient assessors who comment favourably on the quality and variety of food provided. This is further evidenced by the comments we receive regularly from the Friends and Family Test.

Privacy, Dignity & Wellbeing (PD&W)

The PD&W domain score improved slightly from 2023, despite the fact that some of the internal social spaces in the in-patient units were being used to house additional beds during the build of the Willow Therapy Unit. Sites which do not have access to a Quiet Room/Multi-faith room continue to impact on the score for this domain. As day/dining rooms are brought back in use for their intended purpose, the Patient Environment Group will work with clinical colleagues to assess these areas for potential improvement.

Condition, Appearance & Maintenance (CD&W):

The CD&W score, below the national average and slightly below the score achieved for 2023 reflected that the level of investment allocated to PLACE required review in order for the condition scores to improve. As a result of this, additional funding of £75,000 was approved to take the total spend on PLACE outcomes to £125,000 during 2024/25. The impact of this additional funding will be realised at the 2025 round of assessments as all planned projects were either incomplete or not yet started at the time of the 2024 assessments. A PLACE capital programme for 2025/26 to address the outcomes of the 2024 assessments is already underway.

Dementia

This domain reflects the continuing focus on the dementia friendly environment. Suitable décor, use of colour contrasts, compliant signage and wayfinding noted at the assessments contribute significantly to the scores achieved

Disability Access

This domain reflects the improvements completed in year one of a two-year capital project to improve disability access. Access audits conducted by an external contractor have provided the scope for this work. During 2023/24, the focus was on external improvements required at our sites and the internal fitting of toilet risers, shelves, hooks and mirrors in toilets to make them compliant for patients who have a stoma.

Action planning

The Estates & Facilities Team are also reviewing outputs from other internal audits/inspections, bringing together a cohesive set of actions into a master action log, which will further enhance the patient environment, patient experience and the working environment for our members of staff.

Equality, Diversity and Inclusion

NCH&C's Equality, Diversity and Inclusion (EDI) programme has the ambition and commitment that everyone's voices will be heard and that we will engage, listen to and provide fair access to care for all patients and carers as well as members of the public, from a variety of backgrounds, needs and abilities. NCH&C continues to develop close links with local charities and voluntary sector organisations. In addition to this, NCH&C attends numerous outreach events organised by partner organisations such as the Carers' Conference.

To ensure that patients' needs are understood and met, a Fair Access to Care template and a Reasonable Adjustments care plan has been created and implemented on the SystmOne electronic patient record. This supports the documentation of patient needs and the application of adaptation and adjustments where necessary. The template and care plan supports and enables identification and actioning of several needs such as Accessible Information Standards, veteran support, physical, mental and learning disabilities and carer support. Easy identification flags that can be seen as soon as a clinician enters the patient's record can be applied through the template. A Learning Disability flag is already widely used, and we are currently working on adding flags for dementia, epilepsy, autism and reasonable adjustments required.

To meet the communication needs of our patients and carers, clinicians have access to a variety of tools through our partner INTRAN. There is an increased usage of British Sign Language (BSL) interpreting, face-to-face interpreting, telephone interpreting, written translations and video interpretation. Friends and Family Test (FFT) is also available in easy read version. The Children's Service has developed appointment letters which are aimed at children, young people, and families where a more accessible form of appointment letter has been identified as a requirement to support understanding.

NCH&C uses the ReciteMe toolbar which allows visitors to customise their content. All functions support a wide range of disabilities to aid website usability. The data shows a consistent number of unique individuals have used the ReciteMe Toolbar monthly principally for translations.

The 15 Steps Challenge Programme is an ongoing process which has already led to the improvement being made to patient environments and clinical are.

Sustainability Performance (Green Plan)

Our Green Plan

As an NHS organisation, and as a spender of public funds, we continue to have an obligation contractually (NHS Standard Service Conditions) to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities.

Focusing on the three core areas of social, environmental, and economic sustainability, we can improve health both in the immediate and long term. Demonstrating we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) and the National NHS Net Zero targets are met.

NCH&C's Green Plan acknowledges that sustainable development must remain as a key priority in maintaining and further developing an outstanding service for the people of Norfolk. It forms part of the wider Norfolk and Waveney Integrated Care Board (ICB) journey with the aim of reaching net zero by 2045 by reducing carbon emissions, considering areas such as waste, energy, travel, hospital services and procurement. As well as focussing on the three regional priorities (travel and transport, waste, supply chain), the Trust is also prioritising the ongoing decarbonisation of its estate.

It does this by identifying five key action areas:

- Workforce, leadership, engagement, and development
- Sustainable clinical and care models
- Digital transformation
- Travel and transport
- Estates and facilities

Within our Green Plan, specific focus is aimed at:

- Energy
- Water
- Waste
- Medicines
- Medical devices
- Supply chain and procurement
- Food, catering, and nutrition

The Trust's estate team provides a quarterly update to the Trust's Sustainability group and Finance and Performance Committee for review and challenge. The update provides a progress update against summary of the actions being taken to deliver the Trusts Strategic Priorities, which are enabled by the ways of working within the digital service strategy. The last update was presented to the Finance & Performance Committee meeting and confirmed that the 'various areas of development are currently meeting their agreed targets'

Green Plan achievements in 2024/25 include:

Procurement

NCH&C Procurement's five-year strategy includes objective three focused on social value and sustainability, linking to the Trust strategy of being a future focussed organisation. The objective looks to interface social value and environmental impacts and considerations in all applicable procurement activities.

Procurement has continued to meet its compliance targets by ensuring mandatory carbon reduction plans are in place (where required and mandated), and to integrate Social Value and Sustainability considerations in tendered contracts.

A target the Procurement team will be working towards is that with effect from April 2027 all suppliers with contracts for goods and services and/or other works for any value will be expected to publish a carbon reduction plan, or commitment that considers the supplier's direct and indirect emissions. We are now planning our strategy actions for 2025 and beyond.

Energy

The Trust secured significant investment to implement sub-metered controls across our estate utility feeds. This installation programme will finish in early 2025 and will support the analysis of building level data to track and identify building anomalies, i.e., consuming larger than expected amounts of energy.

Final Decarbonisation surveys completed have since been transformed into an investment programme to decarbonise our estate.
During 2024 NCH&C secured funding of £286,000 to complete LED lighting replacement of fluorescent lighting across the NCH&C Estate, with approximately 100% of the trust's lighting being replaced. The benefits of these investments will be evaluated during 2025 and used to inform our carbon emissions management.

Food, catering, and nutrition

Teams have continued to embed a comprehensive catering service to patients, successfully mobilising new services in our Willow Therapy Unit and at Priscilla Bacon Hospice. The move of services to multiple suppliers has delivered greater control over cost and favourably impacted delivery journeys.

We continue to improve our controls over food cost and waste by introduction of electronic food ordering at the point of service, use of cook freeze to control production quantities and waste measurement to manage the impact of menus on patient choice, food production, and food cost.

Transport and travel

The Travel team has aimed to embed low emission vehicles through salary sacrifice webinars held for trust staff in collaboration with Knowles Fleet Management. We continue to work with Norfolk County Council's Sustrans active travel for business project, promoting active travel which has been provided to the Trust at zero cost.

We are currently exploring options with our Fleet Management provider to enable staff to access ULEV/EV vehicles and continue to seek viable ULEV/EV solutions for our commercial vehicles prior to lease expiry.

During 2024/25 we completed planning to move our corporate fleet to fully electric vehicles by 2029. We have made bids for completion of installation across our estate for EV charge points to support the fleet conversion.

Sustainable Clinical Models of Care

We have seen the increased use of Microsoft Teams across the Trust to reduce our carbon footprint for travel. In addition, the text message service, MJOG provides patients with a text reminder prior to their appointment with the aim of improving attendance rates and reducing the number of missed appointments. We have seen an increased use of virtual appointments throughout NCH&C.

Work continues to seek improvement of shared use of estates across integrated care teams with Cloudbooking (accommodation management software) implemented and used to enable multidisciplinary working.

During 24/25 there will continue to be engagement with staff, using the intelligence gained to support and suggest sustainable actions across all areas of the Trust.

Waste management

NCH&C applies the principles of the Waste Hierarchy and Circular Economy in both strategic planning and tactical/operational activity. None of our waste goes to landfill.

Our 'ReUse-It' facility to encourage the re-use of office furniture and equipment has continued to enable the trust to make savings, and our waste management and disposal contracts continue to help to minimise environmental impact.

We publish per site recycling and waste production analyses every month on our intranet. We will seek to find further opportunities for supporting and influencing colleagues.

An email inbox for NCH&C is in use to support staff to be able to offer their ideas and feedback. There is an intranet page, to share the work we are conducting.

We continue to participate in National Performance Advisory Group (NPAG) and the East of England Regional Estates Net Zero Delivery Group – our conduits to NHSE developments.

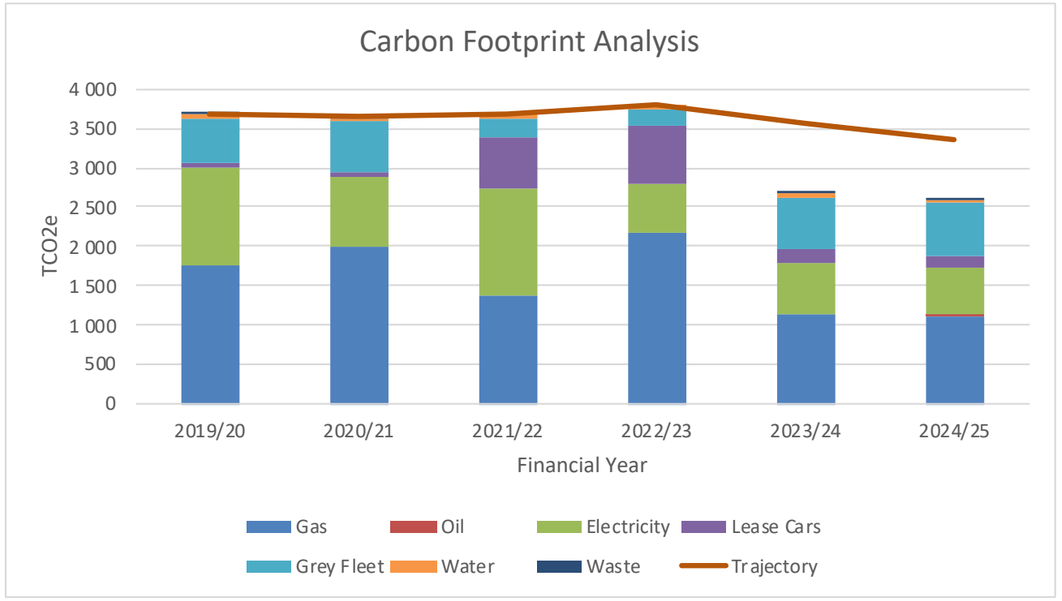
Digital Services

Digital Services aims to reduce its hardware footprint through increased use of cloud computing to continue to support the Trust requirements. We continued to recycle obsolete equipment and also reviewed the possibility of leasing equipment rather than purchasing and replacing. Purchasing and replacing equipment at appropriate points in time offer more cost effectiveness. We have continued to reduce our servers along with upgrading remaining equipment to gain further kWh efficiency. Through changes in the digital equipment, we now have more efficient network storage installed and configured which reduces the carbon footprint within the on-site data centre.

NCH&C GHG emissions

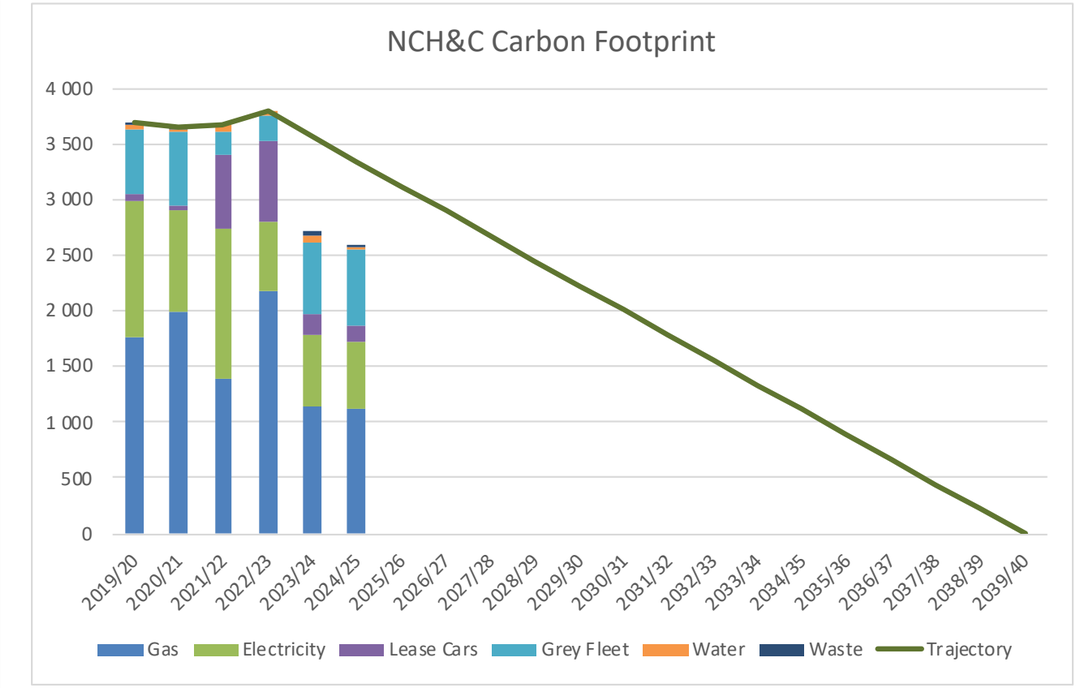
The data below shows NCH&Cs current calculations of carbon emissions. We will continue to enhance and expanding our understanding, calculation, and reporting capacity of the Trust's contribution.

We should remind ourselves that the target to achieve Net Zero is 2040 for scope 1 & 2 emissions, and 2045 for scope 3, with an 80% reduction of emissions by 2032.



2019/20 is the point from which trajectories to Net Zero have been defined in the "Delivering a Net Zero NHS" report and have been identified as the appropriate point to measure the required average contributions from NHS trusts from a pre-COVID baseline.

We show below, our own GHG emissions trajectory to 2040, based on factors we are currently able to measure. We will continue to develop our Carbon calculation ability so that we consider all types of emissions within the NHS definitions of Scope 1, 2 & 3. We expect our scope of measurement to grow across scopes with the effect of reducing our margin of emissions reduction year on year.



We are pleased to report energy use is dropping and as we realise the benefits of further decarbonisation actions to our estate the Trust will expect energy to reduce further. While some of the drop may be in part due to billing based on actual reads rather than estimated reads, weather may have affected use also.

While the consumption of energy has reduced, the cost of energy has increased due to external, worldwide factors. In line with energy pricing starting to come down, the hope is that we see a drop in cost during 2025/26. Furthermore, NCH&C has joined a bespoke NHS Energy purchasing scheme where energy is bought at scale, meaning that over the next two years we should start to realise the benefit of more stable pricing over a longer period.

We will aim during 2025/26 to integrate new data into measuring our own trajectory so that we can remain confident that we will stay on track to meet our Trust's strategic aim for 2023-27 of continuing to be ahead of the NHS national targets for greenhouse gas emissions.

Governance and Risk

Over the next five years we are committed to continuing to embed sustainability within our business and it is important to explain where in our process and procedures that sustainability features. The Green Plan sets out a number of areas including, appraisals, job descriptions, adaptation planning and policies where sustainability will be embedded. In addition, working closely with ICS colleagues to share best practice, create economies of scale and follow national guidance.

The Trust will continue to review the risks and, through the review and delivery of the Green Plan outputs via the quarterly sustainability group meetings, continue to take account of the Greener NHS programme, ensuring that its obligations under the Climate Change Act and the adaptation reporting requirements are adhered to.

While the Sustainability group, which consists of relevant Subject Matter Experts, meets on a quarterly basis, further scrutiny is applied through the subsequent reporting to the Finance and Performance Committee, ensuring Board oversight.

Work on updating the existing Green Plan and extending its reach to a three-year revised Green Plan will also include the enhancing of risk data monitoring.

We continue to want to hear sustainability ideas, there is a specific in-box to enable staff to send their thoughts, ideas, and observations so that we can continue to take on board, adapt and respond.

TCFD Compliance Statement

Norfolk Community Health & Care NHS Trust (NCH&C) has reported on climate-related financial disclosures consistent with HM Treasury's TCFD-aligned disclosure application guidance, which interprets and adapts the framework for the UK public sector. NCH&C considers climate to be a principal risk, and has therefore complied with most of the TCFD recommendations and recommendations disclosures around:

- Governance - recommended disclosures – see 'Governance and Risk'
- Risk Management - recommended disclosures – see 'Governance and Risk'
- Metrics and Targets - recommended disclosures (b) - see NCH&C GHG Emissions
- Metrics and Targets - recommended disclosures (a) and (c) – remain under development as part of Green plan renewal during 2025
- Strategy – recommended disclosure (a) and (b – partial) – remain under development as part of Green plan renewal during 2025

NCH&C has begun to assess the impacts of climate related risks and opportunities on our business strategy and financial planning. During 2025 we are investing in the decarbonisation of our estate to mitigate the effects climate change impacts, addressing energy consumption and work & car environment of our built estate. NCH&C plans to provide recommended disclosures for Strategy recommended disclosure (c) in future reporting periods of our revised Green Plan in line with the central government implementation timetable.

TCFD Reporting Recommendations

Thematic areas (core elements, pillars)	Governance	Strategy	Risk Management	Metrics and Targets
Recommendations	Disclose the organisation's governance around climate related risks and opportunities.	Disclose the actual and potential impacts of climate-related risks and opportunities on the organisation's businesses, strategy, and financial planning where such information is material.	Disclose how the organisation identifies, assesses, and manages climate-related risks	Disclose the metrics and targets used to assess and manage relevant climate-related risks and opportunities where such information is material.
Recommended disclosures				
(a)	Describe the board's oversight of climate-related risks and opportunities	Describe the climate-related risks and opportunities the organisation has identified over the short, medium, and long term	Describe the organisation's processes for identifying and assessing climate-related risks	Disclose the metrics used by the organisation to assess climate-related risks and opportunities in line with its strategy and risk management process

Thematic areas (core elements, pillars)	Governance	Strategy	Risk Management	Metrics and Targets
(b)	Describe management's role in assessing and managing climate-related risks and opportunities	Describe the impact of climate-related risks and opportunities on the organisation's businesses, strategy, and financial planning	Describe the organisation's processes for managing climate-related risks	Disclose Scope 1, Scope 2, and, if appropriate, Scope 3 GHG emissions, and the related risks
(c)		Describe the resilience of the organisation's strategy, taking into consideration different climate-related scenarios, including a 2°C or lower scenario	Describe how processes for identifying, assessing, and managing climate-related risks are integrated into the organisation's overall risk management	Describe the targets used by the organisation to manage climate-related risks and opportunities and performance against targets.

Financial Performance

Income and expenditure

The Trust aims to make the best use of its resources to maximise the delivery of care to patients, while managing within its financial resources. The Trust planned to deliver a £1.5 million surplus at an 'adjusted financial performance' level. This is the Trust's accounting surplus/deficit adjusted for items which are outside the Trust's control, such as changes in asset values due to market price movements. It is the key financial measure the Trust is assessed against by NHS England.

The actual adjusted financial performance for the Trust for 2024/25 was a surplus of £1,582k (£167k for 2023/24). This means the Trust performed £82k favourably to plan. The following table shows the Trust's financial performance over the past four financial years:

	2021/22 Actual £'000	2022/23 Actual £'000	2023/24 Actual £'000	2024/25 Actual £'000
Income	133,444	151,478	161,616	178,519
Pay costs	-93,905	-110,661	-110,387	-126,185
Non-pay costs	-38,251	-40,243	-45,718	-60,349
PDC, financing & gains / losses	-1,405	-1,533	-393	390
Accounting surplus / (deficit)	**-117**	**-959**	**5,118**	**-7,624**
Total adjustments	258	984	-4,951	9,206
Adjusted financial performance surplus	**141**	**25**	**167**	**1,582**

Income grew by £16.9m in 2024/25 (£10.1m 2023/24). The majority of income is received from Norfolk and Waveney Integrated Care Board (ICB) for the provision of community healthcare services to the population of Norfolk. £14.2m of additional income (£5.5m 2023/24) was received from the ICB and NHS England to cover pay and non-pay cost increases and additional services, in particular the opening of the new Willow Therapy Unit. This was offset by a £1.3m reduction in funding from the ICB and NHS England to reflect expected cost reductions (efficiencies) (£1.2m in 2023/24).

Non-pay costs have increased by £13.9m (£5.5m 2023/24). Non-pay costs include £8.2m which relates to a decrease in the value of land and buildings. The majority of this is due to a reduction in the assessed value of the Willow Therapy Unit, which was revalued by the Trust's external valuers when it became an operational asset during the year. It is common for buildings to be devalued when they become operational assets, and the reduction in value is typical of those seen for other properties in the NHS.

The provision of additional services plus inflation and growth has led to higher non-pay costs of £5.7m. £2.1m of this relates to the purchase of certain specialised healthcare services from other NHS providers and £1.1m relates to higher estates costs (including utility costs and the running of the Willow Therapy Unit).

Pay costs have increased by £15.8m compared to the prior year (£0.3m in 2023/24). This is driven by an increase in the size of the workforce, particularly in relation to the new Willow Therapy Unit, and a 5.5% pay increase. Overall, the average number of whole-time equivalent staff paid by the Trust increased from 2,297 in 2023/24 to 2,440 in 2024/25, representing a 6.2% increase in staff. The largest increase was in qualified nursing staff, with an increase of 61 whole time staff (8.6% increase).

The employer contribution to the NHS pension scheme also increased during the year, from 20.6% of pensionable pay to 23.7%. Due to a combination of higher staff numbers, pay inflation and the increase in the contribution, pension costs increased by £4.6m (£1.7m increase 23/24).

The Trust aims to limit its use of temporary staff, including bank staff and the use of agency staff. The Trust is set a limit by NHS England for agency staff which it should not spend above (£1.7m). The Trust was within this limit, spending £1.4m on agency staff. 93% (91% 2023/24) of agency staff spend was for clinical staff, which are primarily used in the Trust's in-patient wards to support temporary beds, higher levels of patient dependency and to maintain safer staffing where there was short-term sickness absence.

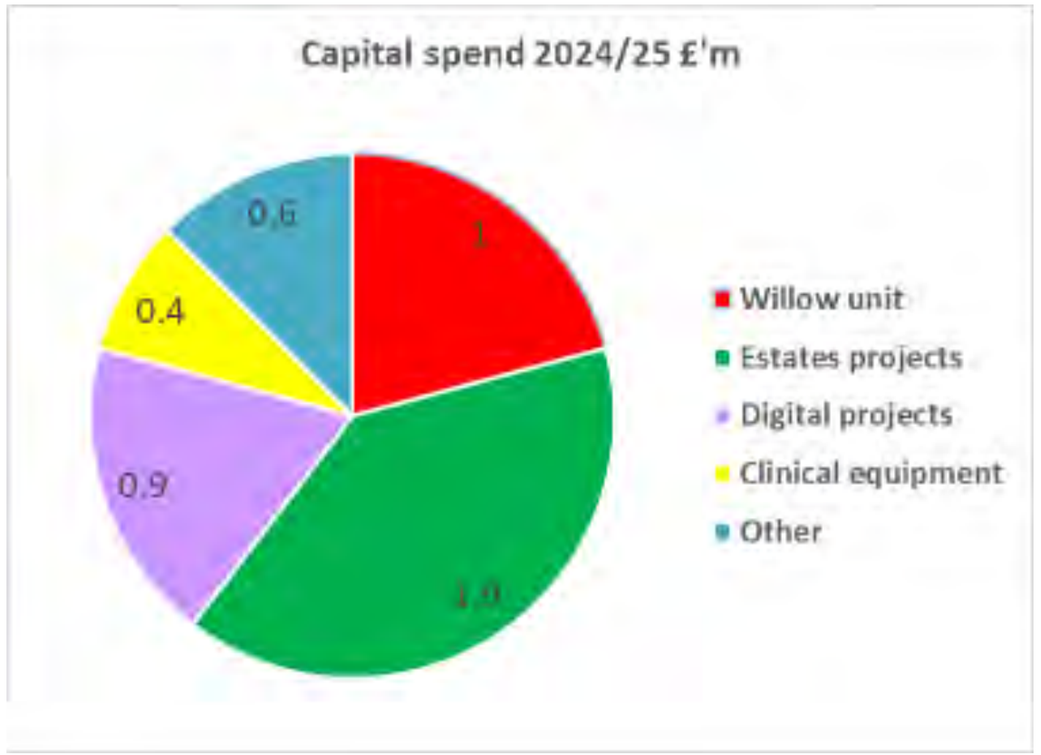
The Trust is required to achieve efficiencies (savings in costs or increases in income) each year. The Trust achieved efficiencies of £8.4m in 2024/25 (£5.6m in 2023/24), in line with the plan for the year. Efficiencies included £1.5m of pay related savings driven by vacancies in year, £1.4m of interest income earned on Trust cash at bank, cost savings generated through procurement processes, and contributions earned from new non-patient care external contracts. £3.1m of the efficiencies achieved were 'recurrent' – that is, they will continue in each financial year going forward. This is £1.5m lower than plan, with the difference made up of non-recurrent (one-off) efficiencies. This mix of efficiencies puts pressure on future year budgets, as a lower level of efficiencies than expected will continue into future years.

Assets and liabilities

Non-current assets, which include property, plant and equipment, intangible assets and right of use assets, have decreased in value by £7.1m in the year, to £96.9m (£104.0m in 2023/24). The decrease is due to the reduction in valuation of certain land and buildings, particularly the Willow Therapy Unit, as mentioned above.

The Trust spent £4.8m on new capital purchases in 2023/24 (£34.0m 2023/24). The table below shows the nature of the projects this was spent on.

Capital spend by area in 2024/25



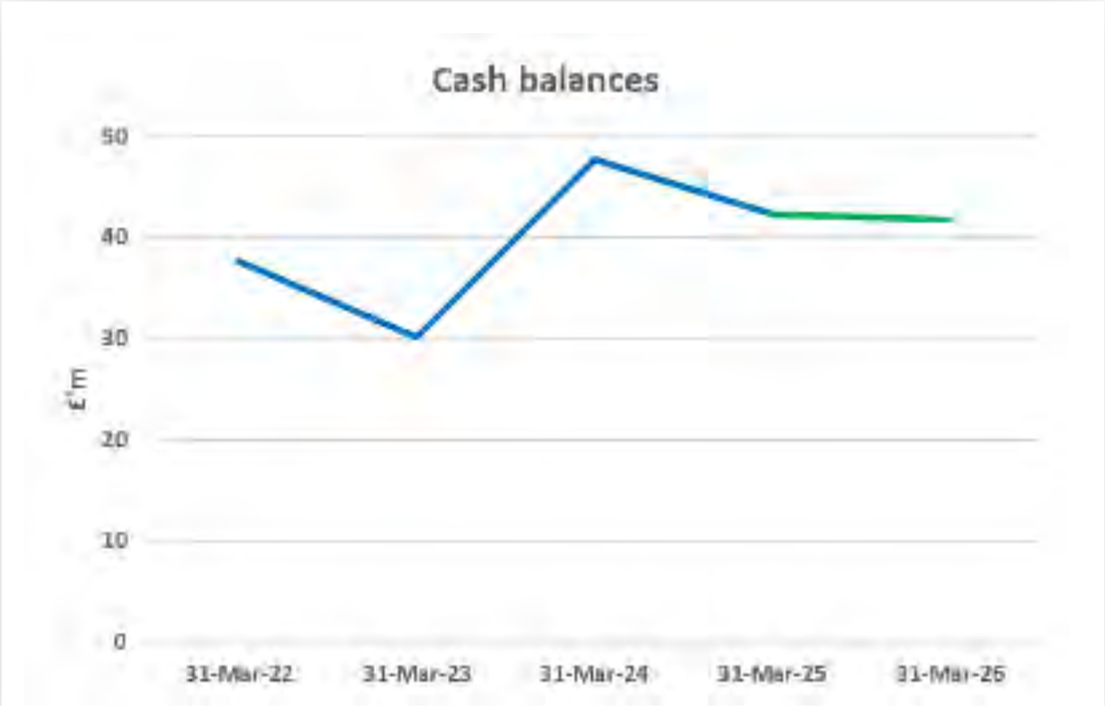
£20.3m was spent across 2023-2025 on the Willow Therapy Unit. The project was delivered within its revised capital envelope of £20.3m.

The Trust's cash position decreased by £5.4m during the year to £42.3m on 31 March 2025 (£47.7m in 2023/24). This primarily reflects payments for the Willow Therapy Unit and demolition of a building with RAAC (reinforced autoclaved aerated concrete) planks. Funding for these projects was received in 2023/24 but the majority of payments were made to suppliers in 2024/25. This is matched by an £11.0m decrease in capital creditors when compared to the prior year.

As can be seen from the cash forecast, cash is expected to fall during 2024/25 as these suppliers are paid. The Trust holds 3.0 times its monthly outgoings in cash, which provides a high level of assurance the Trust can continue to service debts as they fall due. The Trust is unable to use the high cash balance to provide additional services to patients as it is required to balance its income and expenditure each year.

The closing cash position was £42.3m at 31 March 2025, which was a £5.4m decrease from the prior year. This primarily reflects payments for the Willow Therapy Unit and demolition of a building with RAAC (reinforced autoclaved aerated concrete) planks in its roof. Funding for these projects was received in 2023/24 but the majority of payments were made to suppliers in 2024/25. This is matched by a £11.0m decrease in capital creditors when compared to the prior year.
The table below shows the cash balances held at year end over the past four financial years, and a one-year forecast. Cash is expected to stay largely constant over the next financial year.

Four-year cash balance, and one year cash forecast



The Trust's receivables balances (amounts that are owed to the Trust) have increased by £0.6m in the year, to £5.4m at 31 March 2025. The increase is primarily due to a £0.3m increase in prepayments, where cash for services to be provided has been paid in advance of the service actually being provided.

The Trust continues to have a small number of historic commercial debtors who owe rent to he Trust. Much of the remaining historic debt is waiting for finalisation of contractual or other agreements.

The Trust is required to pay its non-NHS and NHS trade payables in accordance with the Confederation of British Industry Better Payment Practice Code. This requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Trust is assessed as compliant with the Code if it meets this requirement 95% of the time. The Trust paid 95% (94% in 2023/24) of non-NHS invoices within 30 days of receipt of a valid invoice, and therefore met the target. 86% of NHS invoices were paid within 30 days of receipt of a valid invoice, compared to 88% in 23/24.

The year ahead

The following table shows the Trust's financial plan for the financial year 2025/26, together with the 2024/25 results:

	2024/25 Actual £'000	2025/26 Actual £'000
Income	178,519	173,480
Pay costs	-126,185	-125,681
Non-pay costs	-60,349	-47,774
PDC, financing & gains / losses	390	-959
Accounting surplus / (deficit)	**-7,624**	**-934**
Total adjustments	9,206	934
Adjusted financial performance surplus	**1,582**	**0**

The Trust plans to deliver a breakeven adjusted financial performance in 2025/26. Income will be received to cover the cost of increased pay costs from pay inflation in 2025/26 and to pay for community-based initiatives to reduce the growth in acute hospital demand. An estimate of likely costs has been included in the plan as the pay increase has not yet been determined. A contribution has also been received towards non-pay inflationary costs. This is offset by a 2% funding reduction that requires savings to be delivered by the Trust.

Pay costs are expected to rise slightly due to the extra activity mentioned above and inflationary pay increases, offset by efficiency requirements. Non-pay costs are expected to fall as there is no planned change in asset values in 2025/26 (and so no asset impairments), and as savings from efficiencies are planned to be higher than increased costs from extra activities and inflation.

Performance Report Signature by Accountable Officer

As the Accountable Officer, I hereby confirm adherence to the reporting framework requirements of the Performance Report and confirm that it is fair, balanced and understandable and that I take personal responsibility for the judgements required for determining this.

Signed:

Matthew Winn
Chief Executive
Norfolk Community Health and Care NHS Trust

Date: 24 June 2025

2. Accountability Report

The purpose of the accountability section of the annual report is to meet key accountability requirements to Parliament.

The requirements of the Accountability Report are based on the matters required to be dealt with in a Directors' Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006 and Schedule 7 of SI 2008 No.410, The Large and Medium- sized Companies and Groups (Accounts and Reports) Regulations 2008, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2013 No 1981, The Large and Medium-sized Companies and Groups (Accounts and Reports) (Amendment) Regulations 2013.

The requirements of the Companies Act 2006 have been adapted for the public sector context and only need to be followed by entities which are not companies to the extent that they are incorporated into the GAM.

Auditors have reviewed the Accountability Report for consistency with other information in the financial statements and provided an opinion on the following disclosures which have been audited within the Accountability Report.

The Accountability Report has three sections:

2.1 Corporate Governance Report

The purpose of the corporate governance report is to explain the composition and organisation of NCH&C's governance structures and how they support the achievement of the NCH&C's objectives.

The Corporate Governance Report includes:

- Directors' Report
- Statement of Accountable Officer's responsibilities
- Governance Statement

The Directors' Report

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year.

In preparing those accounts, the directors are required to:

- Apply on a consistent basis accounting policy laid down by the Secretary of State with the approval of the Treasury
- Make judgements and estimates which are reasonable and prudent
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors 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 trust's performance, business model and strategy

By order of the Board

Matthew Winn
Chief Executive
Norfolk Community Health and Care NHS Trust

Date: 24 June 2025

Jade Schiebler
Interim Finance Director
Norfolk Community Health and Care NHS Trust

Date: 24 June 2025

Board of Directors

All Board members share corporate responsibility for formulating strategy, ensuring accountability and shaping culture. They also share responsibility for ensuring that the Board operates as effectively as possible. The Chair and Chief Executive have complementary roles in Board leadership. The Chair leads the Board and ensures the effectiveness of the Board. The Chief Executive leads the Executive and the organisation.

There are also distinct roles for different members of the Board. The Executive Directors are paid employees of the Trust. They are responsible in their executive role for managing the organisation and, as Board members, for the leadership and direction of the Trust. This managerial role distinguishes the Executive Directors from the Non-Executive Directors, who do not have a managerial role. The Non-Executive Directors are particularly responsible for challenging the executive directors in decision-making and on the Trust's strategy, but they are collectively accountable with the Executive Directors for the exercise of their powers and for the performance of the Trust. Unlike the Executive Directors, they do not have a managerial role. The Non-Executive Directors will include the Chair. One of the independent Non-Executive Directors is appointed by the Board of Directors as the Senior Independent Director (SID). The SID leads the annual appraisal of the Chair. NCH&C has appointed Graham Nice, Deputy Chair, as the SID.

A Statement about the Balance, Completeness and Appropriateness of the Board

The Board currently comprises the Non-Executive Chair appointed by NHS England, Chief Executive, Executive Directors, Non-Executive Directors appointed by NHS England and an Associate Non-Executive Director appointed by NCH&C. There is a clear separation of the roles of the Chairman and the Chief Executive, which has been set out in writing in this report and agreed by the Board. The Chairman has responsibility for the running of the Board, setting the Agenda for the Trust and for ensuring that all Directors are fully informed of matters relevant to their roles. The Chief Executive has responsibility for implementing the strategies agreed by the Board and for managing the day-to-day business of the Trust. All of the Non-Executive Directors are considered to be independent in accordance with the Code of Governance for NHS provider trusts. The Board considers that the Non-Executive Directors bring a wide range of business, commercial, financial, managerial and clinical knowledge required for the successful direction of NCH&C. This includes clinical and financial matters in particular. All Directors are equally accountable for the proper management of the NCH&C's affairs. All Directors are subject to an annual review of their performance and contribution to the management and leadership of the Trust. The Board is satisfied as to its balance, completeness and appropriateness and will keep these matters under review.

Board Members' Biographies

Matthew Winn, Chief Executive, joined NCH&C in November 2023. He joined us as joint CEO, leading both NCH&C and Cambridgeshire Community Services NHS Trust (CCS), spending his time equally across the two CQC rated Outstanding organisations. He has been CEO at CCS for fifteen years where he represents the organisation on the Cambridgeshire/Peterborough and Bedfordshire, Luton and Milton Keynes Integrated Care Boards. On behalf of partners, he is the senior responsible officer across Bedfordshire and Luton for community health and integrated discharge and chairs the children and young people partnership in Cambridgeshire and Peterborough and is a core member of the Board developing the children's physical and mental health services across Norfolk. He has been the NHS England and Improvement Director of Community Health and Senior Responsible Officer for the implementation of the Ageing Well programme in the NHS Long Term Plan. He has an MSc in public policy and public management, focusing on how organisations can work together. Matthew is a voting Board member.

Lynda Thomas CBE, Chair, joined NCH&C in February 2023 from Macmillan Cancer Support, where she became the charity's first female Chief Executive in March 2015. In her 20 years at Macmillan Lynda has worked in a range of roles supporting people living with cancer and securing ground-breaking reforms in cancer care, support and treatment. Lynda leads the sector as an advocate for cancer patients and is currently Chair of the NHS England Cancer Programme Charity Forum, on the board of the Richmond Group, a member of the NHSE National Cancer Board, NHS Assembly and the Cicely Saunders Institute Advisory Board, and is an independent board member for the Cwm Taf Morgannwg University Health Board. Lynda is a voting Board member.

Executive Team

Laura Clear, Deputy Chief Executive and Director of Strategy and Transformation, joined NCH&C in 2009 and has been a Board member since November 2018. She is a registered physiotherapist having trained at the Royal London & Barts Trust and has worked in a variety of clinical roles across the health and social care environment and has experience at a regional level as Allied Health Professions lead. Laura has an MBA from the University of East Anglia and a PGC in executive and organisational coaching. Laura moved with her family to Norfolk in 2003 to work in Great Yarmouth and Waveney. Since joining NCH&C she has undertaken several operational roles. Laura is a voting Board member.

Carolyn Fowler, Director of Nursing and Quality, joined NCH&C in July 2019. Prior to this she led the safety agenda as Deputy Director of Safer Care and Standards at Hertfordshire Partnership University FT and was part of the team that achieved Outstanding for their CQC inspection earlier this year. Her background also includes being Deputy Director of Nursing for East and North Herts NHS Trust, working as a Macmillan Nurse and being Nurse Director for The Mount Vernon Cancer Network. Carolyn is a voting Board member.

Andrew Hopkins, Director of Finance and Performance, joined NCH&C in March 2016. He has worked for the NHS for most of his career, including the last 20 years as an Executive Director. He has experience in acute, community, mental health, and commissioning organisations, as well as working in the private sector with KPMG. Andrew has held Board positions at Huntingdonshire Primary Care Trust and Norfolk and Suffolk NHS Foundation Trust. Andrew is a voting Board member.

Dr Caroline Kavanagh, Chief Medical Officer, joined NCH&C in July 2024.Caroline qualified and trained as a paediatrician in Northern Ireland and undertook specialist respiratory paediatric training in Belfast and the Royal Brompton Hospital in London. She has been a consultant paediatrician since 2007 with most of her consultant career spent at Norfolk and Norwich University Hospitals Trust (NNUH). Caroline is a voting Board member.

Liz Cooke, Director of Human Resources and Organisational Development, trained as a nurse in Cambridge before moving into HR after obtaining her IPD qualifications in Surrey. She joined NCH&C in 2012, bringing a wealth of experience from her time working in human resources at James Paget Hospital. As Director of Human Resources and Organisational Development at NCH&C, Liz oversees the trust's HR Operations, HR Service Support, Workforce, eRostering, and Learning Education and Development (LEAD) teams. Liz is not a Board member and does not have a vote on the Board. She attends in an advisory capacity.

Rob Mack, Director of Community Health and Social Care Operations, has worked as a mental health nurse locally across community and inpatient services, delivering services for children, adults, and older people. He has considerable experience of working in close partnership with local authority and primary care colleagues. Now leading NCH&C's Community Health and Social Care Operations in an integrated post that also oversees social care teams and services at Norfolk County Council, Rob is responsible for strengthening NCH&C's relationships for the benefit of our staff and people across Norfolk.

Non-Executive Directors

Graham Nice, Deputy Chair and Senior Independent Director, joined NCH&C in October 2018, bringing with him a wealth of NHS executive management and professional experience. After qualifying as a nurse at Addenbrooke's Hospital, he specialised in Oncology and Palliative Care, working in the Royal Marsden and Hospices in Oxford and Cambridge. He has led operations, change and professional practice in most community services with most professional groups. Graham has an MBA with a particular interest in leadership development, coaching new and potential talent, and is passionate about enabling people to achieve their full potential. Graham has held Executive Director positions in community NHS services, latterly in Cambridgeshire and Sussex, up until 2013, when he retired from full time work and concluded his nurse registration in 2016. He has been a Specialist Advisor for the Care Quality Commission since 2014 and regularly works on inspection teams in Acute, Mental Health, Community and Ambulance services.

Njoki Yaxley, Non-Executive Director, joined NCH&C in February 2020. She has a law degree and a Master's in housing with a background in the social housing sector, specialising in governance, risk and project management.

John Kennedy, Non-Executive Director, returned to NCH&C's Board as a Non-Executive Director in early 2022. He has experience across the public and private sector in core roles in finance, and has wider skills across, commercial, operations, and sales, where he has held positions including CEO and CFO. With significant involvement on numerous Boards, and audit, risk, and remuneration committees, John has many years of knowledge in managing regulation, corporate governance and risk. He has driven large strategic initiatives, led strategic reviews and major change programmes, and led mergers and acquisitions and business turnarounds.

Steve Crowe, Non-Executive Director, joined NCH&C in October 2019. He has been a Chief Financial Officer and Senior Executive with a blend of front-line financial, commercial and strategic experience in both the private equity and blue-chip corporate environment, underpinned by a "Big 4" background. He is highly experienced in leading businesses in business strategy, M&A, planning and reporting as well as driving major commercial and business change decisions and execution. Has a first-class record of project delivery, building sustainable senior relationships and developing "high performance" teams within differing business environments.

Sue Crossman, Associate Non-Executive Director, has a wealth of experience working with the NHS in a variety of roles including clinical practice, education, research, and senior NHS management. She brings considerable experience of working in collaboration with health, social and education partners to meet the constantly changing requirements of the NHS system and the national regulators, balancing the need for local responsiveness with strong governance and accountability.

David Crawford, Non-Executive Director, started his career as a software developer at His Majesty's Stationery Office (HMSO) in Norwich and has since held tech leadership roles at BT, Sky, and Camelot. He was most recently Chief Technology Officer for Naked Wines. During his career, David has been involved with ground-breaking projects including 3D facial recognition for the Beijing Olympic Games, developing the world's first broadcast TV on a mobile phone, and launching some of the world's largest TV services (BBC iPlayer, NOW TV, F1 TV). David is committed to inclusivity in the workplace and led a successful 'Women in Technology' initiative for Sky. He presents a quarterly panel for the London Tech Leaders community and coaches executive teams on how to better embrace technology.

Register of Board Members

In post for the full year between 1 April 2024 to 31 March 2025 unless stated otherwise DHSC considers that regular attendees of Board meetings are its senior managers.

Name and Position	Status	Interest Declared		Related party transactions
Matthew Winn CEO	Voting Executive	Cambridgeshire Community Services NHS Trust	Chief Executive	None
		NHS England advisor on Intermediate Care.	Specialist advisor	
		Cambridge United Community Trust	Trustee	
		ICB Boards	Member	
Laura Clear Deputy Chief Executive, Director of Strategy and Transformation	Voting Executive	None	None	None
David Crawford Non-Executive Director	Voting Non-Executive	Crawford Solutions Limited	Owner	None
Dr Sue Crossman Associate Non-Executive Director	Non-Voting Non-Executive	Tapping House Hospice	Trustee	None
Steve Crowe Non-Executive Director	Voting Non-Executive	Angling Direct	Executive Director	None
Carolyn Fowler Director of Nursing & Quality	Voting Executive	None	None	None
Andrew Hopkins Director of Finance & Performance	Voting Executive	None	None	None
Dr Caroline Kavanagh Medical Director	Voting Executive	Cambridge Community Services NHS Trust	Joint Medical Director	None
John Kennedy Non-Executive Director	Voting Non-Executive	JF Kennedy Consultants	Director	None
Robert Mack Director of Community Health and Social Care Operations	Non-voting Executive	None	None	None
Graham Nice Non-Executive Director Deputy Chair Senior Independent Director	Voting Non-Executive	Care Quality Commission (CQC)	Specialist Advisor	None
Lynda Thomas Chair	Voting Non-Executive	Cwm Taf Morgannwg University Health Board	Independent Member	None
		Welsh government (3 days p/month)	Employed	
Njoki Yaxley Non-Executive Director	Voting Non-Executive	Connect Futures	Advisory Board Member (voluntary)	None
Elizabeth Cooke Director of Human Resources	Advisory role regular management attender non-voting	None	None	None
Michael Jones Trust Secretary	Advisory role regular management attender non-voting	None	None	None
Vicky Brooke Head of Communications	Advisory role regular management attender non-voting	None	None	None

Attendance at Board meetings held in public

	15.05.24	17.07.24	11.09.24	13.11.24	15.01.25	19.03.25
Lynda Thomas	Yes	Yes	No	Yes	Yes	Yes
Laura Clear	Yes	Yes	Yes	Yes	Yes	Yes
David Crawford	Yes	Yes	Yes	Yes	Yes	Yes
Steve Crowe	No	Yes	Yes	Yes	No	Yes
Carolyn Fowler	Yes	Yes	Yes	Yes	Yes	Yes
Andrew Hopkins	Yes	Yes	Yes	Yes	Yes	No
Caroline Kavanagh		Yes	Yes	Yes	Yes	Yes
John Kennedy	Yes	Yes	Yes	Yes	Yes	Yes
Graham Nice	Yes	Yes	Yes	Yes	Yes	Yes
Matthew Winn	Yes	No	Yes	Yes	Yes	Yes
Njoki Yaxley	Yes	Yes	Yes	Yes	Yes	Yes
Rob Mack	Yes	Yes	Yes	Yes	Yes	Yes
Sue Crossman	Yes	Yes	Yes	Yes	Yes	Yes
Vicky Brooke (advisory role regular management attender non-voting)	Yes	Yes	Yes	No	Yes	Yes
Liz Cooke (advisory role regular management attender non-voting)	Yes	Yes	Yes	Yes	Yes	Yes
Mike Jones (advisory role regular management attender non-voting)	Yes	Yes	Yes	Yes	Yes	

The Board also met in closed session on the above dates.

Audit Committee members and attendance record

	Designation	20.05.24	20.06.24	16.09.24	02.12.24	17.03.25
John Kennedy	Chair, Audit Committee Non-Executive Director	Yes	Yes	Yes	Yes	Yes
Steve Crowe	Non-Executive Director	No	No	Yes	Yes	No
Graham Nice	Non-Executive Director	Yes	Yes	No	Yes	Yes

Quality Committee members and attendance record

	Designation	15.04.24	07.05.24	08.07.24	02.09.24	04.11.24	06.01.25	10.03.25
Graham Nice	Chair / NED	Yes	Yes	No	Yes	Yes	Yes	Yes
Sue Crossman	Deputy Chair / Assoc NED	Yes	Yes	Yes	Yes	Yes	No	Yes
Carolyn Fowler	Director of Nursing & Quality	Yes	Yes	Yes	No	Yes	No	Yes
Venu Harilal / Caroline Kavanagh*	Medical Director			No	Yes	No	Yes	Yes
Njoki Yaxley	NED	No	Yes	Yes	No	Yes	Yes	Yes

**Venu Harilal left the post of Medical Director on 31.03.2024 and Caroline Kavanagh started in the post of Medical Director on 01.07.24.*

Finance and Performance Committee members and attendance record

	Designation	07.05.24	08.07.24	02.09.24	04.11.24	06.01.25	10.03.25
Steve Crowe	Chair, Non-Executive Director	Yes	Yes	Yes	Yes	Yes	Yes
David Crawford	Deputy Chair, Non-Executive Director	Yes	No	Yes	Yes	Yes	Yes
Andrew Hopkins	Finance Director	Yes	Yes	Yes	Yes	Yes	Yes
Rob Mack	Director of Community Health and Social Care Operations	Yes	Yes	Yes	Yes	Yes	No

People Committee members and attendance

	08.05.24	09.07.24	03.09.24	05.11.24	07.01.25	11.03.25
Njoki Yaxley	Yes	Yes	Yes	Yes	Yes	Yes
David Crawford	Yes	No	Yes	Yes	No	Yes
Liz Cooke	Yes	Yes	Yes	Yes	Yes	Yes
Carolyn Fowler	No	No	No	No	No	No

Charitable Funds Committee members and attendance

	30.04.2024	11.07.2024	23.10.2024	05.02.2025
John Kennedy (Chair)	Yes	Yes	Yes	Yes
Andrew Hopkins	Yes	Yes	Yes	Yes
Dr Sue Crossman	No	Yes	Yes	Yes
Carolyn Fowler	Yes	No	No*	Yes

**Carolyn Fowler was represented by Del Mitchell at this meeting.*

Remuneration Committee members and attendance record

	07.02.24	16.07.24	24.10.24	30.09.24**	28.10.24**	10.12.24
John Kennedy	Yes	No	No	No	No	No
Lynda Thomas	Yes	Yes	Yes	Yes	Yes	Yes
Graham Nice	Yes	Yes	Yes	Yes	Yes	Yes
Steve Crowe	Yes	No	No	No	No	No
Njoki Yaxley	Yes	Yes	Yes	No	No	Yes
Sue Crossman	Yes	No	No	No	No	No
David Crawford	Yes	No	No	No	No	No

***These meetings were held jointly with the Cambridge Community Services NHS Trust Remuneration Committee*

Key

Yes	Attended the meeting
No	Did not attend the meeting
	Not in post

Statement of Accountable Officer's responsibilities

Statement of the chief executive's responsibilities as the accountable officer of the trust.

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- Value for money is achieved from the resources available to the trust
- The expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- Effective and sound financial management systems are in place and
- Annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the 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 my letter of appointment as an Accountable Officer.

Signed:

Matthew Winn
Chief Executive
Norfolk Community Health and Care NHS Trust
Date: 24 June 2025

Governance statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Norfolk Community Health and Care NHS 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 Community Health and Care NHS Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The overall responsibility for the management of risk lies with the Chief Executive as Accountable Officer. The Director of Nursing and Quality provides the leadership and management for the risk management function within the Trust. The Director of Nursing and Quality is also the Caldicott Guardian. The Director of Finance and Performance is the designated Senior Information Risk Owner (SIRO).

The Board, collectively and individually, ensures that robust systems of internal control and management are in place. This responsibility is supported through the assurance committees of the Board under the chairmanship of a Non-Executive Director, with appropriate membership or input from Executive Directors. The Board has sought assurance through quarterly scrutiny of the Board Assurance Framework and the receipt of reports to the Board from the Board committees. The Risk Management Strategy describes the process to follow for the escalation and de-escalation of risks throughout the Trust.

The Trust's training programmes support the embedding of risk management policies and procedures throughout the Trust. This includes risk management training for all new staff and regular involvement in risk management practices and awareness through risk reviews and individual appraisals, business unit and performance meetings. Promoting awareness throughout the Trust arising from risk-related issues, incidents, complaints, claims and significant events is central to maintaining the risk management culture within the Trust.

The risk and control framework

The Trust has a Risk Management Strategy and Policy that describes how NCH&C identifies, evaluates, controls and prioritises risk using a risk management matrix, which calculates the possible impact of the risk occurring by the likelihood of it happening, before and after mitigation. The Trust's appetite for risk is established through the agreement of target risk ratings for each risk. Strategic risks are maintained using the Board Assurance Framework. Operational and other corporate risks are maintained through the corporate risk register and local service risk registers. The Trust's governance framework for quality provides assurance to the chief executive, the chairman, the board of directors, senior managers and clinicians that the essential standards of quality and safety are being delivered by the organisation. It also provides assurance that the processes for the governance of quality are embedded throughout the organisation. Assurance is obtained routinely on compliance with CQC registration requirements through self-assessment, peer review and independent scrutiny and audit. Risks to data security are being managed and controlled as part of this process through: (1) better cyber monitoring, threat intelligence, and incident responses, (2) better support and guidance for services, (3) better cyber training and greater awareness and engagement with cyber security national best practice among NHS staff and organisations. No risks to compliance with the NHS Provider Licence have been identified.

The Board Assurance Framework uses the risk matrix below for scoring risks.

	Likelihood				
Consequence	**Rare**	**Unlikely**	**Possible**	**Likely**	**Certain**
Catastrophic	5	10	15	20	25
Major	4	8	12	16	20
Moderate	3	6	9	12	15
Minor	2	4	6	8	10
Negligible	1	2	3	4	5
Target achieved					

The following strategic risks were monitored by the Board through the Board Assurance Framework:

Partner Relations

If the Trust does not have effective and well managed relationships with our key partners then our opportunities for improved patient care, service access and improvements will be compromised.

Quality of Care

If we cannot maintain our quality standards and deliver continuous quality improvement across the Trust then the quality of care and experience for our patients will deteriorate and harm might increase.

Staff Experience

If the experience of staff at work is not a positive one, it is likely that it will impact on the trust's ability to retain its employees.

Recruitment and Retention

If the Trust cannot adequately recruit and retain staff then the delivery of services will be put at risk and there will be significant impacts on patient safety and staff morale.

Digital First

If we do not adequately commit and create the culture change to adapt and adopt data and technology advances in the organisation then there is a risk to delivery of seamless and safe care to manage health conditions closer to home.

Cybersecurity

If NCH&C do not address cybersecurity threats then there is an increased likelihood of a major service disruption and possible compromise to patient care.

Annual Financial Plan

If the Trust is not able to deliver the 2024/25 financial plan, then the Trust risks contributing to an ICS failure to break even. This will lead to a need to repay the system deficit in future years and will result in additional scrutiny from NHS England, potentially reducing the ICS.

Community Capacity

If we are unable to consistently meet the demand for community services, then patients will experience increased waits for services, delays and cancellations, leading to poorer outcomes, escalating need and potential harm. Patient and staff experience will worsen and impact on our relationship with key partners that refer and rely on us to meet needs.

Bed Capacity and Flow

If we are unable to provide the required capacity for intermediate bedded care (Pathway 2 in Discharge to Assess D2A), by either reducing demand or increasing capacity, then we risk poor patient care and outcomes due to extended acute hospital admissions, reduced flow across Urgent and Emergency Care (UEC), poor short and long term health and care outcomes and increased cost for people due to extended stays in hospital care.

Financial Sustainability

If the Trust cannot secure efficiencies and/or additional resources, it may not be able to fund increasing demand for services in future years.

Two new risks were added to the Board Assurance Framework during the year:

Group Model

(1) stakeholder support, (2) board, executive and management oversight, and (3) executive capacity.

Group Model conflicts of interests

There is a risk that conflicts of interest between both Norfolk Community Health and Care (NCH&C) and Cambridgeshire Community Services (CCS) Boards could exist at an individual board member and organisational level that would then lead to poor governance and risk the transaction leading to a single organisation.

The graphic below shows a summary of the residual risk scores over a rolling 12 month period.

REF	Strategic priority	Description	Executive Lead	Committee
A	Partner Relations	If the Trust does not have effective and well-managed relationships with our key partners then our opportunities for improved patient care, service access and improvements will be compromised.	Laura Clear	Finance and Performance
B	Quality of Care	If we cannot maintain our quality standards and deliver continuous quality improvement across the Trust then the quality of care and experience for our patients will deteriorate and harm might increase.	Carolyn Fowler	Quality
C	Staff Experience	If the experience of staff at work is not a positive one, it is likely that it will impact on the trust's ability to retain its employees.	Liz Cooke	People
D	Recruitment and Retention	If the Trust cannot adequately recruit and retain staff then the delivery of services will be put at risk and there will be significant impacts on patient safety and staff morale.	Liz Cooke	People
E	Digital First	If we do not adequately commit and create the culture change to adapt and adopt data and technology advances in the organisation then there is a risk to delivery of seamless and safe care to manage health conditions closer to home.	Andrew Hopkins	Finance and Performance
F	Cybersecurity	If NCHC do not address cybersecurity threats then there is an increased likelihood of a major service disruption and possible compromise to patient care.	Andrew Hopkins	Finance and Performance
G	Annual Financial Plan	If the Trust is not able to deliver the 2024/25 financial plan then the Trust risks contributing to an ICS failure to break even. This will lead to a need to repay the system deficit in future years and will result in additional scrutiny from NHS England, potentially reducing the ICS	Andrew Hopkins	Finance and Performance
H	Community Capacity	If we are unable to consistently meet the demand for community services, then patients will experience increased waits for services, delays and cancellations, leading to poorer outcomes, escalating need and potential harm. Patient and staff experience will worsen and impact on our relationship with key partners that refer and rely on us to meet needs.	Rob Mack	Finance and Performance
I	Bed Capacity and Flow	If we are unable to provide the required capacity for intermediate bedded care (Pathway 2 in Discharge to Assess - D2A), by either reducing demand or increasing capacity, then we risk poor patient care and outcomes due to extended acute hospital admissions, reduced flow across Urgent and Emergency Care (UEC), poor short and long term health and care outcomes and increased cost for people due to extended stays in hospital care.	Rob Mack	Finance and Performance
J	Financial Sustainability	If the Trust cannot secure efficiencies and/or additional resources, it may not be able to fund increasing demand for services in future years.	Andrew Hopkins	Finance and Performance
K	Group Model	(1) stakeholder support, (2) board, executive and management oversight, and (3) executive capacity.	Matthew Winn	Finance and Performance
L	Group Model conflicts of interests	There is a risk that conflicts of interest between both Norfolk Community Health and Care (NCHC) and Cambridgeshire Community Services (CCS) Boards could exist at an individual board member and organisational level that would then lead to poor governance and risk the transaction leading to a single organisation	Matthew Winn	Audit Committee

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Target score	Target date
16	12	12	12	12	12	12	12	12	12	12	8	8	31..03.25
16	16	16	16	16	16	16	16	16	16	16	16	12	30.06.25
6	6	6	9	9	9	12	12	12	12	12	12	3	31.03.25
12	12	12	12	12	12	12	16	16	16	16	8	8	31.03.25
12	12	12	12	12	12	12	12	12	12	12	8	8	31.03.25
16	16	16	16	16	16	16	16	16	16	16	16	12	31.03.25
16	12	12	12	12	12	12	6	6	6	6	6	6	30.04.25
16	16	16	16	16	16	16	Moved to Issues Log						
16	16	16	16	16	16	16	12	12	12	12	12	8	30.04.25
16	16	16	16	16	16	16	16	16	16	16	16	9	31.03.29
New risk added						9	9	9	9	9	9	3	31.03.26
New risk											9	2	31.03.26

Risk management is embedded in the activity of the organisation through a number of ways including:

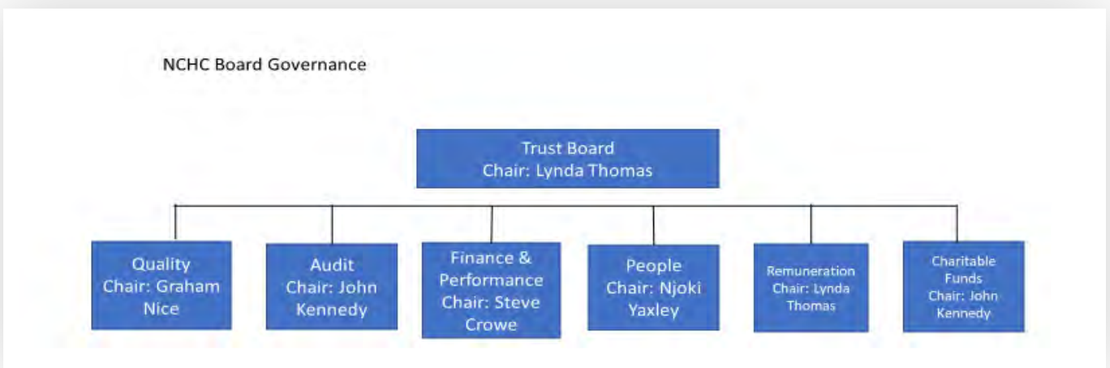
- Staff training and development in risk
- Risk Group monthly meeting of all risks leads from across the Trust.
- Local risk registers kept at service level and a Trust-wide corporate risk register.
- Risks are regularly reviewed in Board committees and by the Executive.
- Equality Impact Assessments (EIA) are integrated into core Trust business through them being required for every policy and strategy.
- Incident reporting is openly encouraged. For example, all serious incidents, including actions and learning, are reported to Board monthly. All serious incidents are investigated using root cause analysis methodology. Initial investigation reports to commissioners are submitted within three days of reporting and full investigation reports are submitted together with any resulting action plan to commissioners within 40 days of the report.

The Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. It is supported in doing this by committees, each chaired by a Non-Executive Board member:

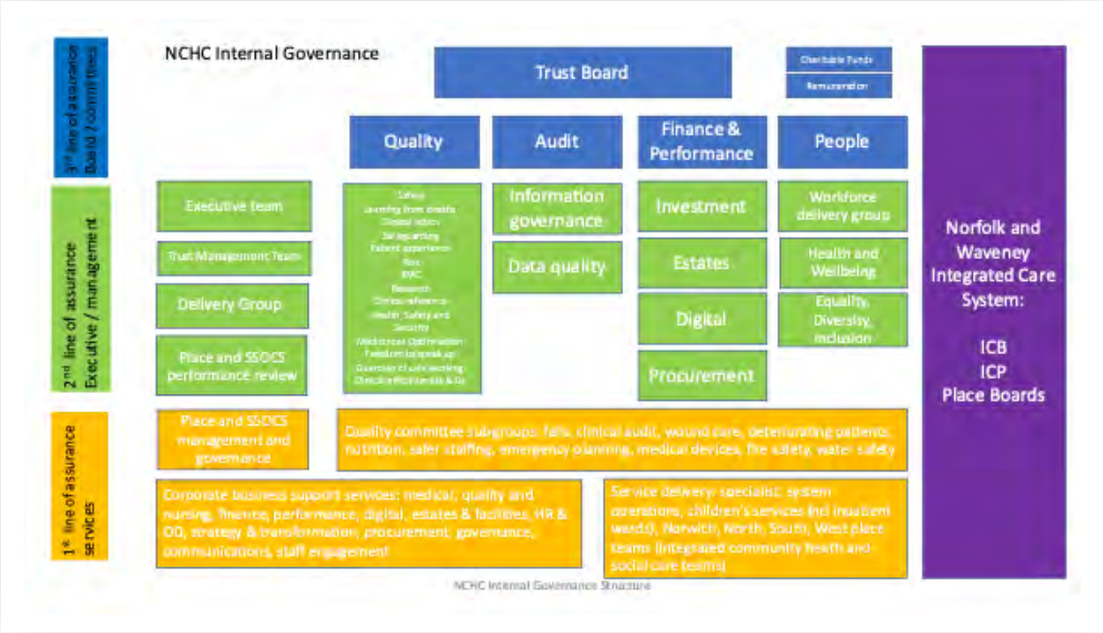
- Audit Committee.
- Quality Committee.
- Finance and Performance Committee.
- Charitable Funds Committee.
- Remuneration Committee.
- People Committee.

They specialise in assuring the Board about the effective running of individual areas of the Trust. In all cases, the Board receives the approved minutes of each committee meeting and a Chair's report is given of the committees' most recent meetings to communicate the issues the committee has reviewed, its principal findings, assurances and gaps and the direction it is giving on key issues.

The Trust's Board governance structure is shown below.



The chart below shows the Trust's governance structure within the context of the Integrated Care System.



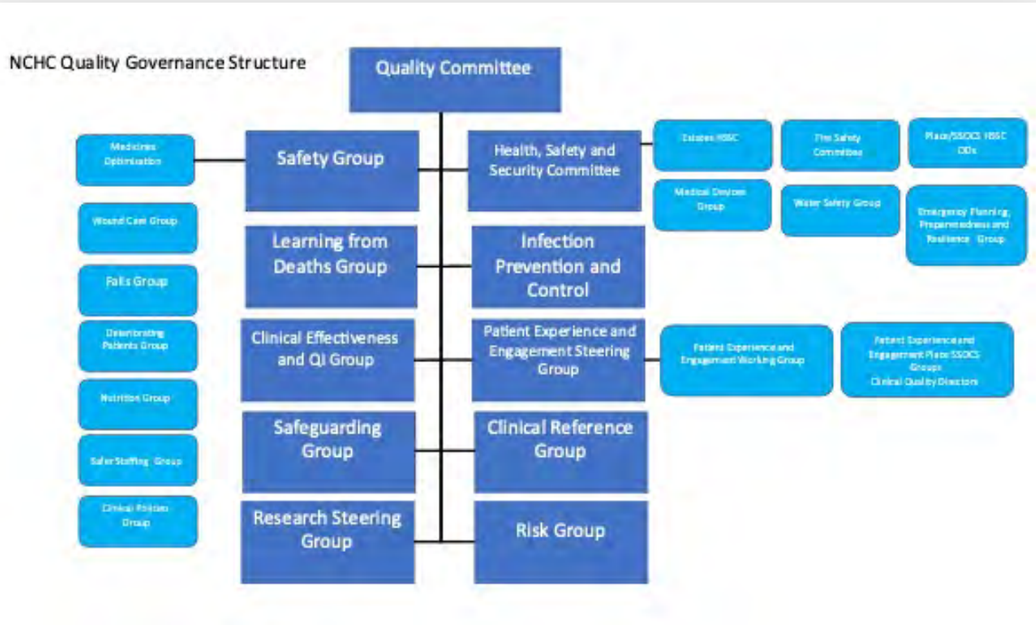
Audit Committee

The Audit Committee usually meets quarterly and reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives. In particular, the Committee reviews the adequacy of: (1) all risk and control related disclosure statements, together with any accompanying Internal Audit Annual Report, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board; (2) the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements; (3) the policies for ensuring compliance with relevant regulatory, legal and Code of Conduct requirements; (4) the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.

Quality Committee

Quality Committee usually meets monthly and provides the leadership, supervision and monitoring of all serious incidents, complaints, claims and Coroner's inquests. It provides the overview, enquiry and challenge to ensure consistency; appropriate levels of investigation; root cause analysis and that key learning is implemented; clear responsibilities and roles within the risk management process ensure that all actions and recommendations identified as part of the process are completed; and that there are effective interfaces between the Trust's directorates, to monitor ongoing compliance. The lessons learnt from these processes are communicated Trust-wide through clear lines of communication. Quality Committee reviews the content of the Quality Account before it is presented to Board. The Committee receives minutes and exception reports from sub-groups that monitor specific areas of clinical quality and risk, for example: Learning from Deaths; Safeguarding; Infection Control; Patient Experience; Clinical Audit and Effectiveness. The Committee has oversight of the Trust's entire risk profile, both clinical and non-clinical and routinely escalates non-clinical risks to other committees. The Committee also monitors other areas of quality and risk, such as: Information Governance; Records Management; Health and Safety; and Equality and Diversity.

The graphic below illustrates the Trust's quality governance structure



Finance and Performance Committee

The Finance and Performance Committee usually meets monthly to: review the financial and performance strategies, policies and reports and efficiency plans of the Trust; to advise the Board on the effective and efficient use of resources; to critically appraise the Trust's annual budgets (revenue and capital) for the Board's approval; to provide a forum for financial issues to be debated and recommendations made for potential resolution; to review the Trust's performance reporting and support the development of appropriate performance measures and KPIs; to review the Trust's in-year performance and any plans for corrective action; to oversee and evaluate the Trust's performance management strategy to ensure a framework is in place which allows the Trust to performance manage against its business plan

Remuneration Committee

The Remuneration Committee usually meets twice per annum to provide a forum for succession planning and consideration of executive pay and conditions.

Charitable Funds Committee

The Charitable Funds Committee usually meets quarterly and has delegated responsibility to make and monitor arrangements for the control and management of the Trust's associated charity, Norfolk Community Health & Care NHS Trust Charitable Funds (registered charity number 1051173). The Trust complies with its legal obligations as set out in the Statement of Recommended Practice (SORP) to produce annual accounts and an annual report for charitable funds. These accounts are subject to external independent examination prior to being approved and submitted to the Charity Commission. More detailed information on the committee and NCH&C's charitable funds are provided in a separate annual report and financial statements for charitable funds.

People Committee

This committee usually meets monthly with responsibility for overseeing the development and implementation of the Workforce Strategy and People Plan, Health and Wellbeing Strategy, Staff Engagement Strategy and the Organisational Development Strategy.

Executive Team and Trust Management Team

The Executive Team (ET) and Trust Management Team (TMT) meet regularly. They comprise the Trust's executive and senior management. Both meetings operate under the principle of collective leadership. Most decisions fall within the remit of individual executives and senior managers, as defined within the Trust's Governance Manual, but they may choose to exercise their discretion in bringing items to the ET and TMT for the purposes of: (1) Making decisions or recommendations together, including expenditure and savings decisions, especially where these impact across more than one directorate or have Trust-wide implications. (2) Sharing information including system intelligence, communicating and educating each other. (3) Large scale or high-risk staff

consultations. (4) Service changes requiring a public consultation. (5) Creating solutions, sharing inspiration and collective problem-solving. (6) Building effective team relationships, including sharing in a safe environment what might be troubling us and how others can help. The Chief Executive reports directly into Board through a regular written report.

Assessment of Board effectiveness

The Board commissioned an external consultancy called the Value Circle to assess and develop Board effectiveness and implement a Board development programme. This commenced in 2023 and is being implemented.

Developing Workforce Safeguards

NCH&C ensures that short, medium and long-term workforce strategies and staffing systems are in place, which assures the Board that staffing processes are safe, sustainable and effective. In particular NCH&C ensures that:

- Sufficient suitably qualified, competent, skilled and experienced staff are deployed to meet care and treatment needs safely and effectively.
- There is a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and always keep them safe.
- Our approach reflects current legislation and guidance.
- Meeting the National Quality Board's (NQB) requirements has helped NCH&C comply with the CQC's fundamental standards on staffing, for example, in the well-led framework and related legislation.

In support of the NQB expectations, NCH&C has taken the required action to ensure that these principles are in place. Therefore:

- NCH&C has formally embedded NQB's 2016 guidance in its safe staffing governance.
- NCH&C has ensured the three components of (1) evidence-based tools, (2) professional judgement, and (3) outcomes, are used in its safe staffing processes.
- NCH&C confirms that its staffing governance processes are safe and sustainable.
- NCH&C is fully compliant with the registration requirements of the Care Quality Commission.
- NCH&C 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.

Greener NHS

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.

Incident reporting and learning

Themes, actions and learning from patient safety incidents are reported each month via a Spotlight Report to Quality Committee and onto Trust Board. Themes and associated learning identified have included observation recording, effective escalation of clinical concerns, availability of equipment, patient education and support to make informed decisions about their care. This has also enabled teams to provide debriefs and psychological support to staff managing the incidents. The National Patient Safety Incident Response Framework (PSIRF) was implemented during 2023. Learning from Patient Safety Events (LFPSE) will be implemented during 2024. PSIRF has resulted in a change from 'serious incident investigations' or 'root causes', to a more flexible, system-focused approach, with improvement and engagement with patients/families/staff taking centre stage. LFPSE will change how incidents are reported both internally by staff and nationally. The Trust has also published its Patient Safety Incident Response Plan which details how the organisation manages and investigates incidents under PSIRF.

Clinical audit

Clinical audit is a way to find out if healthcare being provided by the Trust is in line with standards and enables us as a provider, and our patients to know where their service is doing well, and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients. Clinical audits can look at care nationwide (national clinical audits) and local clinical audits can also be performed locally in Trusts wherever healthcare is provided. NCH&C has participated in both national and local clinical audits, and implemented the learning from these. The clinical audit programme was constrained by the impact of the pandemic and any risks arising from this were mitigated in other ways, as agreed by the Quality and Audit Committees.

Freedom to Speak Up

The Freedom to Speak Up function during 2024/25 has continued to be provided by two part time Guardians. They are supported by several Champions throughout the services in the Trust and continue to raise the importance of creating a positive 'Speaking Up' culture. The Guardians have continued to access support from the National Guardians office and operate within their guidelines, they attend the Eastern region network of Guardians.

Access to the Guardians continues to be via phone, email, or the app. Anonymous feedback can be submitted via the app if required. A change in reporting direct from Datix this year has resulted in greater levels of directed support for concerns. The Guardians aim to get back to all those who raise a concern within 72 hours of receipt. Nationally there has been a year-on-year rise in the use of Freedom to Speak Up Guardians. This shows the continued importance of being able to offer all colleagues a safe, confidential space to raise concerns. Support from the senior leaders within NCH&C continues to be positive.

During the course of the year, in addition to telephone and online meeting support, the Guardians have visited over 30 of our services in person and organised a range of engagement events during Speak Up month. Participation with the staff engagement and wellbeing teams continues.

Learning from the concerns raised by staff is shared in a variety of ways, this includes the Guardians having a continued presence at committees at which they can express the themes from the concerns raised and cascade the learning that has been gained from them.

The themes associated with the concerns raised during 2024/25 relate to inappropriate behaviours from colleagues and patient safety due to increased demand on the services. The Freedom to Speak Up Guardians continue to work with teams to address local concerns wherever possible.

Ensuring the Guardians follow up on each concern raised and feed back to the staff member who has raised the concern ensures that staff feel listened to, without judgement, and supported, which in turn leads to staff feeling valued by the Trust.

David Crawford, Non-Executive Director, is NCH&C's nominated Freedom to Speak Up Board Champion.

Emergency Preparedness

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet in relation to EPRR. These are monitored via an annual assurance process, the results of which are submitted to NHS England.

Counter Fraud

Grant Thornton UK LLP is the Trust's counter fraud provider and has provided a dedicated Local Counter Fraud Specialist (LCFS), for the Trust, who is fully qualified and accredited to undertake counter fraud work. Fraud, bribery, and corruption are some of the many risks the Trust faces, and a focused, risk based counter fraud, bribery and corruption strategy forms part of the Trust's corporate governance arrangements. Those charged with governance are responsible for ensuring that there is an effective risk management programme in place that includes preventing, detecting, and deterring the risk of fraud, bribery, and corruption as part of the Trust's objectives and strategic plans. With appropriate measures in place, the Trust can help protect its resources against criminal activity and ensure that NHS funds are used for their intended purpose.

The Government Functional Standard GovS 013: Counter Fraud, ("Functional Standard") sets the expectations for the management of fraud, bribery and corruption risk in government organisations. In 2021, the NHSCFA published 13 NHS Requirements covering the 12 components of the Functional Standard (13 as there are two NHS Requirements relating to component 1). In accordance with the NHS Requirements of the Counter Fraud Functional Standard 013: Counter Fraud (the "Functional Standard) NCH&C has ensured that there is sufficient coverage both within the work plan and internally within the Trust to reduce fraud, bribery and corruption risk. This resource has been established through risk assessments conducted in accordance with the Government Counter Fraud Profession (GCFP) risk assessment methodologies. The Trust Secretary is NCH&C's nominated Counter Fraud Champion.

Statement on the discharge of statutory functions

The governance arrangements in place for the discharge of statutory functions have been checked through internal assurance processes for any irregularities, and are confirmed as being legally compliant. The Board is responsible for discharging the Trust's statutory functions in accordance with its Governance Manual, which incorporates:

- Standing Orders.
- Standing Financial Instructions.
- Scheme of Delegation and Reservation of Powers to the Board.
- Codes of Conduct.
- Board Committees' terms of reference.

The Governance Manual is reviewed at least annually by subject matter experts with the Audit Committee having oversight of this process. Amendments have been considered by the Committee and the Executive Team to ensure that the document remains fit for purpose as a working document. The proposed changes are then reviewed and ratified by the Board before implementation.

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

The Board, Audit Committee and both internal and external sources of assurance play an important role in seeking and providing assurance in relation to economy, efficiency and effectiveness of the use of resources, as described below.

The Board has exercised effective financial stewardship by assuring itself that the Trust is operating effectively, efficiently, economically and with probity in the use of resources. It has also ensured that financial reporting and internal control principles are applied, and appropriate relationships with the Trust's internal and external auditors are maintained. The Board sees financial stewardship as underpinning and facilitating the delivery of quality care. This includes a careful assessment and understanding of the quality and patient care consequences of financial decisions. The challenge of balancing effective financial stewardship and effective quality governance is a significant one for the Board operating in a financially constrained health and care system. The Board works with staff, patients and stakeholders to identify opportunities for reshaping services and improving quality of care which also delivers value for money.

Audit Committee

The Audit Committee's focus is to seek assurance that financial reporting and internal control principles are applied, and to maintain an appropriate relationship with the Trust's auditors, both internal and external. The Audit Committee offers advice to the Board about the reliability and robustness of the processes of internal control. This includes the power to review any other committees' work, including in relation to quality and risk, and to provide assurance to the Board regarding internal controls. The Quality Committee has oversight of risk management. The Audit Committee is positioned as an independent source of assurance to the Board and guards its independence. Ultimately however the responsibility for effective stewardship of the organisation belongs to the Board as a whole.

Audit

The Trust uses a variety of internal assurance processes, internal audit reviews and independent third-party assessments to ensure that resources are used economically, efficiently and effectively. External and internal auditors play an important independent role in Board assurance on internal controls, and form part of the Board's second and third lines of defence, providing assurance that Executive systems of control are sufficiently comprehensive and operating effectively. There is a clear line of sight from the Board Assurance Framework and the operational risk register to the programme of internal audit and a demonstrable link to the overall programme of clinical audit. Clinical audit serves as a significant source of assurance of clinical quality.

Internal Audit

The Trust's Internal Auditors, TIAA, carried out reviews, which were designed to ascertain the extent to which the internal controls in the system are adequate to ensure that activities and procedures are operating to achieve the Trust's objectives. For each assurance review an assessment of the combined effectiveness of the controls in mitigating the key control risks was provided. A summary of the outcome of these audits is provided below:

TIAA is satisfied that, for the areas reviewed during the year, NCH&C has reasonable and effective risk management, control and governance processes in place.

This opinion is based solely on the matters that came to the attention of TIAA during the course of the internal audit reviews carried out during the year and is not an opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or your ability to meet financial obligations which must be obtained by Norfolk Community Health and Care NHS Trust from its various sources of assurance.

Information governance

There were no personal data related incidents that required reporting to the Information Commissioners Office/Department of Health and Social Care (DHSC) in the Data Security Incident Reporting Tool. The Trust was compliant with the mandatory requirements of the 2024 Data Security and Protection Toolkit assessment.

Data quality and governance

The Data Quality Maturity Index (DQMI) focuses on a core set of data items that have been identified as being important to both commissioners and regulators, as well as being important to support national incentives (e.g., Commissioning for Quality and Innovation). Each month, NCH&C submit over 1m individual data items (across 57 categories) to NHS England (NHSE) as part of the DQMI, for Inpatients, Community Services and Mental Health Services. The 57 categories are administrative and demographic (e.g. name, address, referral source, organisational code, GP code etc).

The DQMI is published every month, three months in arrears, and provides a percentage rating for that month's publication. In the last twelve months, NCH&C rating has varied between 94% and 97%. Overall, data quality completeness for most categories is very good (99 -100% completion for 55 of the 57 categories), other than for two specific data items:

- Ethnicity (DQMI definition - the ethnicity of a person, as specified by the person).
- Language (DQMI definition - the language the patient prefers to use for communication with a health care provider).

(NHS Provider Trusts are required to collect data such as the above relating to the Equality Act to support improving fair access and health services for everyone).

NCH&C scores for Ethnicity recording average of 85% completeness, scores for Language recording average of 67% completeness. A Trust-wide audit is ongoing across all services to support improving the quality of the Shared Care Record. The audit focuses on both quantitative and qualitative elements of the patient record. This audit has been adjusted to include a review of the recording of preferred language and ethnicity for compliance so that the Data Quality team can support by feeding back areas of non-compliance and provide guidance on improving this to operational services.

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

The Trust's Patient Safety Team hold the role of CAS Liaison Officer (CLO) and follows a robust process to manage the received alerts. Subject matter experts along with the CLO assess all central alerts for relevance to the Trust.

All relevant alerts are then cascaded to the appropriate service areas for action or for information. A monthly summary report containing information about all open alerts, action taken, and any alerts closed within the month is shared at Safety Group. The Trust received a total of 11 CAS alerts during the reporting period 1 April 2024 to 31 March 2025.

Review of effectiveness

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

This section describes the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control. The Board undertook a range of actions to support both ongoing assurance and scrutiny, and specific actions to reduce risks. Actions included:

- The Board reviewed the Board Assurance Framework at least quarterly, following review by management and Board committees.
- The Board reviewed Trust performance against national and local clinical quality targets, as well as delivery against corporate and strategic objectives, at each Board meeting.
- The Board regularly reviewed Trust delivery against its annual priorities.
- The Audit Committee reviewed reports from the other Board committees, focusing on the process by which assurance was gained by these committees.
- Each Board Committee provided Annual Assurance Reports, setting out how they have discharged their delegated responsibilities in accordance with their terms of reference.
- Each Board Committee undertook their annual self-assessment of their performance and effectiveness, and identified areas for improvement, and their training needs.
- There is an effective clinical audit programme in place.
- The Accountable Officer has taken into account the views of the Caldicott Guardian and Senior Information Risk Owner.
- The Accountable Officer has taken into account the findings from the Internal Audit programme and the Head of Internal Audit Opinion.
- Performance assessed by NHS regulators. As described in the Performance Summary section above, the CQC has rated the Trust as "Outstanding" following an inspection in 2018 and NHSI has placed the Trust into segment one of the NHS System Oversight Framework since 2021.

The Trust is committed to the continuous improvement of its risk management and assurance systems and processes, to ensure improved effectiveness and efficiency. During the year the Trust received services from internal audit. Work has been commissioned from the internal audit service to review the adequacy of the controls and assurance processes in place and to develop improvements within the governance processes.

Code of governance for NHS provider trusts

The code sets out a common overarching framework for the corporate governance of trusts, reflecting developments in UK corporate governance and the development of integrated care systems. Corporate governance is the means by which Boards lead and direct their organisations so that decision-making is effective, risk is managed and the right outcomes are delivered. For NCH&C this means delivering high quality services in a caring and compassionate environment while collaborating through system and place-based partnerships to integrate care. Best practice is detailed in the following sections: board leadership and purpose, division of responsibilities, composition, succession and evaluation, audit, risk, internal control and remuneration. The tables attached as an appendix at the end of this report describe how NCH&C has met the disclosure requirements and the comply or explain requirements of the code.

Conclusion

No significant internal control issues have been identified.

Signed:

Matthew Winn
Chief Executive
Norfolk Community Health and Care NHS Trust
Date: 24 June 2025

Modern Slavery Act 2015 – Transparency in Supply Chains

There is no legal requirement on the Trust to have a statement regarding the Modern Slavery Act 2015, as its income from non-government sources is less than £36 million. Income earned from CCGs and local authorities is considered to be public funding and is therefore outside the scope of the Modern Slavery Act reporting requirements. However, the Trust is committed to ensuring that there is no modern slavery or human trafficking in its supply chains or in any part of its business. The Trust works to identify and mitigate risk while putting in place contractual terms which allows it to gain assurance that slavery and human trafficking have no place in its business. When procuring goods and services, the Trust additionally applies NHS Terms and Conditions (for non-clinical procurement) and the NHS Standard Contract (for clinical procurement) which both require suppliers to comply with relevant legislation. The Trust also works with suppliers to ensure that they treat their obligations towards modern slavery with the same importance that we do.

The Trust confirms the identities of all new employees and their right to work in the United Kingdom and pay all its employees above the National Living Wage. In addition, its Freedom to Speak Up, grievance and other staff policies additionally give a platform for its employees to raise concerns about any perceived poor working practices. Consequently, while the Trust does not have a specific anti-slavery policy, as it is not required to have one, it acts in accordance with the intentions of the Act with regard to its own operations and that of any sub-contractors and, therefore, the Trust's ability to deliver the contract is in no way compromised.

2.2 Remuneration and Staff Report

The remuneration and staff report sets out NCH&C's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers and where relevant the link between performance and remuneration. In addition, the report provides details on remuneration and staff that users of the accounts see as key to accountability.

Remuneration Report

The Secretary of State for Health and Social Care determines the remuneration of the Chair and Non-Executive Directors nationally. Remuneration for Executive Board members is determined by the Remuneration Committee. In the case of the Chief Executive, a spot salary applies which is calculated based on the weighted population of the county through the Very Senior Managers national framework. For the other Executive Directors' remuneration, the Trust applies the mandatory guidance given by NHS Employers through the Agenda for Change framework for directors holding employment contracts.

Salaries and allowances

The salaries and other allowances of the senior managers who have held office for all or part of the 2024/25 financial year are disclosed in the "Salaries and allowances" table overleaf. Figures for staff appointed or leaving during the financial year are for the part of the year that the individual held the position.

Salaries and allowances of Board members in 2024/25

The following table is subject to audit.

Name	Title	2024/25					
		Salary (Bands of £5,000)	Expense Payments - Taxable (to nearest £100)	Performance Pay & Bonuses (Bands of £5,000)	Long-term Performance Pay & Bonuses (Bands of £5,000)	All Pension-Related Benefits (Bands of £2,500)	TOTAL (Bands of £5,000)
Laura Clear	Director of Strategy & Transformation / Deputy CEO	140-145	1	-	-	87.5-90	230-235
Elizabeth Cooke	Human Resources & Organisational Development Director	85-90	-	-	-	5-7.5	90-95
David Crawford*	Non-Executive Director	10-15	-	-	-	-	10-15
Susan Crossman*	Non-Executive Director	10-15	1	-	-	-	10-15
Steven Crowe*	Non-Executive Director	10-15	-	-	-	-	10-15
Carolyn Fowler	Director of Nursing and Quality	125-130	-	-	-	17.5-20	145-150
Andrew Hopkins	Director of Finance And Performance	135-140	-	-	-	15-17.5	150-155
Caroline Kavanagh**	Executive Medical Director	60-65	-	-	-	192.5-195	255-260
John Kennedy*	Non-Executive Director	10-15	-	-	-	-	10-15
Robert Mack	Director of Community Health & Social Care Operations	110-115	1	-	-	27.5-30	140-145
Graham Nice*	Non-Executive Director	15-20	2	-	-	-	15-20
Lynda Thomas	Chairman	40-45	4	-	-	-	40-45
Matthew Winn**	Chief Executive	90-95	1	10-15	-	82.5-85	175-180
Njoki Yaxley*	Non-Executive Director	10-15	-	-	-	-	10-15

NB: A "-" indicates nil value.
NB: Sarah Buchan commenced in post 24th February 2025, however during this time Sarah observed one Board meeting, therefore was unable to have direct influence on the decisions of the entity and has not been included in the disclosure for this financial year.

* Chairman & Non-executive Directors do not receive pensionable remuneration therefore, there are no entries in respect of pensions.

** Matthew Winn and Caroline Kavanagh's posts are shared 50/50 with Cambridgeshire Community Services NHS Trust. Caroline Kavanagh commenced in post with both organisations on the 1st of July 2024. Total remuneration in 2024/25 across both Trusts was £185,000 - £190,000 for Matthew Winn and £125,000 - £130,000 for Caroline Kavanagh.

Factors determining the variation in the values recorded between individuals include but is 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. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Prior Year salaries and allowances of Board members in 2023/24

The following table is subject to audit.

Name	Title	2023/24					
		Salary (Bands of £5,000)	Expense Payments - Taxable (to nearest £100)	Performance Pay & Bonuses (Bands of £5,000)	Long-term Performance Pay & Bonuses (Bands of £5,000)	All Pension-Related Benefits (Bands of £2,500)	TOTAL (Bands of £5,000)
Laura Clear	Director of Strategy & Transformation / Deputy CEO	135-140	-	-	-	25-27.5	160-165
Stephen Collman***	Chief Executive - Outgoing	100-105	2	-	-	107.5-110	205-210
Elizabeth Cooke	Human Resources & Organisational Development Director	85-90	-	-	-	-	85-90
David Crawford*	Non-Executive Director	5-10	-	-	-	-	5-10
Susan Crossman*	Non-Executive Director	10-15	-	-	-	-	10-15
Steven Crowe*	Non-Executive Director	10-15	-	-	-	-	10-15
Carolyn Fowler*****	Director of Nursing and Quality	125-130	-	-	-	-	125-130
Muhammad Zaeem Ul Haq*	Non-Executive Director	5-10	2	-	-	-	5-10
Venu Harilal****	Medical Director	140-145	-	5-10	-	-	150-155
Andrew Hopkins******	Director of Finance And Performance	130-135	-	-	-	-	130-135
John Kennedy*	Non-Executive Director	10-15	-	-	-	-	10-15
Robert Mack*******	Director of Community Health & Social Care Operations	45-50	-	-	-	37.5-40.0	85-90
Graham Nice*	Non-Executive Director	15-20	2	-	-	-	15-20
Lynda Thomas*	Chairman	40-45	4	-	-	-	40-45
Andrew Williams*	Non-Executive Director	5-10	-	-	-	-	5-10
Matthew Winn**	Chief Executive	35-40	-	-	-	-	35-40
Njoki Yaxley*	Non-Executive Director	10-15	-	-	-	-	10-15

NB: A "-" indicates nil.

* Chairman & Non-executive Directors do not receive pensionable remuneration therefore, there are no entries in respect of pensions.

** From the start of November, Matthew Winn joined the Trust as CEO, the post shared 50/50 with Cambridgeshire Community Services NHS Trust. The above table discloses the share for the Trust from this date. Total remuneration in 2023/24 across both Trusts was £185,000 - £190,000.

*** CEO Stephen Collman left the Trust in November 2023.

**** Dr Harilal's remuneration includes both a Clinical and Medical Director role. The salary is split £87,740.28 for the Clinical role, including £7,819.29 for clinical excellence awards, and £63,236.74 for the Medical Director role.

Fair pay disclosure

The tables and narrative in this section are subject to audit.

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of total remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component. The banded remuneration of the highest paid director / member in NCH&C in the financial year 2024/25 was £142,500 (2023/24, £142,500). The relationship to the remuneration of the organisation's workforce is disclosed in the table overleaf.

The median and 25th and 75th percentile full time equivalent remuneration of the workforce has been calculated based on those receiving remuneration in March 2025. The remuneration received in March has been annualised and excludes the highest paid director. In calculating the monthly hours for the disclosure an assumption has been made of 162.95 working hours and other pay has been annualised. Included within the figures to calculate the median full time equivalent remuneration is the annualised remuneration of agency staff working at the Trust, taken from an average of their worked hours over the full financial year. The annualised remuneration of agency staff has been calculated after deduction of an average commission rate, removing employers NI and excluding those only working less than a month. The calculations are based on an average 40-hour week.

Year 2024/25	25th percentile	Median	75th percentile
Mid-point of banded remuneration of highest paid director	142,500	142,500	142,500
Total remuneration £	25,744	32,704	44,962
Salary component of total remuneration £	24,071	29,861	43,682
Pay ratio information	5.5	4.4	3.2

Year 2023/24	25th percentile	Median	75th percentile
Mid-point of banded remuneration of highest paid director	142,500	142,500	142,500
Total remuneration £	24,833	35,134	42,663
Salary component of total remuneration £	23,278	33,368	42,618
Pay ratio information	5.7	4.1	3.3

*The prior year figures, included in the table above, included a calculation error in the median pay column. This has resulted in figures higher than the true median. The corrected figures would be a total remuneration of £32,105, a salary component of £29,595, and a Pay ratio of 4.4. As the Directors do not consider the effect on the prior period financial statements to be material as a result no prior year restatement has been made.

In 2024/25, no (2023/24 no) employee received remuneration in excess of the highest paid director / member. Remuneration ranged from £9,681 to £142,500 (2023/24 £7,648 to £142,500).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

There is no percentage change in the highest paid director / member in NCH&C from 2023/24 to 2024/25.

2024/25	% change for highest paid director	% change based on median employee
Salary and allowances	-	-1.87%
Performance pay and bonuses	-100.0%	-
Salary, allowances, performance pay and bonuses combined	-	-13.3%

2023/24	% change for highest paid director	% change based on median employee
Salary and allowances	-10.3%	-15.9%
Performance pay and bonuses	100%	-52.8%
Salary, allowances, performance pay and bonuses combined	-5.4%	-12.3%

The increase in the pay ratio information in the current year is a result of a change in responsibilities for a member of executive group who assumed additional responsibilities as Deputy CEO, a reduction in bonuses as previous highest paid director was in receipt of Clinical Excellence Awards.

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".

Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

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

The following table is subject to audit.

2024/25		Real increase during the reporting year in pension at pension age (bands of £2,500)	Real increase during the reporting year in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024 (to nearest £1,000)	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025 (to nearest £1,000)
Name	Title	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Laura Clear**	Director of Strategy & Transformation / Deputy CEO	2.5-5	5-7.5	65-70	175-180	1,475	-	132
Elizabeth Cooke	Human Resources & Organisational Development Director	0-2.5	-	45-50	120-125	1,039	17	1,138
Carolyn Fowler**	Director of Nursing and Quality	0-2.5	-	60-65	155-160	77	28	126
Andrew Hopkins	Director of Finance And Performance	0-2.5	-	65-70	175-180	1,490	31	1,645
Caroline Kavanagh*	Executive Medical Director	7.5-10	20-22.5	70-75	185-190	1,360	217	1,761
Robert Mack	Director of Community Health & Social Care Operations	0-2.5	0-2.5	30-35	70-75	505	22	575
Matthew Winn*	Chief Executive	5-7.5	2.5-5	60-65	150-155	1,201	89	1,394

* The posts occupied by Matthew Winn and Caroline Kavanagh are shared 50/50 with Cambridgeshire Community Services NHS Trust. The above table discloses their full pension values.

** Laura Clear and Carolyn Fowler are at normal retirement age, therefore a CETV calculation is not required.

The following table is subject to audit.

2023/24		Real increase during the reporting year in pension at pension age (bands of £2,500)	Real increase during the reporting year in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2024 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2023 (to nearest £1,000)	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024 (to nearest £1,000)
Name	Title	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Laura Clear	Director of Strategy & Transformation / Deputy CEO	0-2.5	-	55-60	160-165	1,204	132	1,475
Stephen Collman	CEO (Outgoing)	2.5-5.0	50.0-52.5	70-75	190-195	1,115	365	1,606
Elizabeth Cooke	Director of HR and OD	-	17.5-20	40-45	110-115	828	116	1,039
Carolyn Fowler	Director of Nursing & Quality	0-2.5	-	50-55	145-150	1,191	-	77
Venu Harilal	Medical Director	-	-	50-55	40-45	743	111	948
Andrew Hopkins	Director of Finance & Performance	-	25-27.5	60-65	165-170	1,238	103	1,490
Robert Mack	Director of Community Health & Social Care Operations	0-2.5	2.5-5	25-30	65-70	391	33	505
Matthew Winn *	CEO	-	40-42.5	50-55	135-140	945	137	1,201

* From the start of November, Matthew Winn joined the Trust as CEO, the post shared 50/50 with Cambridgeshire Community Services NHS Trust. The above table discloses the full pension value.

Cash Equivalent Transfer Values

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2025. HM Treasury last published updated guidance on 27 April 2023.

Other Finance tables for inclusion in the staff report

Staff costs

	Permanent £000	Other £000	2024/25 Total £000	2023/24 Total £000
Salaries and wages	89,241	4,239	**93,481**	83,673
Social security costs	9,091	386	**9,477**	8,891
Apprenticeship levy	465	-	**465**	429
Employer's contributions to NHS pension scheme	19,838	879	**20,718**	16,159
Pension cost - other	32	-	**32**	40
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	69
Termination benefits	1,087	-	**1,087**	177
Temporary staff	-	1,377	**1,377**	1,387
Total gross staff costs	**119,755**	**6,882**	**126,637**	**110,825**
Recoveries in respect of seconded staff	(10)	-	**(10)**	-
Total staff costs	**119,744**	**6,882**	**126,626**	**110,825**
Of which				
Costs capitalised as part of assets	452	-	**452**	438

Average number of employees (WTE basis)

	Permanent Number	Other Number	2024/25 Total Number	2023/24 Total Number
Medical and dental	15	0	**15**	15
Ambulance staff	-	-	**-**	-
Administration and estates	505	9	**513**	497
Healthcare assistants and other support staff	668	54	**722**	681
Nursing, midwifery and health visiting staff	740	34	**773**	712
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	399	7	**406**	381
Healthcare science staff	3	0	**3**	-
Social care staff	-	-	**-**	2
Other	7	-	**7**	8
Total average numbers	**2,337**	**104**	**2,440**	**2,297**
Of which:				
Number of employees (WTE) engaged on capital projects	7	-	**7**	9

Expenditure on consultancy

Expenditure on consultancy services is shown in accounts Note 6.1 Operating Expenses. There was spend of £18k for consultancy in 2024/25 (no spend in 2023/24), this was primarily used for digital transformation projects for hosted services (Shared Care Services).

- Off-payroll engagements
- There have been no off-payroll engagements.
- Exit Packages
- NHS Trusts are required to disclose summary information of their use of staff exit packages agreed in the year.

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	31-Mar-25	£'000	31-Mar-25	£'000	31-Mar-25	£'000	31-Mar-25	£'000
<£10,000	4	16			4	16		
£10,000 - £25,000								
£25,001 - £50,000	1	39			1	39		
£50,001 - £100,000	3	183			3	183		
£100,001 - £150,000								
£150,001 - £200,000								
>£200,000								
Total	8	238	0	0	8	238	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the 1995/2008 and 2015 NHS Pension Schemes. Exit costs in this note are the full costs of departures agreed in the year. Where the Norfolk Community Health & Care NHS Trust has agreed early retirements, the additional costs are met by the Norfolk Community Health & Care NHS Trust and not by the NHS Pension Schemes. Ill-health retirement costs are met by the NHS Pension Schemes and are not included in the table.

The cost of redundancies shown in the table above is different to the value of redundancy reported in note 6 of the financial statements as the financial statements also show the recognition and release of anticipated redundancies where the Trust has established or released a provision for expected costs.

(a) Chart showing the number of senior managers by pay band.

Brand	Headcount
Band 8A	104
Band 8B	37
Band 8C	17
Band 8D	10
Band 9	3
VSM	1
Total	172

(b) Staff composition – chart providing an analysis of the number of persons of each sex who were directors and employees of NCH&C.

Staff Category	Female	Male	Total
Directors (Voting)	4	5	9
Non-voting directors and other VSMs	2	1	3
Other staff	2,315	437	2,752
Total	2,321	443	2,764

(c) Sickness absence data - The 12-month sickness absence rate for the year is 5.74%, compared to 5.37% for the previous year. This sickness figure is based on NCH&C's internal reporting systems and cover the period 1 April 2024 to 31 March 2025.

Anxiety/stress/depression/other psychiatric illnesses continue to be the highest cost to the organisation accounting for 29% of time lost due to sickness while coughs, colds, and flu accounts for 13%. Short term sickness is mainly influenced by cold/cough/flu (1,401 instances) and Gastro-Intestinal (919 episodes).

Staff turnover percentage - The staff turnover figures for NCH&C are available through NHS Digital's NHS Workforce Statistics, available on their website:

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

Staff Engagement - NCH&C Staff Engagement Scores from 2021 to 2025, from the NHS Staff Survey (NSS) and National Quarterly Pulse Survey (NQPS):

	2021		2022				2023				2024				2025
	Q3 - July NQPS	Q4 - NSS	Q1 - Jan NQPS	Q2 - April NQPS	Q3 - July NQPS	Q4 - NSS	Q1 - Jan NQPS	Q2 - April NQPS	Q3 - July NQPS	Q4 - NSS	Q1 - Jan NQPS	Q2 - April NQPS	Q3 - July NQPS	Q4 - NSS	Q1 - Jan NQPS
Staff Engagement	7.2	7.24	7.20	7.07	7.09	7.32	6.85	6.96	7.24	7.39	7.29	7.59	7.56	7.30	7.18
Advocacy	7.4	7.38	7.39	7.19	7.26	7.4	6.98	7.23	7.46	7.58	7.45	7.82	7.86	7.43	7.42
Involvement	7.1	7.09	7.11	6.97	6.92	7.2	6.78	6.71	6.96	7.26	7.09	7.41	7.37	7.19	7.08
Motivation	7.1	7.26	7.09	7.05	7.10	7.36	6.80	6.95	7.29	7.34	7.33	7.53	7.44	7.28	7.06
Data Source	Q2 21/22	2021	Q4 21/22	Q1 22/23	Q2 22/23	2022	Q4 22/23	Q1 23/24	Q2 23/24	2023	Q4 23/24	Q1 24/25	Q2 24/25	2024	Q4 23/24
	Model Hospital	NSS Data Sheet	NQPS DataS heet	NQPS DataS heet	NQPS DataS heet	NSS Data Sheet	NQPS DataS heet	NQPS DataS heet	NQPS DataS heet	NSS Data Sheet	NQPS DataS heet	NQPS DataS heet	NQPS DataS heet	NSS Data Sheet	NQPS DataS heet

(d) Staff policies applied during the financial year:

Policy	Date Ratified
Flexible Working	April 2024; January 2025
Leave & Pay for New & Existing Parents	April 2024; March 2025
Supporting Attendance & Wellbeing	April 2024; May 2024; February 2025
Grievance	May 2024; March 2025
Carers	June 2024
Induction	June 2024
Leavers	June 2024; September 2024; November 2024; January 2025
Probationary Periods	June 2024; March 2025
Starting Salaries	July 2024
Change Management	September 2024
Disclosure & Barring Service (DBS)	September 2024
Domestic Violence & Abuse	September 2024
Study Leave	September 2024
Discretionary Leave	October 2024; March 2025
Drugs & Alcohol	October 2024

Policy	Date Ratified
Electric Vehicle (EV) Charging	October 2024
Equality, Diversity & Inclusion	October 2024
Fixed Term Workers	October 2024
Retirement	October 2024; February 2025
Social Media	October 2024
Annual Leave	November 2024
Relationships at Work	November 2024
Staff Mental Health & Wellbeing	November 2024
Workplace Adjustments	November 2024
Smarter Working	December 2024
Supervision	December 2024
Bank & Agency	January 2025
Professional Registration	January 2025
Recruitment	January 2025
Time Owing, Additional Hours & Overtime	February 2025
Mediation	March 2025
On-Call	March 2025
Pay Progression	March 2025
Flexible Working	April 2024; January 2025
Leave & Pay for New & Existing Parents	April 2024; March 2025
Supporting Attendance & Wellbeing	April 2024; May 2024; February 2025
Grievance	May 2024; March 2025
Carers	June 2024
Induction	June 2024

Equality, Diversity & Inclusion Policy

NCH&C's Equality, Diversity & Inclusion Policy is in place to ensure we achieve the best from people by valuing differences as laid out in the Workforce and OD Strategy. The Trust will ensure that it works towards becoming a first-choice employer by developing a workforce at all levels which is truly representative of all sections of the community and reflects the community it serves. The Trust is committed to eliminating discrimination and encouraging diversity amongst its workforce.

The Trust participated in the Employers Network for Equality & Inclusion (ENEI) Talent Inclusion & Diversity Evaluation programme to benchmark the trust's progress in fostering diversity and inclusion across several areas. Benchmarking against other member organisations from a variety of sectors, the trust was awarded a Silver Award. Furthermore, the work of the trust was recognised and awarded Highly Commended in the Innovation Approach to Equality, Diversity and Inclusion at the ENEI Excellence Awards.

The Trust continues to review and monitor progress using robust tools and practices including the Equality Delivery System 2022, Workforce Equality Standards and Gender Pay Gap. The trust has extended its commitment to Inclusion by signing up to the East of England Anti-Racism Strategy, Unison Anti-Racism Charter and the NHS Sexual Safety in the Workplace Charter. Through this the trust has completed additional voluntary reporting to raise awareness and understanding of the issues faced by our staff to enable effective action to be taken.

The Trust has continued to celebrate different cultural events and to ensure that we are listening to and learning from the lived experiences of our people and our patients. This is achieved through the three staff networks at the trust and by participating in programmes that support specific work including Employers Carer Friendly Tick Award for staff carers and Disability Confident Leader Status.

To continue to support the development of compassionate and inclusive workplaces, the trust has adopted the NHS Civility & Respect toolkit, implementing a three-phase approach to address behaviours of incivility and disrespect, promoting positive working environments that are kind, compassionate and inclusive for all.

Ethnic Category	Headcount	NCH&C (%)	2021 Census Norfolk (%)
Non-BME	2,254	81.55%	94.70%
BME	306	11.07%	0.00%
Not stated/Undefined	204	7.38%	5.30%
NCH&C Total	**2,764**	**100.00%**	**100.00%**

Religious Belief	Total	NCH&C (%)	2021 Census Norfolk (%)
Atheism	650	23.50%	44.20%
Buddhism	6	0.20%	0.40%
Christianity	1111	40.20%	47.00%
Hinduism	16	0.60%	0.40%
Islam	14	0.50%	0.90%
Jainism	0	0.00%	-
Judaism	3	0.10%	0.10%
Sikhism	1	0.00%	0.10%
Other	257	9.30%	0.60%
Not declared	706	25.50%	6.40%
Total	**2,764**	**100.0%**	**100.0%**

Sexual Orientation	Total	NCH&C (%)	2021 Census Norfolk (%)
Heterosexual or Straight	2156	78.0%	89.3%
Gay or Lesbian	59	2.1%	1.4%
Bisexual	47	1.7%	1.4%
Undecided	4	0.1%	-
Other sexual orientation not listed	8	0.3%	0.3%
Not declared	490	17.7%	7.5%
Total	**2,764**	**100%**	**100%**

Disability Status	Headcount	NCH&C (%)	2021 Census Norfolk (%)
No	2,102	76.0%	**79.9%**
Yes	301	10.9%	**20.1%**
Not Declared	361	13.1%	**-**
Total	**2,764**	**100.0%**	**100.0%**

	16 - 20	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 - 50	51 - 55	56 - 60	61 - 65	66 - 70	71+
NCH&C Staff Profile	1.1%	5.4%	10.4%	11.9%	12.6%	11.8%	10.7%	14.2%	12.6%	7.9%	1.2%	0.3%
2021 Census Norfolk (%)	5.1%	5.6%	5.7%	6.0%	5.8%	5.5%	6.0%	6.9%	7.2%	6.5%	6.1%	18.4%

Trade Union Facility Time Reporting Requirements

NCH&C is in scope of the Trade Union (Facility Time Publication Requirements) Regulations 2017, which took effect from 1 April 2017, and are therefore required to publish detail as prescribed by the Statutory Instrument (SI) in their ARA.

Table 1 Relevant union officials

Total number of employees who were relevant union officials during the relevant period

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
24	21.53

Table 2 Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	0
1%-50%	23
51%-99%	0
100%	1

Table 3 Percentage of pay bill spent on facility time

Percentage of total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column	Figures
Provide the total cost of facility time	£2,995.35
Provide the total pay bill	£93,481,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.003% 2,995.35 divided by £93,481,000 x 100 = 0.003%

Table 4 Paid trade union activities

Percentage of total paid facility time hours, hours spent by employees who were relevant union officials during the relevant period on paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	Total Hours = 76.25 My calculation is 76.25 hrs spent on paid trade union activities divided by £1,187.23 total cost of facility time = 0.0765 x 100 = 6.42%

Publication Material

As part of the Trade Union (Facility Time Publication Requirements) Regulations 2017 we are required to publish information in respect of employees who were relevant Trade Union officials during the period 1st April 2022 to 31st March 2023.

In the above period there were 28 employees (equivalent to 25.8 full-time staff) who were relevant union officials.

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1%-50%	23
51%-99%	0
100%	1

Percentage of pay bill spent on facility time

Total cost of facility time	Total pay bill	Percentage of the total pay bill spent on facility time
£2,995.35	£93,481,000	0.003%

Paid trade union activities

Time spent on paid trade union activities
Total Hours = 161.7

Expenditure on consultancy

Expenditure on consultancy services is shown in accounts Note 6.1 Operating Expenses. There was no consultancy expenditure in 2023/24 (£44k in 2022/23).

2.3 Parliamentary Accountability and Audit Report

As a DHSC group body, NCH&C is not required to produce a Parliamentary accountability report. NCH&C has included the audit certificate and report in the annual report and accounts. NCH&C publishes its annual report and accounts on the Trust's website.

NCH&C may publish its annual report and accounts in advance of the consolidated Resource Account being submitted by DHSC to Parliament. The annual report and accounts is presented formally in public at the Annual General Meeting in September 2024.

Accountability Report Signature

As the Accountable Officer, I hereby confirm adherence to the reporting framework requirements of the Accountability Report and confirm that it is fair, balanced and understandable and that I take personal responsibility for the judgements required for determining this.

Accountable Officer's signature

Signed:
Date: *24 June 2025*

Matthew Winn
Chief Executive
Norfolk Community Health and Care NHS Trust

Code of Governance disclosure provision

Section	Sub-Category	Code Statement	Disclosure statement
Section A: Board leadership and purpose	Provisions	2.1 The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	This described in the Accountability Report in section 2
Section A: Board leadership and purpose	Provisions	2.3 The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	This is described in the Performance Report in section 1
Section A: Board leadership and purpose	Provisions	2.8 The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective.	This is described in the Performance Report in section 1

Section	Sub-Category	Code Statement	Disclosure statement
Section B: Division of responsibilities	Provisions	2.6 The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: has been an employee of the trust within the last two years has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the trust has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme has close family ties with any of the trust's advisers, directors or senior employees holds cross-directorships or has significant links with other directors through involvement with other companies or bodies has served on the trust board for more than six years from the date of their first appointment (but note 4.3 in Section C below, where chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval). is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	The Board considers that all of its Non-Executive Directors are independent against these criteria.
Section B: Division of responsibilities	Provisions	2.13 The annual report should give the number of times the board and its committees met, and individual director attendance. The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.	This is described in the Accountability Report in section 2
Section C: Composition, succession and evaluation	Board appointments	The board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	The statement is included in the Accountability Report in section 2
Section D: Audit, risk and internal control	Provisions	2.4 The annual report should include: the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	 There were no significant issues External Audit are appointed through an open procurement process. The current provider was selected for 3 years up to 2025/26 The external auditor does not provide any non-audit services.
Section D: Audit, risk and internal control	Provisions	2.6 The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	This statement is included on page 87
Section D: Audit, risk and internal control	Provisions	2.7 The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	This is described in the Performance Report section 1 and Accountability Reports section 2

Section	Sub-Category	Code Statement	Disclosure statement
Section D: Audit, risk and internal control	Provisions	2.8 The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	This is included in the Accountability Report in section 2
Section D: Audit, risk and internal control	Provisions	2.9 In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual, which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.	This is included in the Accountability Report in section2
Section E: Remuneration	Provisions	2.3 Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	The Trust has not released an Executive Director to serve as an Non-Executive elsewhere

Code of Governance comply or explain provisions

Section	Sub-Category	Statement	Comply or Explain
Section A: Board leadership and purpose	Provisions	2.2 The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.	Comply
Section A: Board leadership and purpose	Provisions	2.4 The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners (This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system), and that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	Comply
Section A: Board leadership and purpose	Provisions	2.5 In line with principle 1.3 above, the board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, e.g. from the internal audit function, to provide an adequate and reliable level of assurance.	Comply

Section	Sub-Category	Statement	Comply or Explain
Section A: Board leadership and purpose	Provisions	2.6 The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	Comply
Section A: Board leadership and purpose	Provisions	2.7 The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.	Comply
Section A: Board leadership and purpose	Provisions	2.9 The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	Comply
Section A: Board leadership and purpose	Provisions	2.10 The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement (directors are required to declare any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services.	Comply
		The trust must enter these into a register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations. In addition, NHS foundation trust directors have a statutory duty to manage conflicts of interest. In the case of NHS trusts, certain individuals are disqualified from being directors on the basis of conflicting interests).	
Section A: Board leadership and purpose	Provisions	2.11 Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	Comply
Section B: Division of responsibilities	Provisions	2.1 The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	Comply
Section B: Division of responsibilities	Provisions	2.2 The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	Comply
Section B: Division of responsibilities	Provisions	2.3 The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	Comply

Section	Sub-Category	Statement	Comply or Explain
Section B: Division of responsibilities	Provisions	2.5 The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	Comply
Section B: Division of responsibilities	Provisions	2.7 At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	Comply
Section B: Division of responsibilities	Provisions	2.8 No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	Comply
Section B: Division of responsibilities	Provisions	2.9 The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chair ship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.	Comply
Section B: Division of responsibilities	Provisions	2.10 Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	Comply
Section B: Division of responsibilities	Provisions	2.11 In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the Chair appraisal framework.	Comply
Section B: Division of responsibilities	Provisions	2.12 Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	Comply
Section B: Division of responsibilities	Provisions	2.14 When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chair ship of such an organisation.	Comply
Section B: Division of responsibilities	Provisions	2.15 All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	Comply

Section	Sub-Category	Statement	Comply or Explain
Section B: Division of responsibilities	Provisions	2.16 All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	Comply
Section B: Division of responsibilities	Provisions	2.17 The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.	Comply
Section C: Composition, succession and evaluation	Provisions for NHS trust board appointments	3.1 NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.	Comply
Section C: Composition, succession and evaluation		Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	4.1 Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	4.3 Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	4.5 There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.	Comply

Section	Sub-Category	Statement	Comply or Explain
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	4.6 The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	4.11 The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	4.12 The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	4.13 The annual report should describe the work of the nominations committee(s), including: the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives	Comply Comply Comply Comply
		the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served the gender balance of senior management and their direct reports.	Comply Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	5. Development, information and support	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	5.2 The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. Directors should also be familiar with the integrated care system(s) that commission material levels of services from the trust. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	5.3 To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	Comply

Section	Sub-Category	Statement	Comply or Explain
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	5.4 The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	5.5 The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	5.8 The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	5.9 The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	5.10 The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	5.11 The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	5.12 The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	Comply

Section	Sub-Category	Statement	Comply or Explain
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	5.13 Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	5.14 Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	5.16 The board of directors must have regard to the council of governors' views on the NHS foundation trust's forward plan.	Comply
Section C: Composition, succession and evaluation	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	5.17 NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	Comply

Section	Sub-Category	Statement	Comply or Explain
Section D: Audit, risk and internal control	Provisions	2.1 The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	Comply
Section D: Audit, risk and internal control	Provisions	2.2 The main roles and responsibilities of the audit committee should include:	Comply
		monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them	Comply
		providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy	Comply
		reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself	Comply
		monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors	Comply
		reviewing and monitoring the external auditor's independence and objectivity	Comply
		reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements	Comply

Section	Sub-Category	Statement	Comply or Explain
		reporting to the board of directors on how it has discharged its responsibilities.	Comply
Section D: Audit, risk and internal control	Provisions	2.3 A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. These timeframes are not affected by an NHS trust becoming a foundation trust.	Comply
Section D: Audit, risk and internal control	Provisions	2.5 Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor.	Comply
Section E: Remuneration	Provisions	2.1 Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients.	Comply
Section E: Remuneration		Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate.	
Section E: Remuneration		Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and must be limited to the lower of £17,500 or 10% of basic salary.	
Section E: Remuneration		The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	
Section E: Remuneration	Provisions	2.2 Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	Comply
Section E: Remuneration	Provisions	2.4 The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a director returns to the NHS within the period of any putative notice.	Comply
Section E: Remuneration	Provisions	2.5 Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity (severance payment includes any payment whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements).	Comply
Section E: Remuneration	Provisions	2.7 The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	Comply

Norfolk Community Health and Care NHS Trust

Annual accounts for the year ended 31 March 2025

Statement of Comprehensive Income

	Note	2024/25 £000	2023/24 £000
Operating income from patient care activities	4	162,191	140,457
Other operating income	5	16,328	21,159
Operating expenses	7	(186,534)	(156,105)
Operating surplus/(deficit) from continuing operations		**(8,014)**	**5,510**
Finance income	11	2,398	1,505
Finance expenses	12	(66)	(60)
PDC dividends payable		(1,723)	(1,542)
Net finance costs		**609**	**(96)**
Other gains / (losses)	13	(219)	(296)
Surplus / (deficit) for the year		**(7,624)**	**5,118**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	-	(410)
Revaluations	16	2,817	449
Other reserve movements		(40)	-
Total comprehensive income / (expense) for the period		**(4,847)**	**5,157**

Statement of Financial Position

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	14	1,067	1,435
Property, plant and equipment	15.1	83,509	91,040
Right of use assets	17.1	12,014	11,505
Receivables	19	29	30
Total non-current assets		**96,619**	**104,010**
Current assets			
Inventories	18	18	24
Receivables	19	5,487	4,846
Cash and cash equivalents	20	42,325	47,707
Total current assets		**47,830**	**52,577**
Current liabilities			
Trade and other payables	21	(24,428)	(32,136)
Borrowings	23	(642)	(406)
Provisions	24.1	(4,411)	(2,997)
Other liabilities	22	(1,537)	(1,766)
Total current liabilities		**(31,018)**	**(37,305)**
Total assets less current liabilities		**113,431**	**119,282**
Non-current liabilities			
Borrowings	23	(3,670)	(4,506)
Provisions	24.1	(320)	(487)
Total non-current liabilities		**(3,990)**	**(4,993)**
Total assets employed		**109,440**	**114,288**
Financed by			
Public dividend capital		40,246	40,246
Revaluation reserve		28,801	26,024
Income and expenditure reserve		40,393	48,018
Total taxpayers' equity		**109,440**	**114,288**

The notes on pages 6 to 44 form part of these accounts.

Name	Matthew Winn
Position	Chief Executive
Date	19 June 2025

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024	**40,246**	**26,024**	**48,018**	**114,288**
Surplus/(deficit) for the year	-	-	(7,624)	**(7,624)**
Revaluations	-	2,817	-	**2,817**
Other reserve movements	-	(40)	-	**(40)**
Taxpayers' equity at 31 March 2025	**40,246**	**28,801**	**40,394**	**109,441**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2023	**18,131**	**25,985**	**42,900**	**87,016**
Surplus/(deficit) for the year	-	-	5,118	**5,118**
Impairments	-	(410)	-	**(410)**
Revaluations	-	449	-	**449**
Public dividend capital received	22,115	-	-	**22,115**
Taxpayers' equity at 31 March 2024	**40,246**	**26,024**	**48,018**	**114,288**

Statement of Cash Flows

	Note	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(8,014)	5,510
Non-cash income and expense:			
Depreciation and amortisation	7	6,676	6,629
Net impairments	8	8,168	261
Income recognised in respect of capital donations	5	(42)	(6,399)
(Increase) / decrease in receivables and other assets		(409)	9,317
(Increase) / decrease in inventories		6	137
Increase / (decrease) in payables and other liabilities		3,057	(2,003)
Increase / (decrease) in provisions		1,247	(1,117)
Other movements in operating cash flows		(41)	-
Net cash flows from / (used in) operating activities		**10,648**	**12,335**
Cash flows from investing activities			
Interest received		2,398	1,505
Purchase of intangible assets		-	(100)
Purchase of PPE and investment property		(15,859)	(16,348)
Receipt of cash donations to purchase assets		42	54
Net cash flows from / (used in) investing activities		**(13,419)**	**(14,889)**
Cash flows from financing activities			
Public dividend capital received		-	22,115
Capital element of lease rental payments		(591)	(529)
Interest paid on lease liability repayments		(66)	(66)
PDC dividend (paid) / refunded		(1,954)	(1,411)
Net cash flows from / (used in) financing activities		**(2,611)**	**20,110**
Increase / (decrease) in cash and cash equivalents		**(5,382)**	**17,556**
Cash and cash equivalents at 1 April		**47,707**	**30,151**
Cash and cash equivalents at 31 March		**42,325**	**47,707**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care (DHSC) has directed the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.

Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

The functional and presentational currency of the Trust is pounds sterling.

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 Charitable Funds

Under the provisions of IFRS10 Consolidated Financial Statements those Charitable Funds that fall under the common control of NHS bodies are consolidated within the entity's financial statements. The Trust has determined that consolidation of its related Charitable Fund is not required as the Charitable Fund is not material in the context of the Trust's accounts. Consolidated financial statements have therefore not been presented for the current or previous period.

Note 1.4 Critical judgements and estimates in applying accounting policies

The following are the judgements, apart from those involving estimates, that management has made in applying the Trust's accounting policies and that have a material effect on the amounts recognised in the financial statements.

Consolidation of the Norfolk Community Health & Care NHS Trust Charitable Fund

Per note 1.3 regarding the consolidation of Charitable Funds, the Trust has determined the Norfolk Community Health and Care NHS Trust Charitable Fund does not meet the criteria required for consolidation into the Trust accounts. This is on the basis that, although the Trust continues to exercise control of the charity through its role as sole corporate Trustee, the value of the Charitable Fund's net assets, revenue and expenses are not considered material to the consolidated financial statements.

Note 1.4 Critical judgements and estimates in applying accounting policies continued

Revaluation of the Trust's land and buildings

The Trust conducts a revaluation of land and buildings valuations where there are indications of a significant change in the fair value of land and buildings when compared to their book value.

A full revaluation was performed at 31 December 2024. Land and buildings held by the Trust were revalued and building useful economic lives were reviewed. The valuation and useful economic lives review were undertaken by the Trust's property valuer in accordance with the requirements of the RICS Valuation – Global Standards 2021, effective from 31 January 2022, and the accounting framework. See note 16 for further information on key judgements and estimates used in the valuation process.

The closing book value of the Trust's land and buildings is disclosed in the property, plant and equipment note to these financial statements.

Useful lives of the Trust's property, plant and equipment and intangible assets

Depreciation is provided on a straight-line basis on all property, plant, and equipment other than land, and on intangible assets, at rates that will write off the cost (or valuation) of the assets to their estimated residual values over their useful lives.

The useful lives applied to the Trust's non-current assets is therefore a critical judgement in determining the depreciation and amortisation charge recognised in the financial statements, and also the fair value of the Trust's noncurrent assets.

The useful lives applied to these assets are disclosed in the property, plant and equipment and intangible assets accounting policies.

Notes to the accounts

Note 1.5 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 income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity.

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 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.

Note 1.6 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.

Notes to the accounts

Note 1.7 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 1.8 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 1.9 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 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 Trust 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.

Notes to the accounts

Note 1.9 Property, plant and equipment continued

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Surplus land - market value
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees.

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.

Assets in the course of construction are not depreciated until the asset is brought into use.

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.

Note 1.9 Property, plant and equipment continued

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

An asset is de-recognised when it is disposed of 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.

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**
Buildings, excluding dwellings	1	90
Plant & machinery	3	30
Information technology	3	10

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust which are capable of being sold separately or which 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.

Software which is integral to the operation of hardware, e.g. 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, e.g. 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.

Intangible assets are not revalued as there is no open market to value these assets and they have short useful lives.

Amortisation

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

Notes to the accounts

Note 1.10 Intangible assets continued

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 between 5 and 10 years.

Note 1.11 Inventories

Inventories are valued at cost until used or disposed of. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks, and as using an alternative method would not have a material effect on the financial statements.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the DHSC at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the DHSC ceased in March 2024.

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 (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.

The Trust only holds financial instruments classified as 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, and rights and obligations under lease arrangements.

After initial recognition, 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 as a finance income or expense.

Notes to the accounts

Note 1.13 Financial assets and financial liabilities continued

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).

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 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not discount leases where the discount effect is immaterial.

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.

Note 1.14 Leases continued

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

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.

The Trust does not hold any finance leases as lessor.

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 where a reliable estimate of the value can be made. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in the clinical negligence liabilities note to these financial statements, but is not recognised in the Trust’s accounts.

Note 1.15 Provisions continued

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 (assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in the contingent assets and liabilities note to these financial statements where an inflow of economic benefits is probable.

Contingent liabilities are not recognised but are disclosed in the contingent assets and liabilities note to these financial statements, 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 DHSC (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 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 Financial Reporting Manual (*FReM)* .

Notes to the accounts

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

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

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2024/25.

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the Trust's financial statements.

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

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

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

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:
•Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
•Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements. The Trust does not hold non-specialised assets for their service potential.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:
•A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
•Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The effect of applying these changes in future periods has not yet been assessed. PPE and right of use assets currently subject to revaluation have a total book value of £80.9m at 31 March 2025. No assets are valued on an alternative site basis.

Notes to the accounts

Note 1.23 Information on reserves

Public dividend capital (PDC)

PDC is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the Trust. Additional PDC is 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, and this is shown in the Statement of Comprehensive Income as an expense.

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.

Note 2 Operating segments

The Trust does not have separately identifiable operating segments. The Trust operates in the healthcare sector.

Notes to the accounts

Note 3 Adjusted financial performance

The Trust's financial performance is assessed by NHS England using an adjusted financial result. The following table demonstrates the relationship between the Trust's accounting surplus / (deficit) for the year as shown in the Statement of Comprehensive Income, and the adjusted financial result:

	2024/25	2023/24
	£000	£000
Surplus / (deficit) for the period	(7,624)	5,118
Remove net impairments not scoring to the Departmental expenditure limit	8,168	261
Remove SoCI effect of donated assets and capital grants	1,038	(5,212)
Adjusted financial surplus	**1,582**	**167**

Note 4 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with the Trust's accounting policies.

Note 4.1 Income from patient care activities (by nature)

	2024/25	2023/24
	£000	£000
Income from commissioners under API contracts*	143,287	125,157
Income from other sources (e.g. local authorities)	10,659	10,403
Private patient income	67	-
National pay award central funding**	6	9
Additional pension contribution central funding***	8,172	4,888
Total income from activities	**162,191**	**140,457**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

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

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

***Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

Note 4.2 Income from patient care activities (by source)

	2024/25	2023/24
Income from patient care activities received from:	**£000**	**£000**
NHS England	8,709	13,110
Integrated care boards	142,756	116,944
Department of Health and Social Care	-	60
Other NHS providers	4,807	4,598
Local authorities	5,845	5,680
Non-NHS: private patients	67	28
Non NHS: other	7	37
Total income from activities	**162,191**	**140,457**

Notes to the accounts

Note 5 Other operating income

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	833	-	**833**	756	-	**756**
Education and training	1,283	492	**1,775**	1,285	325	**1,610**
Non-patient care services to other bodies	10,182		**10,182**	8,972		**8,972**
Income in respect of employee benefits accounted on a gross basis	2,365		**2,365**	2,306		**2,306**
Receipt of capital grants and donations and peppercorn leases		42	**42**		6,399	**6,399**
Charitable and other contributions to expenditure		9	**9**		32	**32**
Revenue from operating leases		967	**967**		904	**904**
Other income	155	-	**155**	180	-	**180**
Total other operating income	**14,818**	**1,510**	**16,328**	**13,499**	**7,660**	**21,159**

Notes to the accounts

Note 6 Operating leases - Norfolk Community Health and Care NHS Trust as lessor

This note discloses income generated in operating lease agreements where Norfolk Community Health and Care NHS Trust is the lessor.

Note 6.1 Operating lease income

	2024/25	2023/24
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	967	904
Total in-year operating lease income	**967**	**904**

Note 6.2 Future lease receipts

	31 March 2025	31 March 2024
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	159	195
- later than one year and not later than two years	94	195
- later than two years and not later than three years	79	187
- later than three years and not later than four years	62	161
- later than four years and not later than five years	59	77
- later than five years	1,297	1,347
Total	**1,750**	**2,162**

Notes to the accounts

Note 7 Operating expenses

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,605	2,680
Purchase of healthcare from non-NHS and non-DHSC bodies	1,466	2,501
Staff and executive directors costs	125,098	110,210
Remuneration of non-executive directors	131	142
Supplies and services - clinical (excluding drugs costs)	7,866	7,930
Supplies and services - general	18,659	13,892
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	975	968
Consultancy costs	18	-
Establishment	1,148	981
Premises	4,156	4,414
Transport (including patient travel)	2,612	2,369
Depreciation on property, plant and equipment	6,308	6,341
Amortisation on intangible assets	368	288
Net impairments	8,168	261
Movement in credit loss allowance: contract receivables / contract assets	246	496
Movement in credit loss allowance: all other receivables and investments	-	(4)
Change in provisions discount rate(s)	3	-
Fees payable to the external auditor for statutory audit services	156	159
Internal audit costs	129	97
Clinical negligence	603	447
Legal fees	626	99
Insurance	75	2
Education and training	1,213	936
Expenditure on short term leases	236	502
Expenditure on low value leases	127	33
Variable lease payments not included in the liability	33	20
Redundancy	1,087	177
Car parking & security	74	74
Losses, ex gratia & special payments	2	-
Other services, eg external payroll	340	91
Other	6	-
Total	**186,534**	**156,105**

Note 7.1 Limitation on auditor's liability

The limitation on the auditor's liability for external audit work carried out for the financial year 2024/25 is £1m (2023/24: £1m).

Notes to the accounts

Note 8 Impairment of assets

	2024/25 £000	2023/24 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	8,168	233
Other	-	28
Total net impairments charged to operating surplus / deficit	**8,168**	**261**
Impairments charged to the revaluation reserve	-	410
Total net impairments	**8,168**	**671**

Note 9 Employee benefits

	2024/25 Total £000	2023/24 Total £000
Salaries and wages	93,481	83,673
Social security costs	9,477	8,891
Apprenticeship levy	465	429
Employer's contributions to NHS pensions	20,718	16,159
Pension cost - other	32	40
Other employment benefits	-	69
Termination benefits	1,087	177
Temporary staff (including agency)	1,377	1,387
Total staff costs	**126,637**	**110,825**
Of which		
Costs capitalised as part of assets	452	438
Pay costs recognised in the statement of comprenhensive income	126,185	110,387
Recoveries from other bodies in respect of staff costs netted off expenditure	-	-
	126,637	**110,825**

Note 9.1 Retirements due to ill-health

During 2024/25 there were no early retirements from the Trust agreed on the grounds of ill-health (5 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is 0k (£354k in 2023/24).

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

Notes to the accounts

Note 10 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2024, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay (previously 20.6%). 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.

Notes to the accounts

Note 11 Finance income

Finance income represents interest received on cash held in the government banking service in the period.

Note 12 Finance expenditure

Finance expenditure relates to interest on lease obligations under IFRS16 Leases.

Note 12.1 The late payment of commercial debts (interest) Act 1998

There have been no costs incurred over £500 during 2024/25 or 2023/24 in relation to the late payment of commercial debts.

Note 13 Other gains / (losses)

	2024/25	2023/24
	£000	£000
Losses on disposal of assets	(219)	(296)
Total (losses) on disposal of assets	**(219)**	**(296)**

Notes to the accounts

Note 14 Intangible assets

	Software licences 31 March 2025	Intangible assets under construction 31 March 2025	Total 31 March 2025	Software licences 31 March 2024	Intangible assets under construction 31 March 2024	Total 31 March 2024
	£000	£000	£000	£000	£000	£000
Gross cost at 1 April	**2,025**	**100**	**2,125**	**716**	**1,300**	**2,016**
Additions	-	-	**-**	-	100	**100**
Reclassifications	100	(100)	**-**	1,309	(1,300)	**9**
Disposals / derecognition	(29)	-	**(29)**	-	-	**-**
Gross cost at 31 March	**2,096**	**0**	**2,096**	**2,025**	**100**	**2,125**
Amortisation at 1 April	**690**	**-**	**690**	**402**	**-**	**402**
Provided during the year	368	-	**368**	288	-	**288**
Disposals / derecognition	(29)	-	**(29)**	-	-	**-**
Amortisation at 31 March 2025	**1,029**	**-**	**1,029**	**690**	**-**	**690**
Net book value at 31 March	**1,067**	**0**	**1,067**	**314**	**1,300**	**1,614**
Net book value at 1 April	**1,335**	**100**	**1,435**	**1,335**	**100**	**1,435**

Notes to the accounts

Note 15 Property, plant and equipment

Note 15.1 Property, plant and equipment - 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024	**8,186**	**54,353**	**26,797**	**6,317**	**13,817**	**109,470**
Additions	-	-	4,823	42	-	**4,865**
Impairments	(741)	(7,252)	-	-	-	**(7,993)**
Reversals of impairments	990	(64)	-	-	-	**926**
Revaluations	(153)	(5,393)	-	-	-	**(5,546)**
Reclassifications	-	24,045	(29,224)	3,499	1,680	**-**
Disposals / derecognition	-	-	-	(760)	(563)	**(1,323)**
Valuation/gross cost at 31 March 2025	**8,282**	**65,689**	**2,396**	**9,098**	**14,934**	**100,399**
Accumulated depreciation at 1 April 2024	**-**	**3,152**	**-**	**4,558**	**10,720**	**18,430**
Provided during the year	-	3,576	-	894	1,019	**5,489**
Impairments	-	580	-	-	-	**580**
Reversals of impairments	-	521	-	-	-	**521**
Revaluations	-	(6,986)	-	-	-	**(6,986)**
Disposals / derecognition	-	-	-	(581)	(563)	**(1,144)**
Accumulated depreciation at 31 March 2025	**-**	**843**	**-**	**4,871**	**11,176**	**16,890**
Net book value at 31 March 2025	**8,282**	**64,846**	**2,396**	**4,227**	**3,758**	**83,509**
Net book value at 1 April 2024	**8,186**	**51,201**	**26,797**	**1,759**	**3,097**	**91,040**

Notes to the accounts

Note 15.2 Property, plant and equipment - 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023	**8,702**	**53,773**	**2,415**	**5,839**	**13,833**	**84,562**
Additions	-	54	26,812	-	-	**26,866**
Impairments	(92)	(579)	-	-	-	**(671)**
Revaluations	27	422	-	-	-	**449**
Reclassifications	(451)	747	(2,430)	605	1,069	**(460)**
Disposals / derecognition	-	(64)	-	(127)	(1,085)	**(1,276)**
Valuation/gross cost at 31 March 2024	**8,186**	**54,353**	**26,797**	**6,317**	**13,817**	**109,470**
Accumulated depreciation at 1 April 2023	**-**	**20**	**-**	**3,862**	**10,221**	**14,103**
Provided during the year	-	3,196	-	767	1,344	**5,307**
Disposals / derecognition	-	(64)	-	(71)	(845)	**(980)**
Accumulated depreciation at 31 March 2024	**-**	**3,152**	**-**	**4,558**	**10,720**	**18,430**
Net book value at 31 March 2024	**8,186**	**51,201**	**26,797**	**1,759**	**3,097**	**91,040**
Net book value at 1 April 2023	**8,702**	**53,753**	**2,415**	**1,977**	**3,612**	**70,459**

Notes to the accounts

Note 15.3 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Owned - purchased	7,122	59,025	2,256	4,028	3,739	**76,170**
Owned - donated/granted	1,160	5,821	140	199	19	**7,339**
Total net book value at 31 March 2025	**8,282**	**64,846**	**2,396**	**4,227**	**3,758**	**83,509**

Note 15.4 Property, plant and equipment financing - 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Owned - purchased	6,997	45,018	26,657	1,327	3,003	**83,001**
Owned - donated/granted	1,189	6,183	140	432	94	**8,039**
Total net book value at 31 March 2024	**8,186**	**51,201**	**26,797**	**1,759**	**3,097**	**91,040**

Note 15.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	35,787	-	-	-	**35,787**
Not subject to an operating lease	8,282	29,059	2,396	4,227	3,758	**47,722**
Total net book value at 31 March 2025	**8,282**	**64,846**	**2,396**	**4,227**	**3,758**	**83,509**

The value disclosed for buildings subject to operating lease includes the total value of the building or site even if a portion of the building or site is occupied by the Trust.

Note 15.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	14,066	-	-	-	**14,066**
Not subject to an operating lease	8,702	39,687	2,415	1,977	3,612	**56,393**
Total net book value at 31 March 2024	**8,702**	**53,753**	**2,415**	**1,977**	**3,612**	**70,459**

The value disclosed for buildings subject to operating lease includes the total value of the building even if a portion of the building is occupied by the Trust.

Note 16 Revaluations of land and property

The Trust conducts a revaluation of land and buildings valuations where there are indications of a significant change in the fair value of land and building when compared to their book value.

A full revaluation was performed at 31 December 2024. Land and buildings held by the Trust were revalued and building useful economic lives were reviewed. The valuation and useful economic lives review were undertaken by the Trust's property valuer in accordance with the requirements of the RICS Valuation – Global Standards 2021, effective from 31 January 2022, and the accounting framework. Significant judgements are used in determining the fair value of land and buildings. For assets valued at depreciated replacement cost, key judgements include remaining and total useful lives, construction costs and professional fees, unit costs, optimisation, and the Trust's required service potential from assets. For assets valued at existing use value the key judgement is the market value of the asset given its existing use. For assets valued at market value, the key judgement is the value the property would obtain on an open market.

Notes to the accounts

Note 17 Right of use assets

Note 17.1 Right of use assets - 2024/25

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

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

	Property (land and buildings) £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024	**12,070**	**952**	**13,022**	**3,319**
Additions	-	13	**13**	-
Revaluations	1,095	-	**1,095**	-
Disposals / derecognition	(31)	(85)	**(116)**	-
Valuation/gross cost at 31 March 2025	**13,134**	**880**	**14,014**	**3,319**
Accumulated depreciation at 1 April 2024	**1,324**	**193**	**1,517**	**383**
Provided during the year	599	220	**819**	197
Revaluations	(282)	-	**(282)**	-
Disposals / derecognition	(9)	(45)	**(54)**	-
Accumulated depreciation at 31 March 2025	**1,632**	**368**	**2,000**	**580**
Net book value at 31 March 2025	**11,502**	**512**	**12,014**	**2,739**
Net book value at 1 April 2024	**10,746**	**759**	**11,505**	**2,936**

Net book value of right of use assets leased from other NHS providers	1,623
Net book value of right of use assets leased from other DHSC group bodies	1,116

Notes to the accounts

Note 17.2 Right of use assets - 2023/24

	Property (land and buildings) £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023	**5,496**	**227**	**5,723**	**3,541**
Additions	6,345	786	**7,131**	-
Remeasurements of the lease liability	(222)	-	**(222)**	(222)
Reclassifications	451	-	**451**	-
Disposals / derecognition	-	(61)	**(61)**	-
Valuation/gross cost at 31 March 2024	**12,070**	**952**	**13,022**	**3,319**
Accumulated depreciation at 1 April 2023	479	9	**488**	227
Provided during the year	845	189	**1,034**	156
Disposals / derecognition	-	(5)	**(5)**	-
Accumulated depreciation at 31 March 2024	**1,324**	**193**	**1,517**	**383**
Net book value at 31 March 2024	**10,746**	**759**	**11,505**	**2,936**
Net book value at 1 April 2023	**5,017**	**218**	**5,235**	**3,314**

Net book value of right of use assets leased from other NHS providers	1,633
Net book value of right of use assets leased from other DHSC group bodies	1,303

Notes to the accounts

Note 17.3 Revaluation of right of use assets

The Trust has one material right of use leased asset. This is a low value ('peppercorn') lease for a palliative care building and adjoining land in Colney, Norwich. The building was constructed by the Priscilla Bacon Norfolk Hospice Care Ltd charity using public donations, and has been leased to the Trust for 30 years to provide palliative care services to the community.

As a low value lease, the fair value of the asset cannot be determined by reference to the rent payable under the lease. The asset has therefore been subject to a revaluation at 31 December 2024.

The valuation was undertaken by the Trust's property valuer in accordance with information from RICS and the accounting framework. A modified depreciated replacement cost methodology was used for the building valuation. Significant judgements are used in determining the fair value of the asset. Key judgements for valuing the building include remaining and total useful life, construction costs and professional fees, and unit costs. Key judgements for valuing the land include freehold land rates and land rental rates.

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 the borrowings note to these financial statements.

	2024/25	2023/24
	£000	£000
Carrying value at 1 April	**4,912**	**4,939**
Lease additions	13	786
Lease liability remeasurements	-	(222)
Interest charge arising in year	66	60
Early terminations	(22)	(56)
Lease payments (cash outflows)	(657)	(595)
Carrying value at 31 March	**4,312**	**4,912**

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 the operating expenditure note.

Cash outflows in respect of leases recognised in the Statement of Financial Position are disclosed in the reconciliation above.

Note 17.5 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2024	31 March 2024
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	642	265	596	184
- later than one year and not later than five years;	1,780	1,065	2,124	1,065
- later than five years.	2,984	2,678	3,232	2,867
Total gross future lease payments	**5,406**	**4,008**	**5,952**	**4,116**
Finance charges allocated to future periods	(1,094)	(931)	(1,040)	(972)
Net lease liabilities at 31 March 2025	**4,312**	**3,077**	**4,912**	**3,144**
Of which:				
Leased from other NHS providers		1,634		1,645
Leased from other DHSC group bodies		1,443		1,499

Notes to the accounts

Note 18 Inventories

	31 March 2025 £000	31 March 2024 £000
Consumables	18	24
Total inventories	**18**	**24**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £6,747k (2023/24: £9,570k). Write-down of inventories recognised as expenses for the year were nil for both periods.

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £24k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 19 Receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables	5,051	5,435
Allowance for impaired contract receivables / assets	(1,351)	(1,669)
Prepayments	1,264	1,004
PDC dividend receivable	280	49
VAT receivable	240	27
Other receivables	3	-
Total current receivables	**5,487**	**4,846**
Non-current		
Other receivables	29	30
Total non-current receivables	**29**	**30**
Of which receivable from NHS and DHSC group bodies:		
Current	2,335	3,148
Non-current	29	30

Notes to the accounts

Note 19.1 Allowances for credit losses

	2024/25		2023/24	
	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	**1,669**	-	**1,620**	**4**
New allowances arising	488	-	189	5
Changes in existing allowances	251	-	334	(4)
Reversals of allowances	(493)	-	(27)	(5)
Utilisation of allowances (write offs)	(564)	-	(447)	-
Allowances at 31 March	**1,351**	**-**	**1,669**	**-**

Note 19.2 Exposure to credit risk

In assessing the required expected credit loss (ECL), the Trust takes a number of factors into account, including historic, current, and forward looking information. Factors include the age of the debt, past history of losses with a particular debtor (either individually or as a group with similar characteristics), and any known factors which may increase the likelihood of default for a particular debtor.

	Face value of invoiced contract receivables	Expected credit loss	Adjusted value of invoiced contract receivables
	£000	£000	£000
Invoice age at 31 March 2025			
0-30 days	1,618	124	1,494
31-90 days	849	35	813
91-365 days	233	230	3
Over 365 days	962	962	-
Total*	**3,661**	**1,351**	**2,311**
Invoice age at 31 March 2024			
0-30 days	2,836	357	2,479
31-90 days	22	21	1
91-365 days	403	403	-
Over 365 days	869	869	-
Total*	**4,130**	**1,650**	**2,480**

* Totals do not match the value of contract receivables in note 19 as the value in note 19 includes accruals, which are not yet invoiced and so do not incur an expected credit loss. The value of accruals is regularly reviewed and their value is adjusted to represent fair value where required.

Notes to the accounts

Note 20 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.

	31 March 2025 £000	31 March 2024 £000
At 1 April	47,707	**30,151**
Net change in year	(5,382)	17,556
At 31 March	**42,325**	**47,707**
Broken down into:		
Cash at commercial banks and in hand	4	4
Cash with the Government Banking Service	42,321	47,703
Total cash and cash equivalents in the Statement of Financial Position	**42,325**	**47,707**
Total cash and cash equivalents in the Statement of Cash Flows	**42,325**	**47,707**

Note 21 Trade and other payables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade payables	10,226	7,669
Capital payables	1,028	12,022
Accruals	9,338	8,887
Social security costs	2,379	2,214
Pension contributions payable	1,457	1,345
Total current trade and other payables	**24,428**	**32,136**
Of which payables from NHS and DHSC group bodies:		
Current	3,832	2,236

Note 21.1 Early retirements in NHS payables above

There are no early retirements in NHS payables above for both periods.

Note 22 Other liabilities

'Other liabilities' as shown in the Statement of Financial Position are deferred income contract liabilities.

Notes to the accounts

Note 23 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Lease liabilities	642	406
Total current borrowings	**642**	**406**
Non-current		
Lease liabilities	3,670	4,506
Total non-current borrowings	**3,670**	**4,506**

Note 23.1 Reconciliation of lease liabilities arising from financing activities

	31 March 2025 £000	31 March 2024 £000
Carrying value at 1 April 2024	**4,912**	**4,939**
Cash movements:		
Financing cash flows - payments and receipts of principal	(591)	**(529)**
Financing cash flows - payments of interest	(66)	**(66)**
Non-cash movements:		
Additions	13	**786**
Lease liability remeasurements	-	**(222)**
Application of effective interest rate	66	**60**
Early terminations	(22)	**(56)**
Carrying value at 31 March 2025	**4,312**	**4,912**

Notes to the accounts

Note 24 Provisions for liabilities and charges

Note 24.1 Provisions for liabilities and charges at 31 March 2025

	Pensions: injury benefits	Legal claims	VAT provisions	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2024	**178**	**132**	**1,122**	**1,343**	**709**	**3,484**
Transfers by absorption	-	-	-	-	-	**-**
Change in the discount rate	3	-	-	-	-	**3**
Arising during the year	7	484	431	1,205	133	**2,260**
Utilised during the year	(14)	-	-	(257)	(484)	**(755)**
Reversed unused	-	(84)	-	(121)	(58)	**(262)**
Unwinding of discount	-	-	-	-	2	**2**
At 31 March 2025	**175**	**532**	**1,553**	**2,169**	**303**	**4,732**
Expected timing of cash flows:						
- not later than one year	14	510	1,553	2,169	165	**4,412**
- later than one year and not later than five years	51	22	-	-	90	**163**
- later than five years	110	-	-	-	48	**157**
Total	**175**	**532**	**1,553**	**2,169**	**303**	**4,732**

The provision for injury benefits relates to injury benefit claims for formers employee. Its carrying amount is the present value of the expected cash flows discounted using the HM Treasury rate of 4.03% (2023/24: 4.26%). There is no uncertainty in respect of timings of future liabilities.

The legal claims provision relates to employer cases which are managed by the Trust and public liability cases which are managed on the Trust's behalf by NHS Resolution. The timings of payments are uncertain but are expected to fall within the next five years.

The redundancy provision relates to employees whose roles are expected to be disestablished following service reconfiguration. Costs have been identified based on the affected individuals. All payments are expected to occur in financial year 2025/26.

VAT provision reflects uncertainty over VAT treatment of certain transactions. Any cash outflows are expected to occur in 2025/26.
The 'other' provisions category includes dilapidation estimates for leased properties and a provision to remove asbestos from Trust buildings. The timing of potential outflows for all of these provisions is uncertain, but the majority are expected to occur within the next 12 months. Dilapidation provision outflows are expected to align to the end of the lease contract period.

Note 24.2 Provisions for liabilities and charges at 31 March 2024

	Pensions: injury benefits	Legal claims	Redundancy	VAT provisions	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2023	**169**	**160**	**1,355**	**926**	**1,991**	**4,601**
Change in the discount rate	-	-	-	-	(7)	**(7)**
Arising during the year	22	83	340	196	440	**1,081**
Utilised during the year	(13)	-	(237)	-	(54)	**(304)**
Reversed unused	-	(111)	(115)	-	(1,663)	**(1,889)**
Unwinding of discount	-	-	-	-	2	**2**
At 31 March 2024	**178**	**132**	**1,343**	**1,122**	**709**	**3,484**
Expected timing of cash flows:						
- not later than one year	13	89	1,343	1,122	430	**2,997**
- later than one year and not later than five years	48	43	-	-	167	**258**
- later than five years	117	-	-	-	112	**229**
Total	**178**	**132**	**1,343**	**1,122**	**709**	**3,484**

Notes to the accounts

Note 24.2 Clinical negligence liabilities

At 31 March 2025, £383k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Norfolk Community Health and Care NHS Trust (31 March 2024: £227k).

Note 25 Contingent assets and liabilities

There were no contingent assets or liabilities at 31 March 2025 and 31 March 2024.

Note 26 Contractual capital commitments

	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	353	1,013
Total	**353**	**1,013**

Note 27 Financial instruments

Note 27.1 Financial risk management

Financial reporting standard IFRS 7 Financial Instruments: Disclosures requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an organisation faces in undertaking its activities. Due to the continuing service provider relationship the Trust has with NHS commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Financial instruments also play a more limited role in creating or changing risk that would be typical of listed companies. The Trust has limited power 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.

Currency Risk

The Trust is principally a domestic organisation with the significant 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 is not exposed to interest rate risk as it does not hold any borrowings or investments.

Credit Risk

As the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure at 31 March 2025 and 2024 are in receivables from customers, as disclosed in the receivables note.

Notes to the accounts

Note 27.1 Financial risk management continued

The Trust is exposed to some risk from debt due for rent from certain GP surgeries. Surgeries can reclaim this expense back from NHS England and integrated care boards, but have yet to sign lease agreements to enable this to occur. Where uncertainty over recovery of this debt exists, debt has been provided for within the expected credit loss provision disclosed in the allowances for credit losses note to these financial statements.

Liquidity Risk

The Trust's operating costs are mainly incurred under contracts with integrated care boards, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from the same source plus grants provided by central government and other parties. The Trust is therefore not exposed to significant liquidity risk.

Note 27.2 Carrying values of financial assets

All financial assets held by the Trust are classified in the category 'held at amortised cost'. The carrying value shown below is consistent with the fair value of the assets.

Carrying values of financial assets at 31 March	31 March 2025 £000	31 March 2024 £000
Trade and other receivables excluding non financial assets	3,732	**3,735**
Cash and cash equivalents	42,325	**47,707**
Total at 31 March	**46,057**	**51,442**

Note 27.3 Carrying values of financial liabilities

Financial liabilities are held by the Trust at amortised cost.

Carrying values of financial liabilities at 31 March	31 March 2025 £000	31 March 2024 £000
Obligations under leases	4,312	**4,912**
Trade and other payables excluding non financial liabilities	19,776	**29,001**
Provisions under contract	4,408	**2,997**
Total at 31 March 2025	**28,496**	**36,910**

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 2025 £000	31 March 2024 £000
In one year or less	24,829	32,594
In more than one year but not more than five years	1,943	2,382
In more than five years	3,141	3,461
Total	**29,914**	**38,438**

Notes to the accounts

Note 28 Losses and special payments

	2024/25		2023/24	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	2	0
Bad debts and claims abandoned	38	78	20	619
Stores losses and damage to property	9	5	-	-
Total losses	**47**	**83**	**22**	**619**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	3
Ex-gratia payments	-	-	1	5
Extra-statutory and extra-regulatory payments	1	26	-	-
Total special payments	**1**	**26**	**2**	**8**
Total losses and special payments	**48**	**109**	**24**	**627**

Data in the note above is recognised at the point the loss or special payment is approved for payment or write off. This can be different to the point the cost of the loss or special payment is incurred in the Statement of Comprehensive Income. For example, the cost of providing for a potential bad debt may be recognised in the Statement of Comprehensive Income at an earlier point than the debt is approved to be written off.

Special payments and losses are typically recorded by nature of expense in the operating expenses note. Only loss of personal effects are recorded as 'losses, ex gratia and special payments' in the operating expenses note to these financial statements.

Note 29 Events after the reporting date

On 1 April 2025 the Trust moved into a group model with Cambridgeshire Community Services NHS Trust.

Under the model both organisations have a single Group Board, including non-executive and executive directors. The Board oversees both Trusts. Each organisation continues to exist as a legal entity.

Notes to the Accounts

Note 30 Related Parties

DHSC is the Trust's parent department. During the 2024/25 financial year the Trust had a significant number of material transactions with DHSC and with other entities for which DHSC is regarded as the parent department, as well as other entities which are part of the Crown.

Those parties the Trust has transactions over £100,000 with in 2024/25 were:

Bedfordshire, Luton and Milton Keynes ICB	NHS Pension Scheme
Cambridgeshire Community Services NHS Trust	NHS Property Services Limited
Cambridgeshire and Peterborough Integrated Care Board (ICB)	NHS Resolution
Community Health Partnerships	NHS Shared Business Services
Hertfordshire and West Essex ICB	NHS Supply Chain
James Paget University Hospitals NHS FT	Norfolk and Waveney ICB
NCH&C Charitable Funds	Norfolk and Norwich University Hospitals NHS FT
Mid and South Essex ICB	Norfolk and Suffolk NHS FT
NHS Business Services Authority	Queen Elizabeth Hospital Kings Lynn NHS FT
NHS England	Suffolk and North East Essex ICB

The Trust also had a number of material transactions with other government departments and other central and local government bodies. Those the Trust had transactions over £100,000 in the year were:

Breckland District Council	Norfolk County Council
HM Revenue and Customs	North Norfolk District Council
Kings Lynn and West Norfolk Borough Council	Norwich City Council
South Norfolk District Council	

The Trust is the sole Corporate Trustee of the Norfolk Community Health and Care NHS Trust Charitable Fund (the Charitable Fund), which is a registered charity. The financial results of the Charitable Fund are not consolidated within these financial statements as they do not meet the criteria required for consolidation into the Trust's financial statements. This is on the basis that, although the Trust continues to exercise control of the charity through its role as sole Corporate Trustee, the value of the Charitable Fund's net assets, revenue and expenses are not considered material to the consolidated financial statements.

	2024/25	2023/24	31 March 2025	31 March 2024
	£000	£000	£000	£000
Total income received from the Charitable Fund	274	391	-	-
Accounts receivable balance due from the Charitable Fund	-	-	41	32
Total expenditure payable to the Charitable Fund	-	-	-	-
Accounts payable balance due to the Charitable Fund	-	-	-	-

Disclosure of compensation and other transactions with management and Board members is made in the Remuneration Report. All transactions with management and Board members were made in the ordinary course of the Trust's operations. All transactions with parties related to Government Ministers were also made in the ordinary course of the Trust's operations.

Notes to the accounts

Note 31 Better Payment Practice code

	2024/25	2024/25	2023/24	2023/24
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	19,749	71,642	16,118	72,387
Total non-NHS trade invoices paid within target	18,691	68,336	15,141	69,996
Percentage of non-NHS trade invoices paid within target	94.6%	95.4%	93.9%	96.7%
NHS Payables				
Total NHS trade invoices paid in the year	494	4,521	439	4,773
Total NHS trade invoices paid within target	427	3,271	387	3,770
Percentage of NHS trade invoices paid within target	86.4%	72.4%	88.2%	79.0%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 32 Capital Resource Limit

	2024/25	2023/24
	£000	**£000**
Gross capital expenditure	4,878	33,875
Less: Disposals	(244)	(352)
Less: Donated and granted capital additions	(42)	(6,399)
Charge against Capital Resource Limit	**4,592**	**27,124**
Capital Resource Limit	4,595	27,124
Under / (over) spend against CRL	**3**	**-**

Notes to the accounts

Note 33 Breakeven duty performance and rolling assessment

Under the Health and Care Act 2022 the Trust has a financial duty to achieve financial requirements set by NHS England. One requirement is for the integrated care system of which the Trust is a part (the Norfolk and Waveney ICS) to seek to achieve system financial balance.

The Trust has achieved financial balance in 2024/25, as can be seen in the table below. The table also sets out the previous four years of breakeven information.

At 31 March 2025 the Trust also had a cumulative breakeven position of £13.2m from the establishment of the Trust in 2010/11.

	2020/21	2021/22	2022/23	2023/24	2024/25
	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	1,085	742	25	167	1,582
Breakeven duty cumulative position	10,646	11,387	11,412	11,579	13,161
Operating income	128,537	133,409	151,478	161,616	178,519
Cumulative breakeven position as a percentage of operating income	8.3%	8.5%	7.5%	7.2%	7.4%

NHS

Norfolk Community Health and Care

NHS Trust