



Norfolk Community
Health and Care
NHS Trust

Our story

Our people

Annual Report 2025/2026



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. The Annual Report and Accounts is set out as follows:

1. Performance Report

- Overview
- Performance Analysis

2. Accountability Report

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

3. 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.

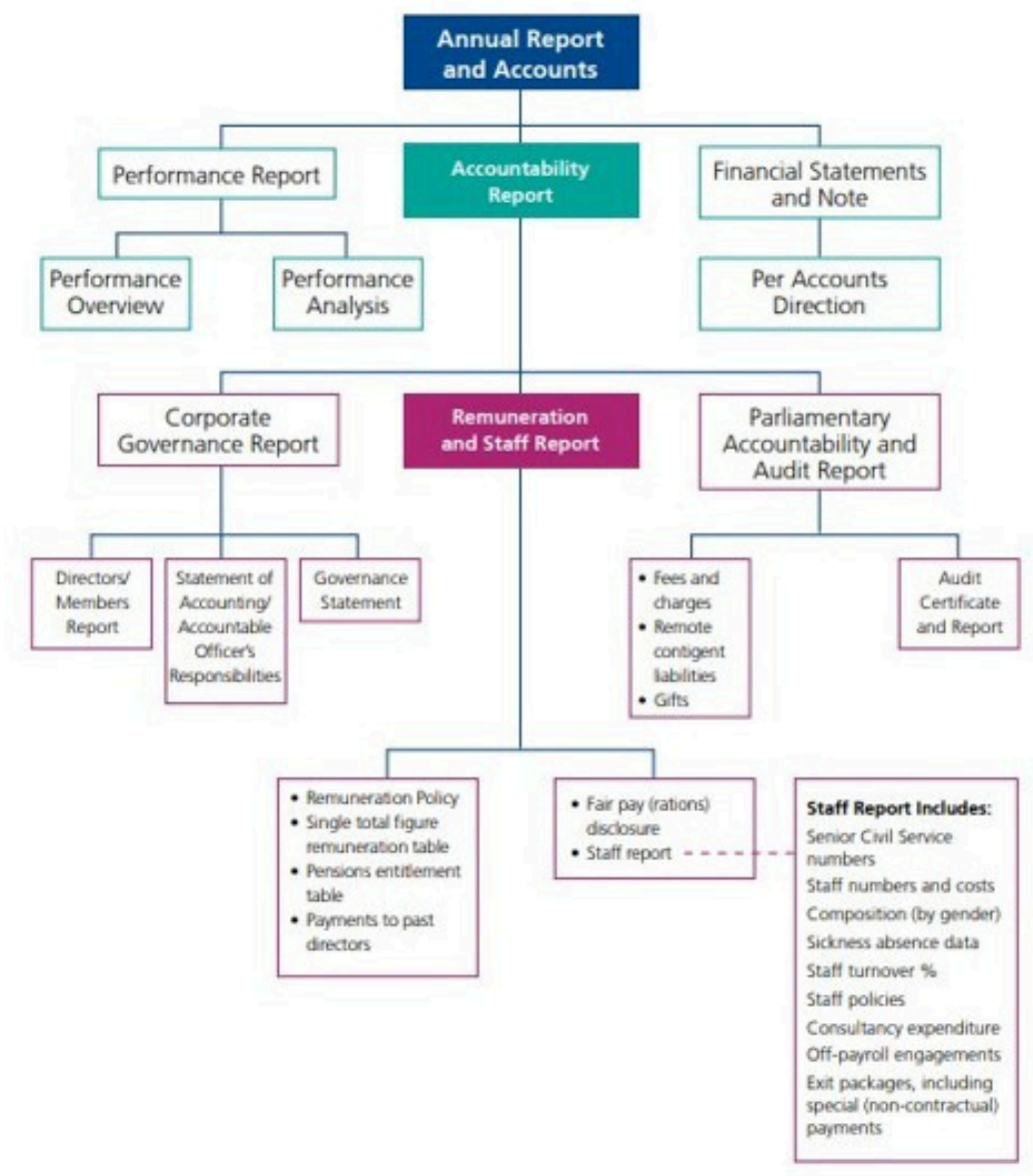


Abbreviations used in this report

CCS	Cambridgeshire Community Services NHS Trust
CQC	Care Quality Commission
EEC	East of England Community Health and Care NHS Trust
NCC	Norfolk County Council
NCH&C	Norfolk Community Health and Care NHS Trust
NED	Non-Executive Director
NHSE	NHS England
NHSI	NHS Improvement
PCN	Primary Care Networks



Structure



General Principles

Group Accounting Manual (GAM) guidance sets out the minimum content of our 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

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. Our External Auditors have reviewed the Performance Report for consistency with other information in the financial statements. Our External Auditors have read the information in the annual report and refer to this in their audit report.

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

This Annual Report marks an important moment in our history, as it will be the final report we publish as Norfolk Community Health and Care NHS Trust (NCH&C). From 1 April 2026 our people and services will join with Cambridgeshire Community Services (CCS) to form East of England Community Health and Care NHS Trust (EEC).

As we look back, we do so with real pride. We have remained unwavering in our focus on compassionate and high-quality care. That same commitment will guide us as we move into the new organisation.

The most important measure of quality is always the experience of the people we serve. It is therefore extremely encouraging that once again service users have provided highly positive feedback. Of the 3,450 individuals who responded to the Friends and Family Test question during the year, 96.94% reported that the service they received was very good or good.

Our staff feedback is equally powerful. I am pleased that our latest staff survey shows 78% of colleagues would recommend NCH&C to their own friends and family for care. 75% of our staff would recommend NCH&C as a place to work - the highest rating for a community trust nationally.

This year also saw the publication of the NHS 10-Year Health Plan which set out three ambitions of shifting from: hospital to community care; sickness to prevention; and analogue to digital. These mirror our own ambitions. As leaders in community health, we see opportunities to support this "Fit for the Future" agenda both within our services and across the system. We are actively developing new ways to help deliver these shifts for our communities.

Financially, the environment remains difficult across the NHS, and NCH&C has not been immune to these challenges. Despite this, our teams have identified and delivered efficiencies that have helped us reach a positive position. We will close the year with £1.642 million surplus. Every service within the Trust has examples of excellent practice, and I want to offer my heartfelt thanks to our staff and volunteers, whose dedication makes our services so caring, compassionate and effective.

As we transition into the new Trust, our commitment to continuing to improve our outstanding, person-centred care will remain at the heart of everything we do. We look forward to working closely with our patients, partners, and communities as we embrace the opportunities ahead and strive to make an even greater difference for the people we serve.

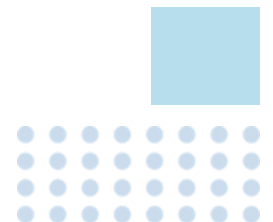
Warm regards,



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 Norfolk and Waveney Integrated Care Board (N&W 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 (N&W) 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. 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 66](#).

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

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.

Strategic and annual priorities

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

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 were made in 2025/26.



Strategic performance

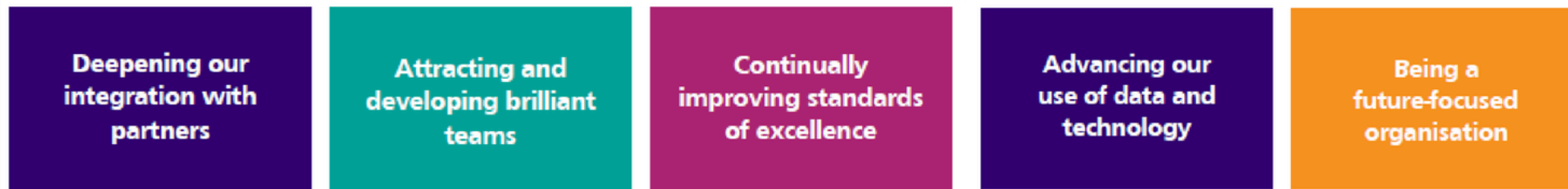


The NCH&C Trust Strategy 2023-27 was developed by the Trust Board, working in close consultation with our leadership teams. We also undertook engagement with our external stakeholders.

In determining the Trust's commitments for each of the five strategic priorities for 2023-27, we 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



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.

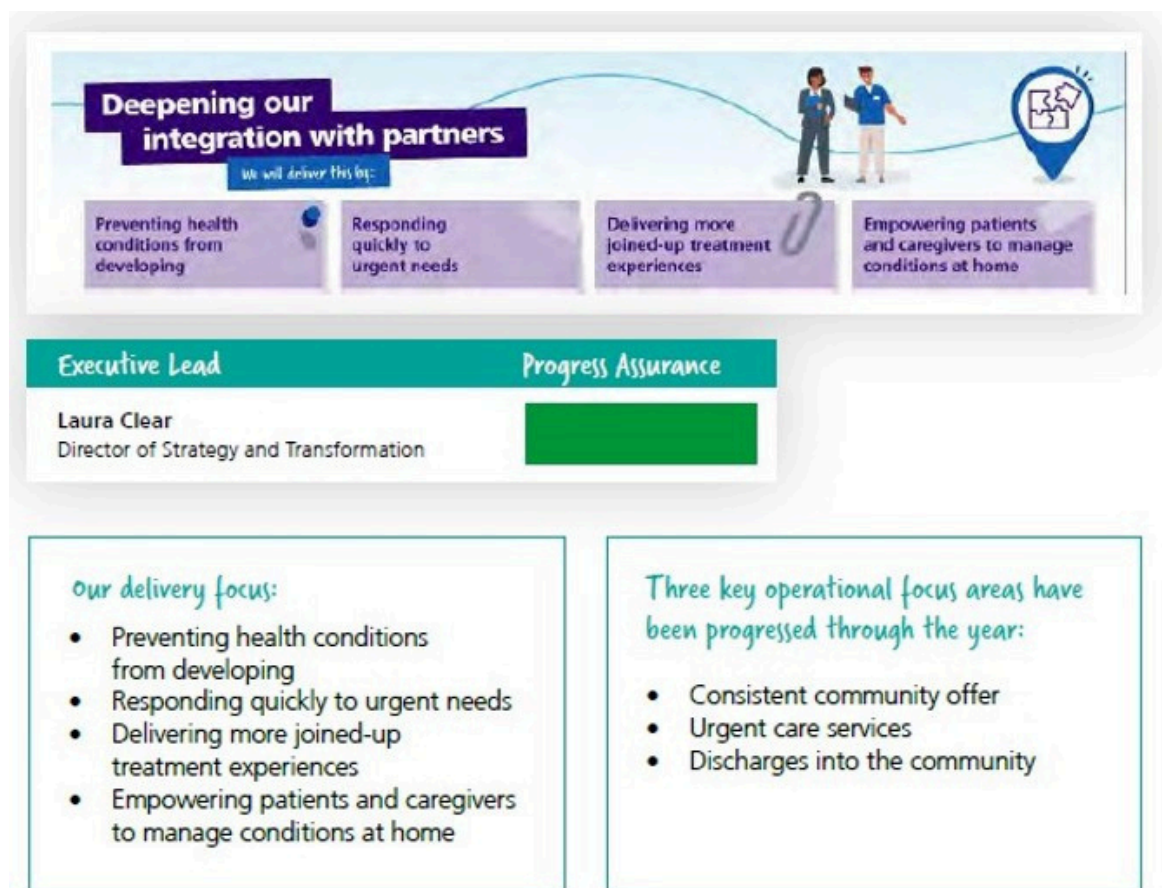
Each strategic priority has been given a red, amber or green rating. In summary, progress in all five areas is good, and we are generally on track, with some areas needing further focus and others ahead of schedule.

In 2025/26 we embraced a new Group model and were subsequently authorised to merge with Cambridgeshire Community Services NHS Trust (CCS), on 1 April 2026, to become the East of England Community Health and Care NHS Trust (EEC). As part of this process a new Clinical and Care Strategy 2026-2031 has been developed and adopted from 1 April 2026. This supersedes the previous strategies of NCH&C and CCS. Our new Clinical and Care Strategy recognises the changes in the NHS and the opportunities and challenges this brings the Trust as well as the progress made on NCH&C's strategic priorities.

Against the background of the new EEC strategy, this section provides a high-level overview of our progress against our strategic aims through delivery of our operational focus areas.



Deepening our integration with partners



We have maintained our progress with embedding consistent models of operation across Places, in particular through our delivery of services in partnership with Norfolk County Council. We renewed our contractual arrangements under a Section 75 agreement from 1 April 2025 for three years with a further six years available under the agreement. This partnership means we can support people to live well at home, minimise any time spent in hospital and, by supporting them more effectively in their own homes, reduce the impact of ill health. We are committed to the delivery of Place-based care within our neighbourhoods and have re-confirmed neighbourhood care as one of our four priority service areas within our Clinical and Care Strategy.

Case studies

As part of a three-year commissioned project, Healthwatch Norfolk engaged with patients, their relatives and staff to understand experiences of the inpatient general rehabilitation service.

Using surveys and structured interviews, the study explored the full rehabilitation journey:

- Transfer from acute care
- Inpatient rehabilitation stay
- Post discharge experiences

Carers Hospital Booklet

Feedback from unpaid carers highlighted a lack of communication and involvement when the person they care for is admitted to hospital. In response, a co-produced Carers Hospital Booklet was piloted at:

- Swaffham Community Hospital
- Dereham Hospital

The pilot phase provided valuable insight and informed the production of the final version of the booklet. This will now be rolled out:

- Across all NCH&C inpatient units
- Across the wider Norfolk health and care system

The booklet aims to improve communication, partnership working and support for unpaid carers at key points in the patient journey.



Public health role

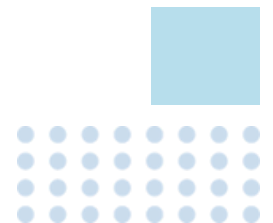
The Infection Prevention and Control (IPaC) service continued to provide specialist support across NCH&C and the wider Norfolk and Waveney system, contributing to infection prevention, outbreak response and broader public health management.

A key enhancement this year has been the introduction of a new decontamination unit, increasing local capability to respond to High Consequence Infectious Diseases (HCID), including emerging threats such as avian influenza.

Two new pathways have also been implemented:

- Looked After Children Screening (fixed-term pathway): Developed in partnership with Children's Services, the Tuberculosis (TB) service and the Integrated Contraception and Sexual Health service strengthening screening, early identification and safeguarding for Looked After Children.
- Community Methicillin-Resistant Staphylococcus Aureus (MRSA) Pathway: Established collaboratively with the Norfolk and Norwich University Hospital and the Queen Elizabeth Hospital to improve community-based identification, management and follow-up.

These developments strengthen local public health resilience and ensure timely, coordinated responses across the system.



Attracting and developing brilliant and fulfilled teams



Staff survey results

All our staff were invited to complete the National NHS Staff Survey 2025. It is one of the world's largest workforce surveys and the best way for colleagues to share their views about their job, the Trust, and the NHS. 62% of our substantive staff and 24% of our bank-only workers responded.

The findings are benchmarked against 13 community trusts and are grouped under the seven People Promises, along with the themes of Staff Engagement and Morale.



Survey highlights include:

- Colleagues rated NCH&C above average in all People Promises and Themes, except 'we are safe and healthy' which was rated average against our comparators
- Colleagues rated NCH&C the best performing community trust (joint with CCS) for 'we work flexibly'
- Colleagues rated NCH&C experience above average, and improved from last year, in 'we are compassionate and inclusive', 'we are always learning', 'we are a team', and 'morale'
- 93% of NCH&C colleagues have had an appraisal in the last 12 months
- 86% of colleagues report that the trust has made reasonable adjustments to enable them to carry out their work
- 82% of colleagues believed their manager takes a positive interest in their health and wellbeing, and 72% say the Trust takes positive action on health and wellbeing
- 80% of colleagues report that the people they work with are understanding and kind
- 76% of colleagues can access clinical supervision opportunities when they need to
- Against the backdrop of change in the NHS colleague experience has deteriorated in the following areas:
 - We work flexibly
 - We each have a voice that counts
 - We are recognised and rewarded
 - We are safe and healthy
 - Staff engagement

Whilst results in these areas remain at or above average, the Trust wants the experience of our staff to improve year-on-year, and it is disappointing to see that scores have gone down in these areas. We know there is always more we can do to improve your experience working at our Trust.

We recognise this year has been challenging at times with pressure on our services in the wider NHS, globally, and in our personal lives. Local teams will be supported by HR Business Partners to analyse and understand their results, talk with colleagues, and agree and implement a few actions that will improve overall staff experiences. Valuing our colleagues is one of our four strategic priorities in our new Clinical and Care Strategy.

Case studies Continuing Professional Development

During 2025/26, the Trust received £408,531.43 in Continuing Professional Development (CPD) funding from NHS England to support the development of clinical competencies for all registered Nurses and Allied Health Professionals (AHPs).

CPD activity was managed through the Trust's study leave approval process, ensuring that all training accessed was aligned with service needs, professional requirements, and individual development objectives. Funded activity included both individual and group bookings, with a significant proportion allocated to accredited courses, which continued to represent the majority of CPD provision across the organisation.

AHPs demonstrated a particularly strong uptake of CPD opportunities, accounting for a level of activity 35% higher than that of nursing staff.

Professional Advocate Role

The Trust continues to strengthen its Professional Advocate (PA) provision, supporting staff wellbeing, professional development, and quality improvement through restorative supervision and career-focused conversations. As of February 2026, the Trust has 27 registered Professional Advocates, an increase on the previous year.

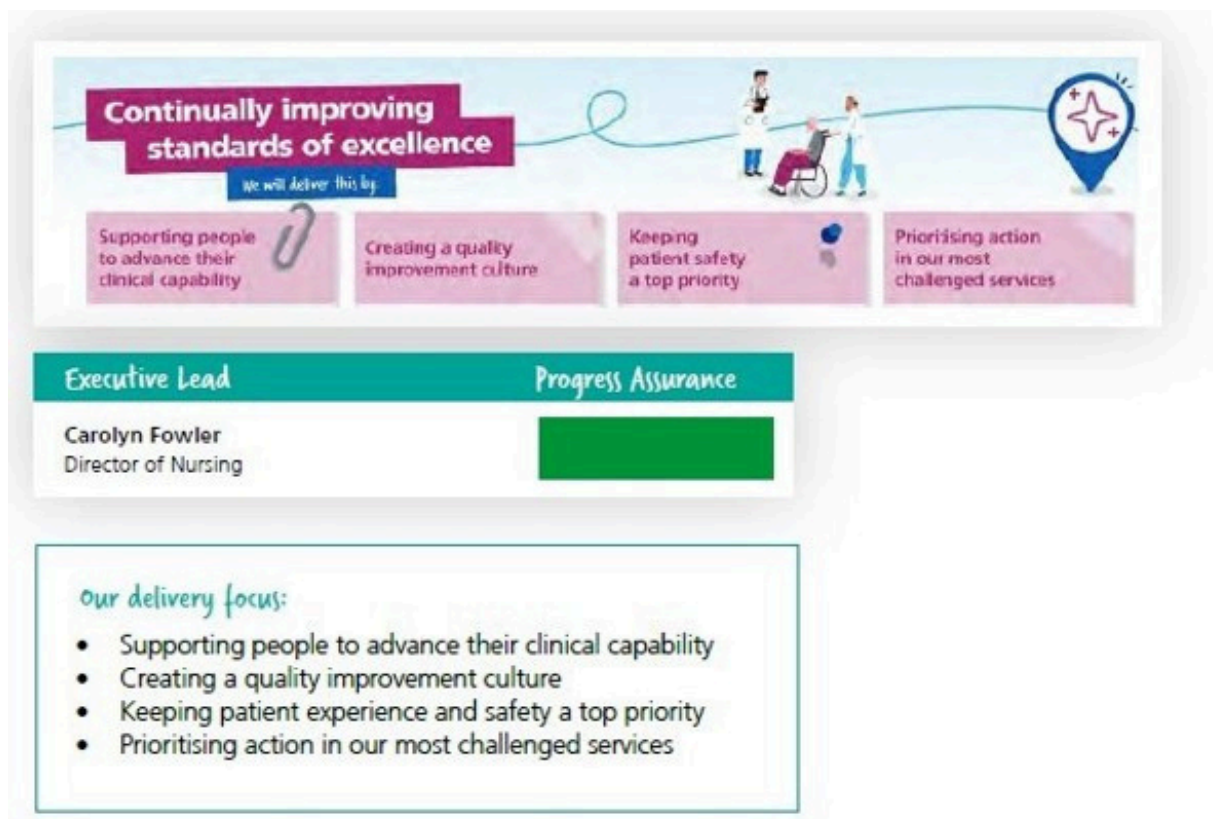
Improving Staff Experience

Throughout 2025/26, the team delivered a broad range of staff-focused programmes and support activities:

- 394 new starters attended face-to-face induction sessions, and 78 leaders participated in the Leadership Way induction programme.
- Nearly 2,000 staff completed clinical mandatory training. Significant work is underway to streamline mandatory training requirements in line with updated NHS England guidance.
- The Trust continued to support its network of 108 Mental Health First Aiders, providing both new training and refresher sessions.
- Staff networks continued to expand, with 425 members across four networks and two wellbeing groups.
- Over 2,300 staff completed career conversations, and 1,642 staff recorded supervision plans.
- Staff engagement remained strong, with a 62% response rate to the NHS Staff Survey (a slight reduction from 2024).
- Recognition activity was extensive, including 1,883 peer-to-peer 'star' nominations, 153 STAR of Recognition badges, and 300 REACH Award nominations.
- Career development activity included 41 new apprentices, 37 apprenticeship completions, expansion of T-Level placements, and continued delivery of successful work experience programmes.



Continually improving standards of excellence



As part of the development of the new Clinical and Care Strategy there has been Trust-wide engagement to identify and embed a consistent approach to raising standards in our services and embedding a new Quality Improvement approach. Key focuses in the year included:

- New 'waiting well' standards and processes and implementation of the waiting well audit outcomes
- A review of training and education
- Implementing consistent Quality Improvement processes, training and resource across NCH&C and CCS in preparation for merger on 1 April 2026
- Development of a Trust-wide co-production and community engagement model
- Merging of safeguarding policies, processes and learning across both Trusts

We have also continued to focus improvement activity across NCH&C wheelchair and neurodevelopmental services, which have both seen improvements in service delivery, as well as palliative and end of life care, which forms one of the continuing key focuses within our neighbourhood care priority.

Case studies Neurodevelopmental Service improvements

During 2025/26, our neurodevelopmental assessment leads began working with paediatric and neurodevelopmental services across CCS to take a group-wide approach to improvement. Each area has different commissioned models, but all face the challenge of high and rising numbers of children experiencing very long waits for assessment.

Aligned to the Norfolk neurodevelopmental transformation programme, the group has focused on:

- Standardising and streaming pathways to ensure consistent access.
- Expanding skill mix and capacity to improve equity of access.
- Improving data quality to monitor equity and target interventions where delays are greatest.
- Embedding early awareness and outreach in schools and communities to support needs earlier, without requiring a diagnosis.

In Norfolk, revised triage and streaming pathways are being developed to ensure assessments are proportionate to each child's need. For children with less complex presentations, this includes piloting a one-day assessment process (ODAC) and a fast-track route that confirms assessments completed by other professionals, such as local authority educational psychologists or community speech and language therapists.

Our established skill-mix neurodevelopmental (ND) team has begun delivering this revised pathway, improving efficiency and reducing assessment times.

Reporting processes have also been reviewed and adapted to strengthen data quality and increase efficiency across the assessment pathway.

The service continues to work with the Norfolk System Collaborative to embed early identification and promote self-care, prevention and early intervention. This includes developing an innovative digital needs-assessment tool to help families and professionals identify needs earlier and link to advice, information and support without delay.



Wheelchair Service improvements

The Wheelchair Service has continued to innovate as part of its ongoing transformation programme, focused on reducing waiting times and improving service-user experience. This has included a review of the staffing model and the appointment of two Assistant Practitioners. These roles have strengthened operational resilience within this highly specialist service during periods of high demand and have helped maintain continuity of care during planned staff absences. The service continues to demonstrate adaptability, innovation and a strong commitment to high-quality patient care.

Specific improvement work:

- The service has secured NHS England funding to further reduce waiting times and support more timely provision of equipment. This funding has enabled the purchase of additional wheelchairs for Norwich and King's Lynn clinics, supporting the introduction of a Chair-in-a-Day delivery model.
- Under this model, patients assessed at triage who meet the clinical criteria will be able to leave their first appointment with a fully configured wheelchair, removing the need for a follow-up visit. This approach will significantly shorten the patient journey, improve experience and enhance service efficiency by reducing delays in providing essential mobility equipment.
- Development and implementation of a Just in Time model is nearing completion and represents a key advancement for the service. The model aims to improve the efficiency and accuracy of equipment ordering and allocation. Once fully embedded, anticipated benefits include:
 - Aligning purchasing decisions more closely with real-time patient need will reduce unnecessary expenditure and support more controlled financial planning.
 - Avoiding premature deliveries and excess stockholding, so the model can reduce storage needs and associated handling.

The new model of provision will enable clinical and procurement teams to focus resources more effectively, supporting timely decision-making and improving the overall responsiveness of the service.

Due to these ongoing improvements, the number of patients waiting more than 52 weeks has continued to reduce significantly.



Unallocated visits in the community

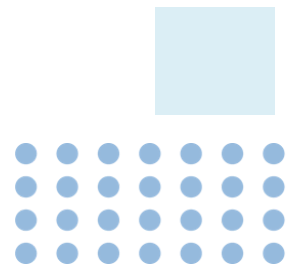
During 2025/26, our community nursing teams continued to experience sustained and high levels of demand. This included a growing number of patients with increasingly complex needs and higher acuity who require care at home. The number of patients needing insulin administration has continued to rise significantly.

Recruiting nurses and healthcare assistants in some rural areas of Norfolk remains challenging, and sickness levels were high at various points throughout the year. These combined pressures have contributed to the number of rescheduled visits across the four Places. However, through strengthened caseload management and targeted quality improvement initiatives, several areas have achieved a steady reduction in rescheduled visits. Continuing this reduction will be a key focus throughout 2026/27 through service development plans to increase the responsiveness capacity of our services.

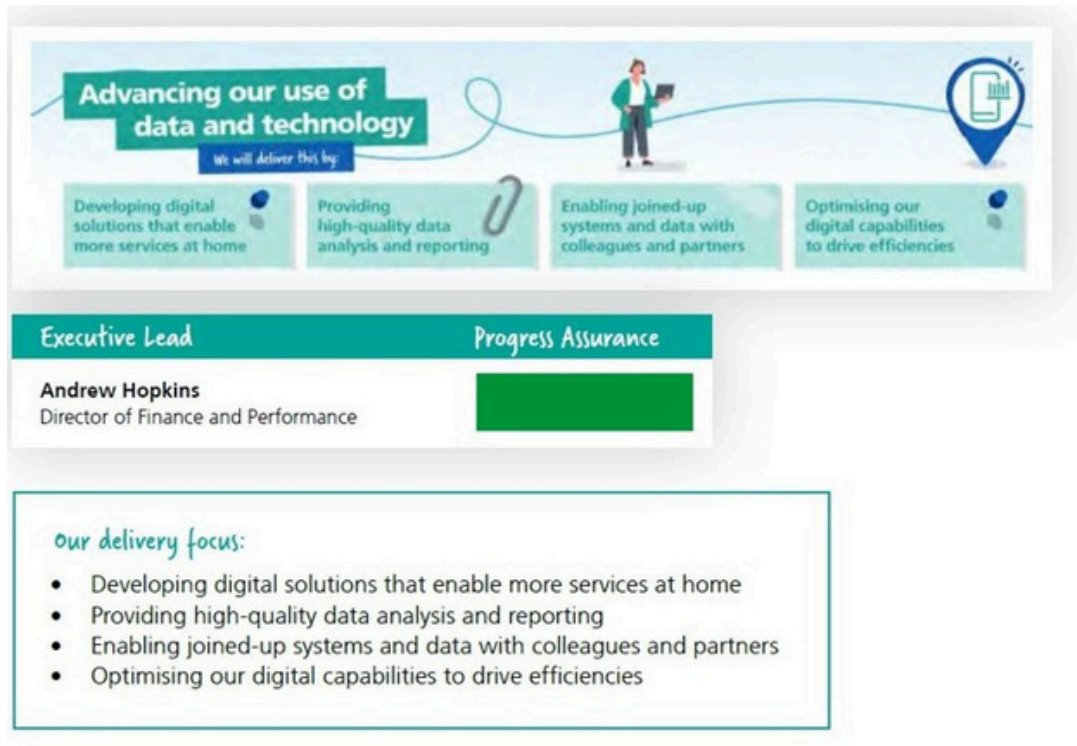
Specific improvement work:

- In times of high demand teams undertake regular safety-netting throughout the day to ensure that patients with the most urgent clinical needs are prioritised. Where possible, patients are contacted by telephone if a visit cannot take place. We recognise that this does not happen as consistently as we would wish, and this has impacted patient experience. It continues to be a key theme in the feedback we receive.
- Each team and Place escalate staffing and capacity concerns through Trust-wide operational meetings and safer staffing groups. Staff continue to work flexibly across boundaries to minimise risk and ensure patient needs are met. NCH&C also contributes to system-wide calls throughout the day to provide updates, seek support where required and offer mutual aid to partners.

Looking ahead to 2026/27, we will take a focussed approach to reviewing and redesigning our community nursing and therapy model. This work will support neighbourhood-based delivery in partnership with system partners. The initial phase will concentrate on improving referral and access pathways, alongside demand and capacity modelling. This will help us better understand population need and ensure we can continue to provide safe, effective, high-quality care.



Advancing our use of data and technology



In advance of merger, the key digital transformation projects that enable the Clinical and Care Strategy have been identified and included within that. Our Chief Information Officer continues to drive delivery of our use of data and technology.

Key areas of focus during the year were:

- Improvements to SystmOne usage through standardisation of templates and care plans, and a comprehensive review of services offered and reporting.
- Building a digitally literate and confident workforce through embedding digital skills assessment into induction of staff and providing access to relevant training to foster a digital first culture.
- Improving digital communication channels (e.g. SMS in place of letters) and embedding a digital first culture.
- Expanding our use of Robotic Process Automation.
- Identifying, planning and commencing delivery of our digital architecture to deliver our 'one trust' approach post-merger.

Case study Better For All – Brilliant Care That Counts

During 2025/26 the Trust undertook a service design programme focused on improving clarity around core pathways and priorities that would also help reduce pressure on our community nursing and therapy teams.

A big part of this programme was reconfiguring the clinical computer system we use to store and manage patient medical records. This system is called SystmOne. The aim of this was:

- Fewer errors, meaning everyone records and reads information in the same way, so nothing is missed.
- Safer decision-making so clinicians can trust what they see in the record.
- Better continuity – patients don't have to repeat their story or experience variation in care quality.
- Everyone can find information quickly, because it is stored in the same place and uses the same titles.
- Clinicians can move between teams without confusion, because the system behaves consistently.
- More efficient working – less time spent searching, correcting, or duplicating information.
- Data recorded in the same way, makes it accurate and comparable across teams and Places.
- Capacity planning, workforce allocation, and service improvement is enabled with reliable data.
- Early phases in West Place, North Place, Norwich Place, and South Place therapy teams were successfully completed by October 2025.
- Subsequent phases were delayed or halted due to operational pressures and the system constraint of transferring 18,000 rotas, which did not allow sufficient capacity for sustainable operational requirements for all Place Nursing Services on the one unit.
- In March 2026, a decision was made to cease further migration to a single unit, with revised scope delivered by April 2026.
- The achieved outcomes of the project include:
 - Standardised streamlined configuration across Community SystmOne units
 - A reduction in system fragmentation (from six to four units)
 - Improved data quality and reporting consistency, with recommendations on the steps that could be taken to develop and implement a SystmOne SOP, including support and training for operational staff.

Being a Future Focussed Organisation

This year, our merger with Cambridgeshire Community Services was approved for 1 April 2026, when we became East of England Community Health and Care NHS Trust. It has been agreed that merging offered the most beneficial way to improve the services we deliver and the sustainability of both NCH&C and CCS, thereby supporting system improvement.

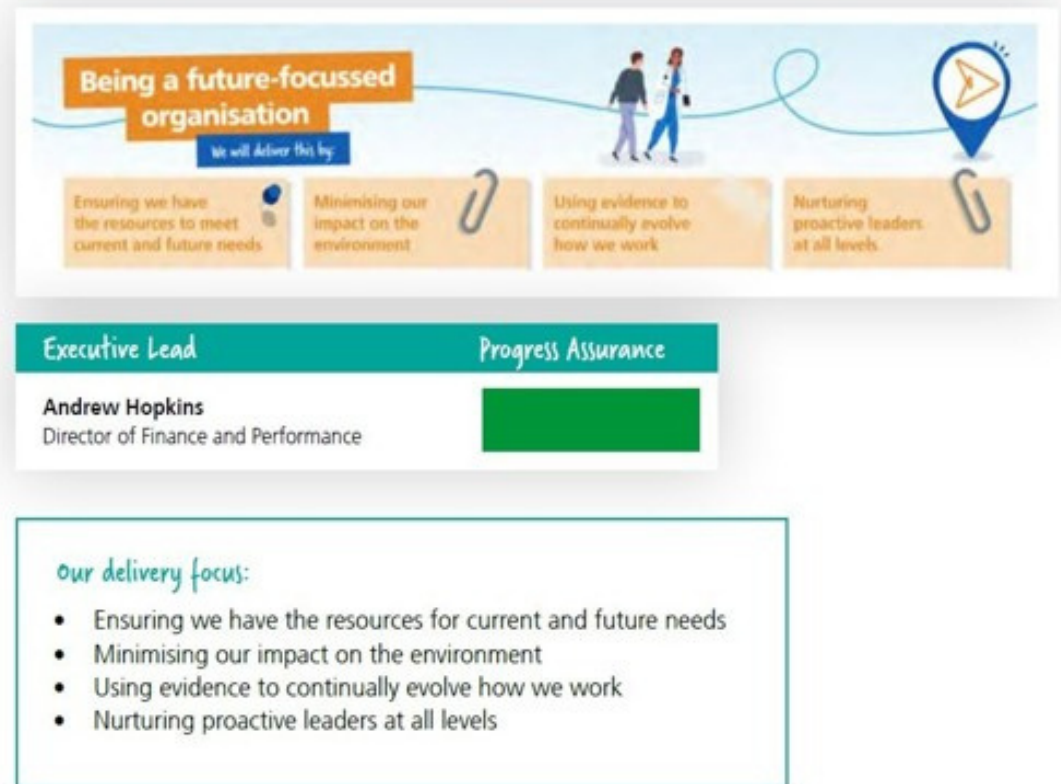
In our case for merger, we identified anticipated beneficiaries of the merger as:

- Patients: by enhancing how care is delivered.
- Colleagues: by focusing on improved support to our colleagues.
- Our systems: by maximising our delivery from our finance and resource allocation and strengthening our organisational capability.

Working within the Group, we have already started to deliver financial and operational benefits and have the support of our ICB and local authority partners where, for example, we have renewed our Section 75 contract with Norfolk County Council for the delivery of integrated community services.

We have delivered our efficiency targets, albeit with an increased reliance on non-recurrent savings in year. We are integrating estates and facilities functions across the two Trusts, both operationally and strategically, to deliver improved use of resources by maximising utilisation across our group service delivery.

A focussed, cross group, transformation methodology has been implemented to support the continued evolution of the Trust's services.



Operational Performance

Demand and capacity

In 2025/26, overall referral activity shows a mixed picture compared to 2024/25, with significant growth in several key services alongside reductions in others. Notable increases in referral volumes are seen in Urgent Community Response (43%), Community Therapy (59%), Discharge to Assess (23%), Community Access Team (30%), and Specialist Palliative Care Nursing (12%). There have also been substantial increases in N&W Care Coordination and lymphoedema services, indicating rising demand in complex care coordination and long-term condition management.

Conversely, some services have experienced reductions in referrals, including Community Dietetics (-10%), Post Covid Assessment Service (37%), Prosthetics (-41%), and Community Home Based Intermediate Care (-15%). Community Nursing referrals have remained relatively stable overall (-1%), though demand remains high given the scale of activity.

These changes in referral patterns can be partly attributed to continued transformation in service delivery. For example, the expansion and utilisation of Urgent Community Response services and Discharge to Assess pathways have supported more care being delivered in community settings. In addition, ongoing collaboration between NCH&C and East Coast Community Healthcare (ECCH) has contributed to sustained growth in MSK services, with combined activity increasing across both providers.



NCH&C Community Nursing and Therapy teams continue to face significant pressure due to increasing service demand, particularly in high-growth areas such as Community Therapy and urgent care pathways. While overall Community Nursing referrals have remained stable, the increase in complexity and redistribution of demand across pathways has contributed to operational challenges, including waiting times, unallocated visits, and service pressures across all Places.

District Nursing Benchmarking Project 2025

NCH&C's participation in the NHS Benchmarking Network District Nursing Project 2025 has provided valuable insight into the strength, responsiveness and efficiency of our district nursing services.

The benchmarking data shows that NCH&C receives and accepts a significantly higher volume of referrals (76,282 referrals per 100k aged 65+), than the national median (33,917 referrals per 100k aged 65+), reflecting the scale of demand managed by our teams and their continued commitment to supporting patients in the community.

Despite operating with comparatively lower workforce capacity and financial investment than many peers, NCH&C's productivity remains in line with sector norms, delivering 6.6 contacts per clinical whole time equivalent (WTE) per day, matching the national sample median. The service also demonstrates strong patient flow, with shorter average time on caseloads and high caseload turnover, supported by proactive caseload management and timely discharge processes.

The data also highlights the responsive nature of our district nursing model. NCH&C records a higher proportion of unplanned contacts, indicating the ability of teams to respond flexibly to urgent patient need. Longer average contact times suggest that staff are providing focused, timeintensive care, particularly for patients with more complex requirements.

Overall, the benchmarking findings demonstrate a service that is managing high levels of demand, maintaining productivity, and delivering responsive care for local communities. The project also gives us a strong evidence base to support future service improvement, helping us identify where further analysis, investment and innovation can strengthen care for patients and support our teams.



Inpatient Beds

The Trust operates an extensive network of inpatient beds across six geographical sites, primarily focused on delivering intermediate care and rehabilitation. Our service model prioritises admission avoidance and supported discharge through a highly integrated, multidisciplinary approach. By embedding physiotherapy and occupational therapy into the core of our ward operations, we ensure every patient maximises their rehabilitation potential in the most appropriate setting.

The Willow Therapy Unit at Norwich Community Hospital is now fully operational as our flagship 48-bedded, therapy-led rehabilitation unit. Since opening in March 2025, it has supported significantly in streamlining discharges from the Norfolk and Norwich University Hospital (NNUH).

- **Current Capacity:** The integration of the Willow Unit has stabilised our intermediate care capacity at 183 beds across NCH&C wards.
- **System Support:** Beyond our own estate, NCH&C continues to manage patient flow for 28 recovery and reablement beds within three ICB-commissioned care homes across the county.

Palliative and Specialist Inpatient Provision

We maintain a robust portfolio of specialist beds designed for complex recovery and end-of-life care:

- **Palliative Care:** Priscilla Bacon Lodge (PBL) provides 16 specialist palliative beds. An additional 8 beds continue to be utilised to support patients with complex Continuing Health Care (CHC) needs.
- **Stroke & Amputee Care:** We provide 24 specialist stroke rehabilitation beds in Beech Ward and a dedicated 9-bed facility for amputee care at Pine Cottage.
- **Neurological Rehabilitation:** Caroline House provides 20 beds for highly specialist rehabilitation for individuals with complex acquired brain injuries.

System Leadership and Surge Management

To manage seasonal surge pressures and maintain Discharge to Assess (D2A) Pathway flow from acute partners, increasing bed stock temporarily is an option which can still be utilised.

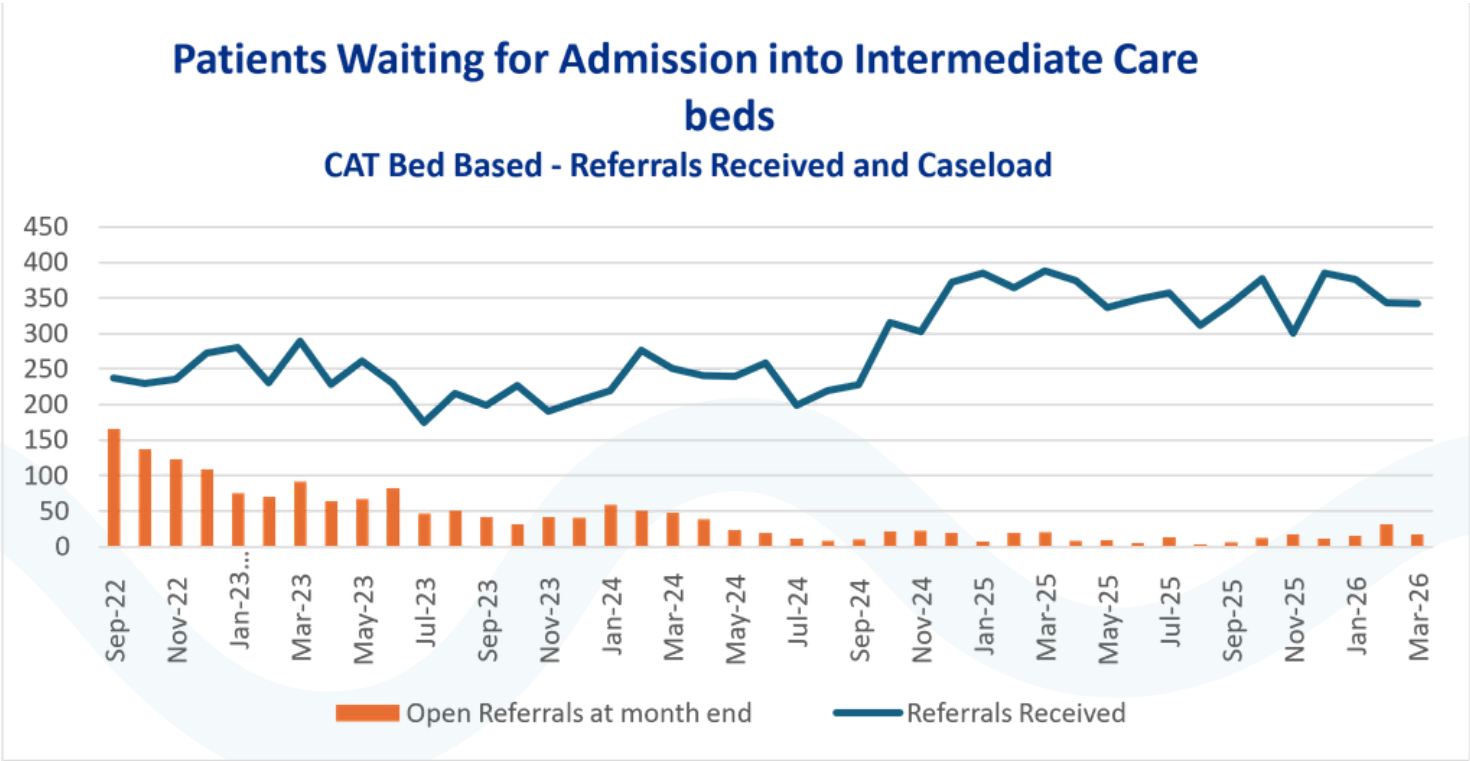
We continue to facilitate the system's SPRINT group, ensuring that bed planning is data-driven and aligned with the evolving needs of the local population.

Discharge to Assess (D2A) Pathway Two

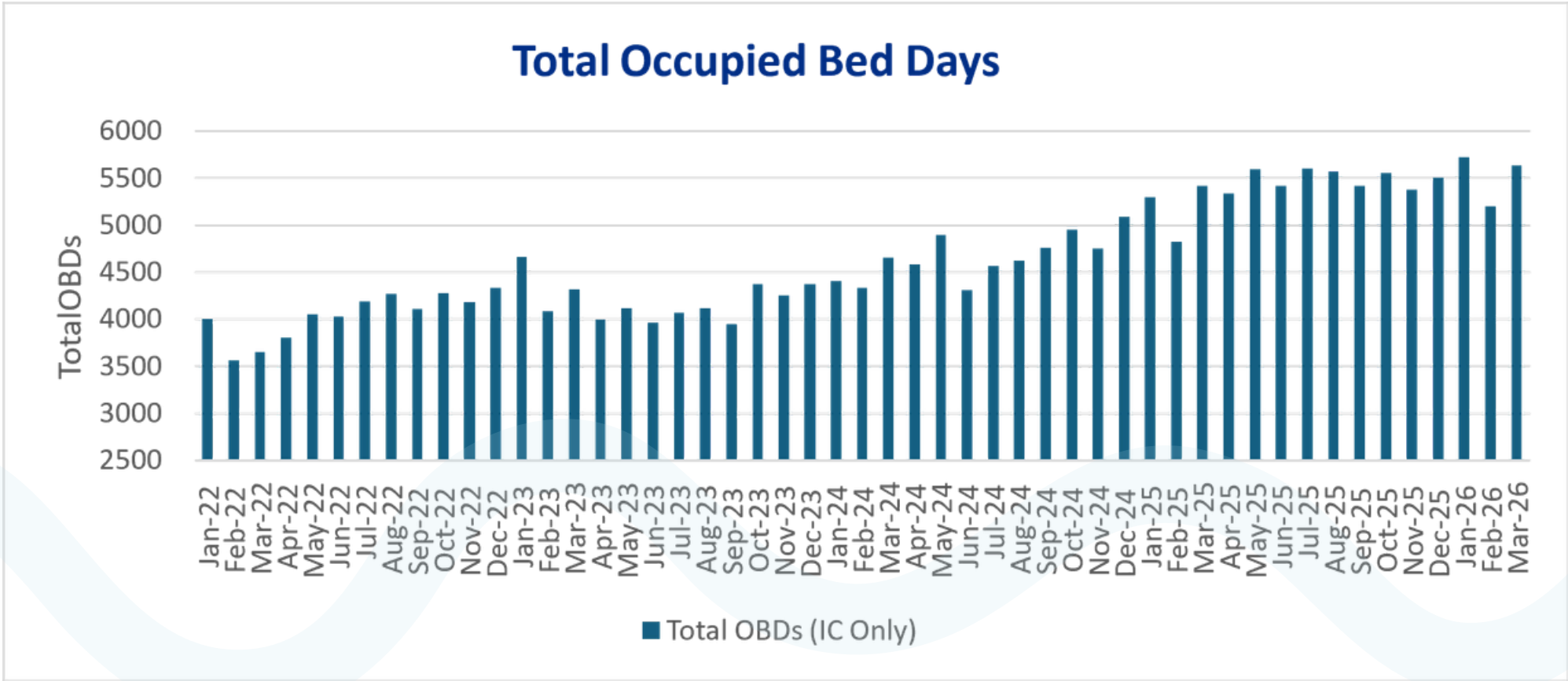
The Trust has successfully reduced the significant backlogs seen in 2022/23. While waiting lists peaked at 165 patients during that period, despite significantly increased demand, the waiting list at the end of each month has averaged 12 patients for the last 12 months. The strategic expansion of our estate, specifically the Willow Therapy Unit in early 2025, has fundamentally improved bed availability and reduced wait times across the system.

Waitlist Trends and Capacity Impact

Throughout 2024 and 2025, a combination of additional capacity, including the temporary use of Birch Ward and the subsequent permanent opening of the Willow Therapy Unit, allowed us to absorb seasonal pressures more effectively.



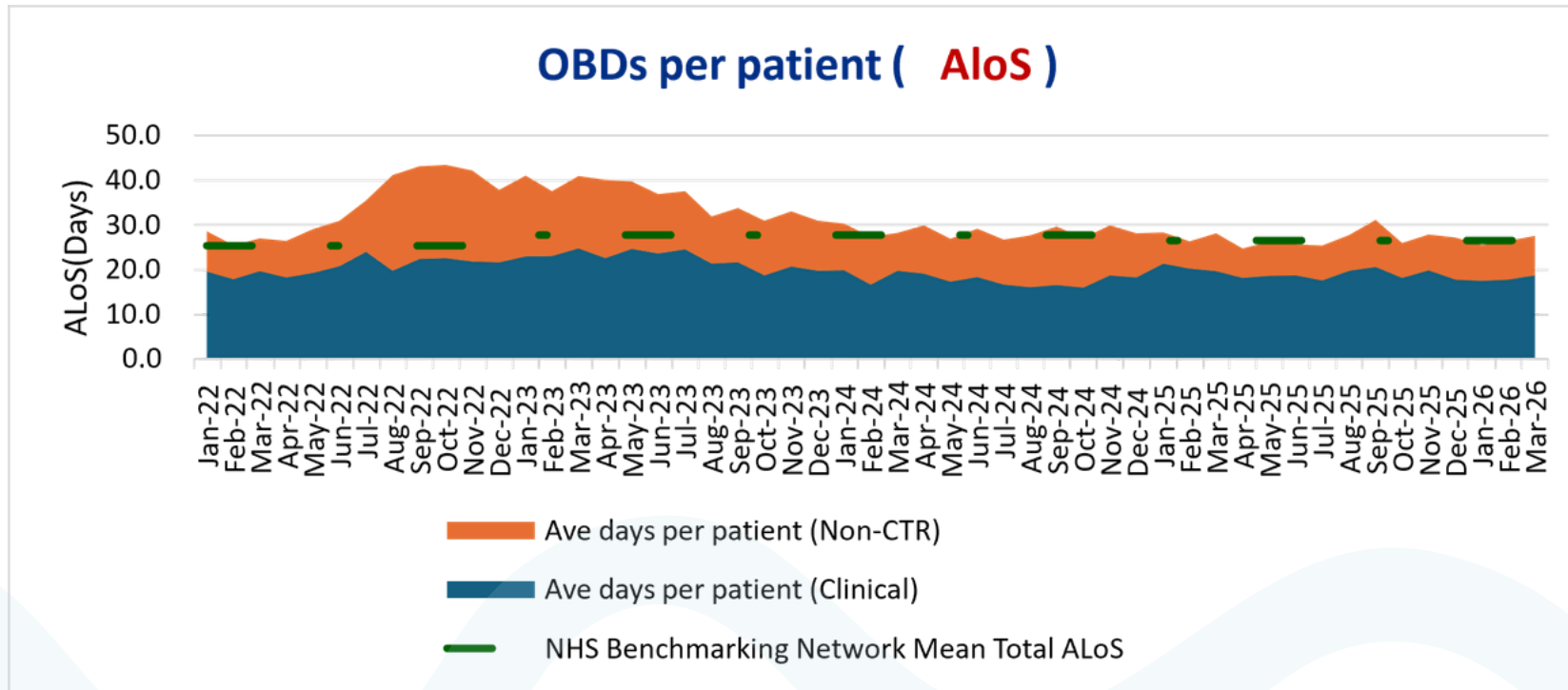
- **Waitlist Reduction:** In 2023, the average waitlist sat at 58 patients. Following the full integration of the Willow Therapy Unit in 2025, this average has decreased to 12 patients.
- **Demand increase:** in 2025, 359 referrals a month on average were received into the Community Access Team. A 40% increase compared to 255 referrals a month in 2024.
- **Occupied Bed Days (OBD):** Our activity levels have reached record highs. From a pre-pandemic average of 3,700 OBDs, we scaled to over 5,000 in late 2024. With the Willow Therapy Unit now fully operational, our current OBD delivery averages 5,500 representing an 18% increase in system support compared to 2024.



Average Length of Stay (LoS)

NCH&C has focused on reducing the time patients spend in hospital once they no longer meet the Criteria to Reside (CTR). Through integrated working with our system partners, we have successfully maintained the efficiencies gained over the last three years:

- Historical Context: Length of Stay (LoS) peaked at over 40 days in 2022.
- Current Performance: The average LoS was 28.2 days in 2024. For the 2025/26 period, we have maintained an average LoS of 26.7 days, ensuring that rehabilitation is intensive, effective, and focused on a timely return home.



National Benchmarking

NCH&C is the host provider of the NHS England Benchmarking Network. Our 2025 data shows that, when compared to 30 peer Trusts in the latest Intermediate Care outputs, we continue to perform at around the national average across most key metrics.

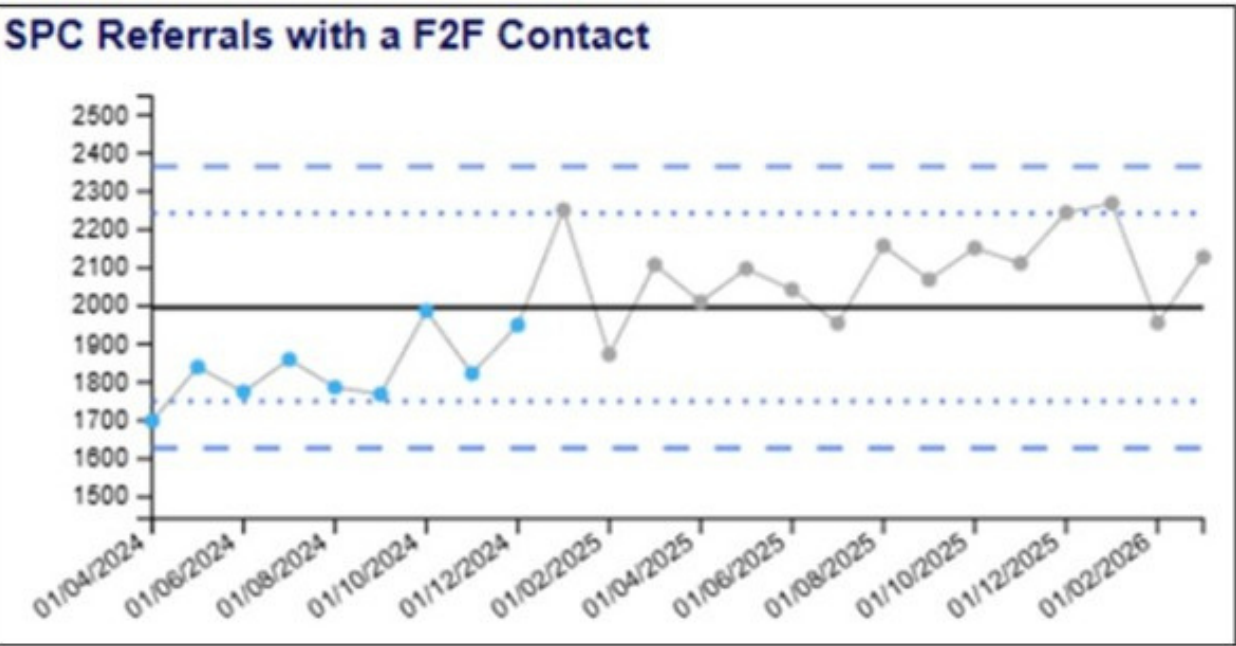
BASED ON 2025 DATA SUBMISSIONS

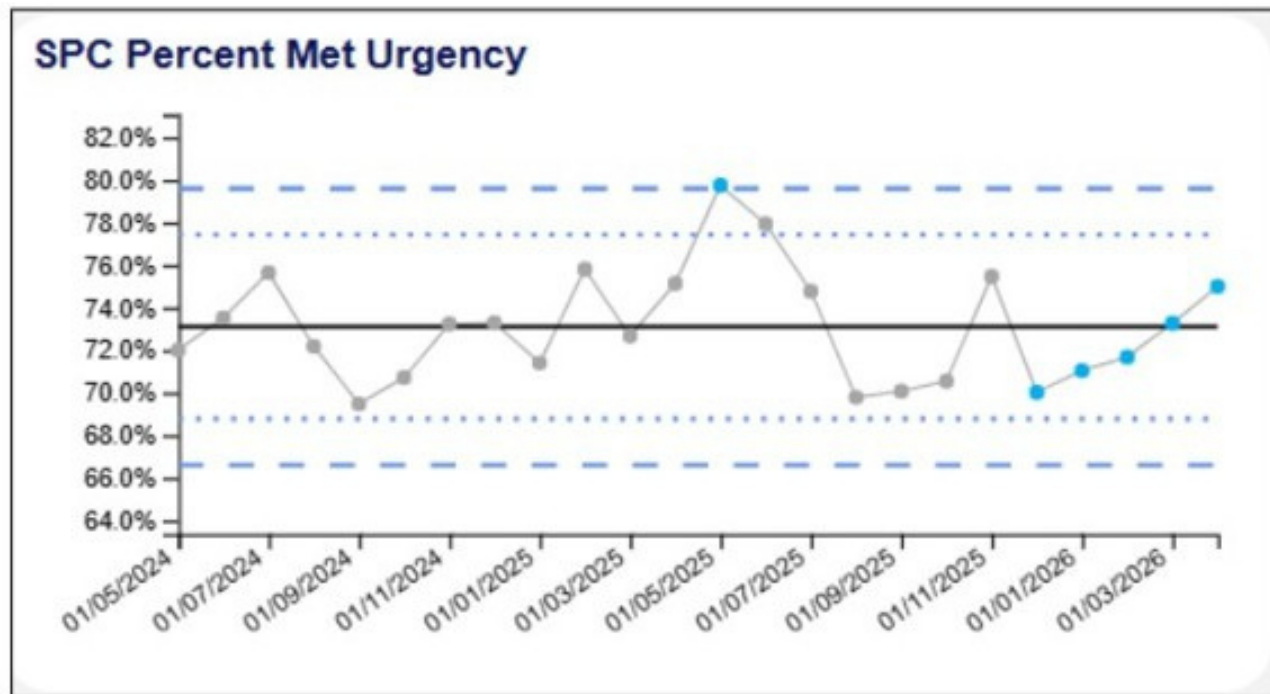
Metric	NHS Benchmarking (mean)	NCH&C
Average Length of Stay (days)	26.5	26.7
Non-Criteria to Reside (%)	26.8	28.9
Discharge to own home (%)	64.4	62.5

Urgent Care Response (UCR)

Demand for Urgent Community Response (UCR) services is continuing to grow at pace, with total referrals increasing by approximately 25% year-on-year. This is reinforced by a more targeted rise in two-hour UCR referrals, which increased by 11% (from 22,723 to 25,196), indicating not just overall growth but a sustained increase in higher-acuity demand requiring rapid response.

Despite this increase in demand, overall two-hour performance has improved from 72.8% in 2024/25 to 73.3% in 2025/26. This suggests that, at a system level, services have been able to absorb additional demand without deterioration in performance. Norwich Place stands out as the most consistent performer, maintaining performance around or above 80% even during periods of workforce pressure, demonstrating the impact of local operational resilience and service configuration.





The data highlights ongoing structural challenges within the out-of-hours service. The removal of the twilight shift in July 2025 is clearly reflected in performance, with a sharp drop in 6–8pm performance from 51.7% to 38.3%. Although recovery is evident by year-end (69.8%, with March at 70.5%), this variation indicates a sensitivity of performance to relatively small changes in workforce availability at key times of day.

Demand variability has also increased, with monthly referrals ranging more widely than in the previous year. This growing volatility, combined with higher overall volumes, places additional strain on workforce planning and real-time responsiveness, particularly in already pressured services such as Out-of-Hours.

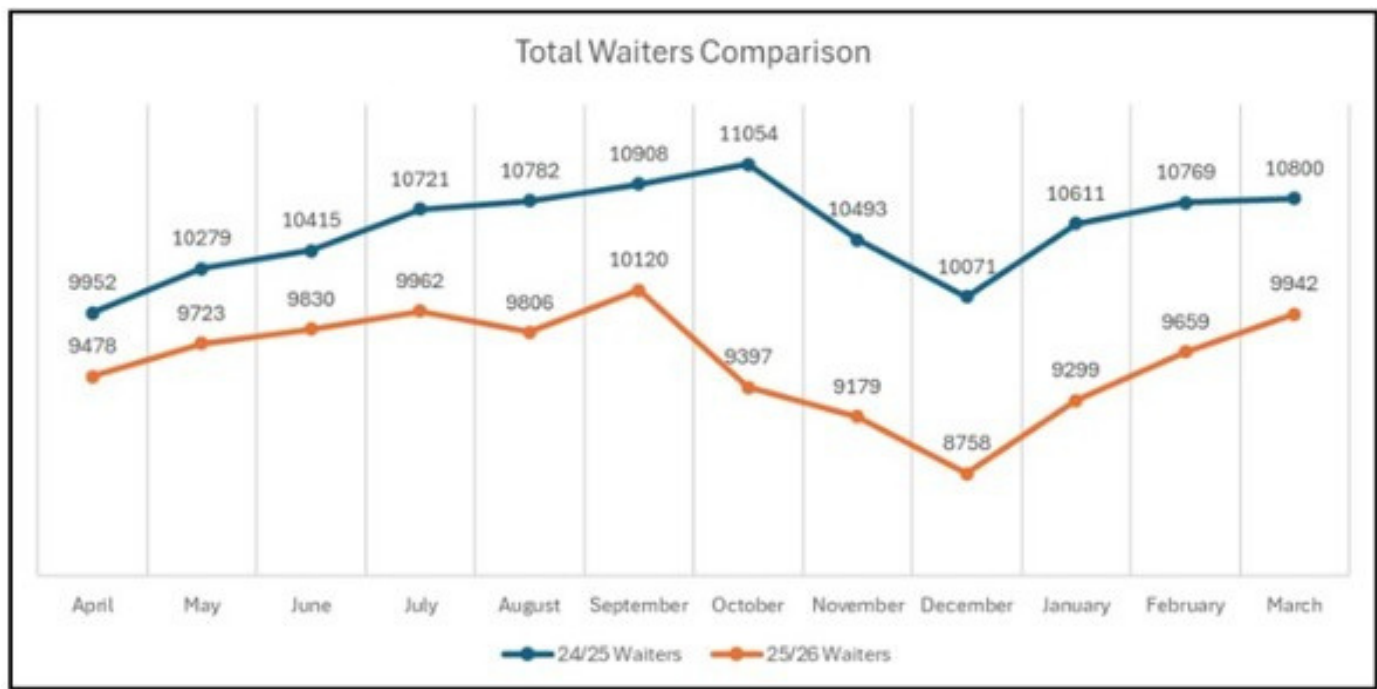
Overall, the data tells us that while UCR services are maintaining and improving performance in the face of rising and more volatile demand, this is being achieved within a system that has identifiable structural constraints, particularly around workforce distribution, shift design, and data quality. Addressing these factors will be critical to delivering further improvements and achieving the 80% Trust target.

Waiting Times

Total Waiters Performance

Across April 2024 to March 2025, the total number of waiters showed a steady upward trajectory, rising from 9,952 in April to a peak of 11,054 in October. Although there was a dip towards the end of the calendar year, waiters increased again, finishing the period at 10,800 in March. In contrast, April 2025 to March 2026 shows a more mixed but overall downward pattern in waiting list size.

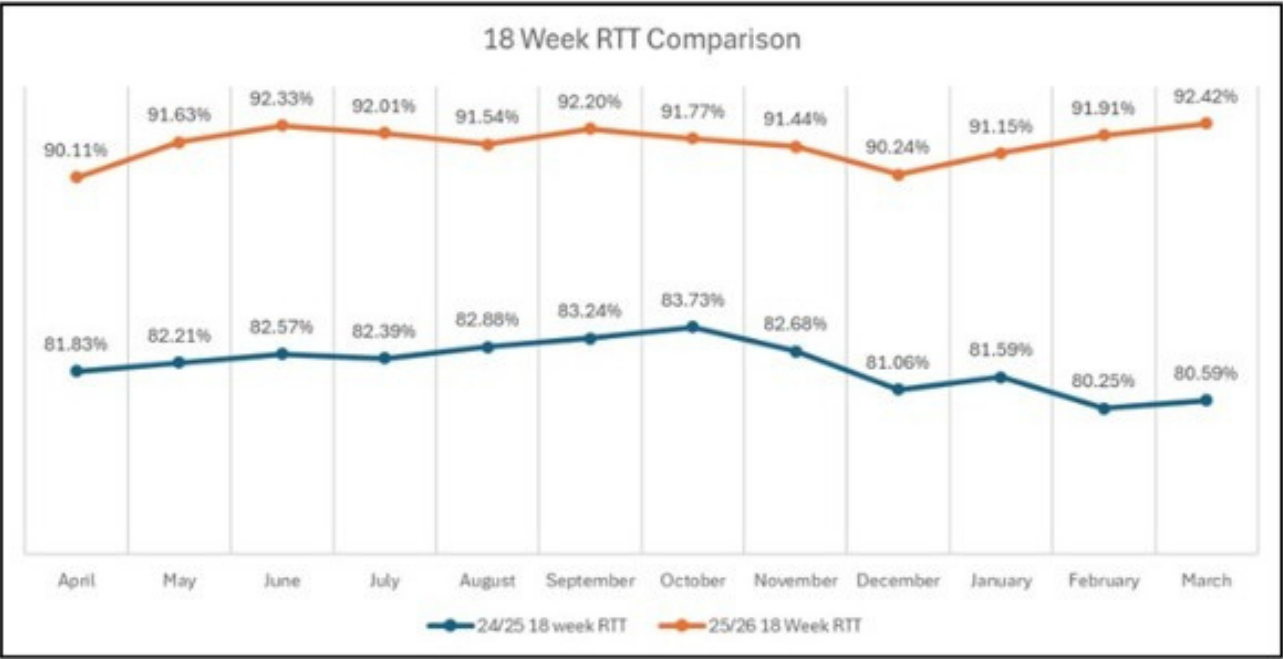
Starting lower than the previous year at 9,478 in April, volumes increased gradually to a local high of 10,120 in September, before falling sharply to 8,758 in December. This was followed by a steady recovery through the final quarter, reaching 9,942 by March 2026. Overall, this represents a year-on-year reduction of 858 waiters at year end (10,800 vs. 9,942). While the decrease is less pronounced than previously described, it still indicates an overall improvement in backlog management and throughput during 2025/26, albeit with some mid-year volatility.



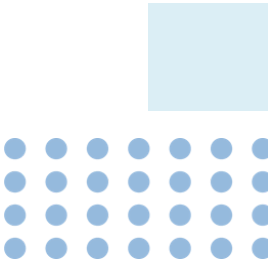
18-Week RTT Performance

Performance against the 18-week Referral to Treatment (RTT) target shows a clear and sustained improvement between the two periods.

- In 2024/25, performance remained relatively stable but below optimal levels, generally ranging between 80% and 84%. After peaking at 83.73% in October, there was a gradual decline through the latter months, with the year ending at 80.59%.
- In 2025/26, performance is consistently strong from the outset, starting at 90.11% in April and remaining above 90% throughout the entire year. Levels peak at 92.33% in June and remain stable in the 91–92% range thereafter, with a slight dip in December (90.24%) before recovering to 92.42% by March.



Overall, this represents a year-on-year improvement of 11.83 percentage points at year end (80.59% vs. 92.42%).



Patient and Carer Experience

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 was 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 and 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.

In 2025/26 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, as well as a chance to gain an insight into areas that require improvement. 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.

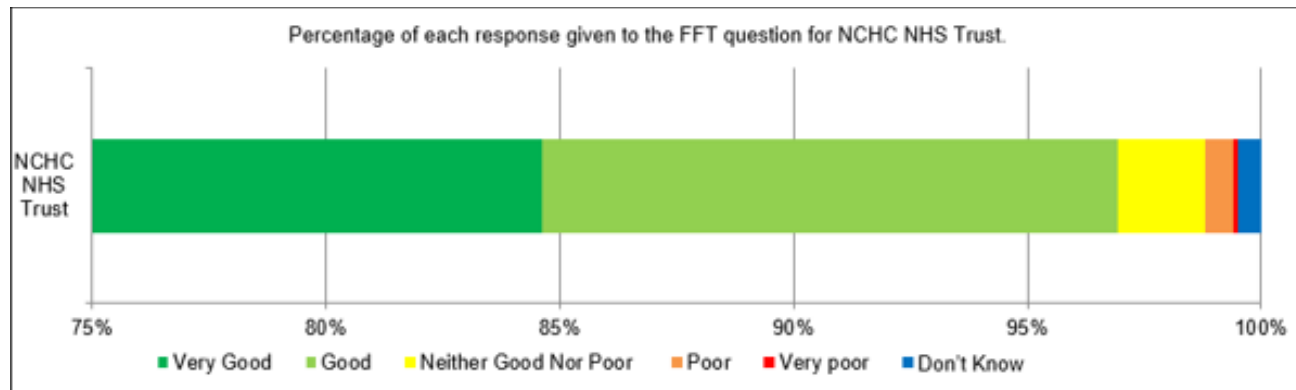


Friends and Family Test

The quality of our services and the experience of our patients, service users, carers and staff remain central to everything we do. Feedback from those who use our services provides valuable insight into what matters most to them and helps us to continually improve the care we deliver.

To build a comprehensive understanding of experience, we draw on a wide range of sources, including compliments, complaints, PALS enquiries, the Friends and Family Test (FFT), Healthwatch, patient and carer surveys, focus groups, patient stories, staff surveys, local working groups, staff networks and public engagement opportunities.

Throughout 2025/26, service user feedback remained highly positive. Of the 3,450 individuals who responded to the Friends and Family Test question during the year, 96.94% reported that the service they received was very good or good. This reflects our continued emphasis on compassionate, person-centred care, as well as the commitment of staff across all services to improving experience and outcomes.



Patient Advice and Liaison Service (PALS)

In addition to the Friends and Family Test (FFT) results, the Trust continues to receive a substantial volume of positive feedback directly from patients, carers, families and members of the public. During 2025/26, a total of 1,010 compliments were formally logged through the Patient Advice and Liaison Service (PALS). These were submitted through letters, emails and verbal expressions of thanks and praise to individual services and teams. This feedback highlights the ongoing commitment of staff across NCH&C to delivering high-quality, compassionate care.

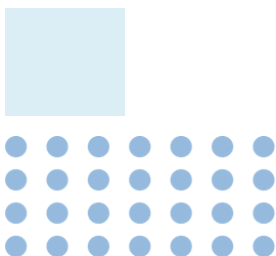
During 2025/26, PALS received, managed and resolved 744 contacts, many of which were addressed in partnership with Place-based teams. These included:

- 38 appointment changes or cancellations
- 30 concerns raised by patients or carers who did not wish to proceed with a formal complaint
- 447 requests for general guidance or information
- 9 general feedback comments
- queries from Medical Examiners
- 131 enquiries not related to NCH&C services
- 75 general Trust enquiries not directly involving patient care
- 10 locally raised concerns

These contacts provide valuable insight into the issues that matter most to patients and carers and support the Trust to identify opportunities for service improvement.

PALS Activity Summary 2025/2026

Category	2025/2026	Total
Appointment change / cancellation	38	38
Comment	9	9
Compliment	1,010	1,010
Concern / Informal complaint	30	30
Guidance / Information	447	447
Locally raised concern	10	10
Medical Examiner query	4	4
Non-NCH&C related query	131	131
Non-PALS but NCH&C query	75	75
Total	1,754	1,754



Complaints

During 2025/26, the Trust received 112 formal complaints, representing a reduction compared with 139 complaints in 2024/25 and 134 complaints in 2023/24. In addition, 271 concerns were managed informally and resolved promptly through local resolution within clinical services or directly by service managers.

Local resolution is usually achieved through a telephone discussion and, where appropriate, followed by a written response from the service manager. This approach supports early resolution and helps address concerns quickly and effectively.

All formal complaints are subject to a full investigation. People who make a formal complaint receive a written response signed by the Chief Executive. This response explains the outcome of the investigation, highlights any learning identified and describes the actions taken to improve services. Where appropriate, Trust representatives also meet with complainants or their families to discuss the findings and support resolution.

Of the 112 formal complaints received during the year, 95 have been fully reviewed and coded to date:

- 55 complaints (58%) were upheld, meaning the complaint was found to be justified
- 33 complaints (35%) were partially upheld, meaning some aspects of the complaint were upheld
- 7 complaints (7%) were not upheld

The Trust continues to use complaints as an important source of learning to drive service improvement and improve patient experience.



Learning from complaints

Regular thematic analysis of complaints, alongside triangulation with inquests and incidents, continues to help the Trust identify opportunities for learning. Themes and outcomes from complaints have been reviewed at relevant committees and presented to Trust Board throughout the year.

NCH&C Youth Forum

“Young Voices Together”, NCH&C’s forum for children and young people who use our services, was launched at the beginning of July 2023. A series of engagement events were held with the Youth Forum in 2025 to support meaningful engagement and coproduction for the new Children’s Neurodevelopmental Project. Hearing directly from children and young people has helped shape service development by providing insight into:

- what it feels like to be neurodivergent
- how young people may mask their emotions
- what matters most to them when attending assessments or follow up appointments

This feedback has strengthened the child centred approach within service redesign.

Volunteers

Volunteers continue to make an important contribution to patient and carer experience at NCH&C. Throughout 2025 and 2026, volunteers were recruited, trained and supported across a range of key areas, including:

- support for the newly opened Willow Therapy Unit
- support for inpatient services across all Places
- support for outpatient services and community teams

Interest in volunteering remains high. Between April and December 2025, 275 new volunteer applications were received, representing a 35.5% increase compared to the same period in the previous year. This growth reflects the work of the NCH&C Volunteer Service, delivered by Voluntary Norfolk, to engage with local communities and promote volunteering opportunities.

An example of volunteer involvement is shown in the table below, which sets out the number of volunteers active in each type of role during Quarter 3 of 2025 and 2026. The total number of active volunteers represents a 56.5 percent increase compared with Quarter 3 of 2024 and 2025. All volunteer roles are designed to have a direct or indirect positive impact on patient experience.

Patient Reported Outcome Measures

The Trust has carried out a scoping exercise aligned with the NHS Fit for the Future: 10 Year Health Plan for England, which sets the expectation that Patient Reported Outcome Measures (PROMs) will be used universally and published publicly by 2029. In line with national terminology, the Trust has adopted the term Patient Reported Outcome Measures (PROMs).

Activity Support	28
Patient Support (including Therapy Dogs)	55
Visitor & Team Support	13
Stockroom Support / Other Practical	19
Meet & Greet	2
Patient Contact & Feedback	4
Gardening	7
Admin	5
PLACE Assessment	5
Consultations & Focus Group	1
Community Therapy Group Support	5
Total	144

PROMs are standardised tools, usually questionnaires, completed by patients to report their progress, outcomes and the impact of treatment. They help services understand the effect of care from the patient’s perspective, complementing traditional clinical measures.

A range of PROMs are already used across the Trust, including within:

- inpatient services
- specialist therapy services
- cardiac and pulmonary rehabilitation
- prosthetics services
- therapy services
- neurological outpatient services

A project plan is being developed to support the wider implementation of PROMs. This will include:

- establishing a clear baseline
- conducting a gap analysis
- supporting services to identify appropriate PROMs
- embedding meaningful PROMs into clinical practice

PROMs have significant potential to reduce inequalities by ensuring all patients have the opportunity to provide feedback on their care in a consistent, outcomes focused way. This work will help ensure that all service users benefit from an evidence-based approach to understanding and improving the outcomes that matter most to them.

Sustainability Performance 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.

During 2025/26, NCH&C has focussed on the co-production of its new Green Plan, to be jointly created with Cambridgeshire Community Services (CCS) as the two organisations become one from April 2026. The 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, and beyond, as new geographies emerge during the alignment period of the two Trusts. The Green Plan is an important part of the wider NHS 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. During the year Trust focus has been on the alignment of our green planning with CCS and the wider future geographies in which our services will operate. The Trust has prioritised and maximised the ongoing decarbonisation of its estate, having secured significant funding opportunity from the NHS.

The renewed green plan identifies nine priorities on which the Trust places focus in delivery through its Green Plan Delivery Group:

Engagement, collaboration, and communication

Building staff, patient and partner engagement so sustainability is embedded in everyday decision making and behaviours.

Sustainable Clinical and Care Models

Redesigning care pathways to reduce environmental impact while improving outcomes (e.g. prevention, community-based care, reduced unnecessary interventions). Digital transformation

Using digital solutions such as virtual consultations and digital records to reduce travel, paper use and emissions.

Transport and travel

Cutting carbon from staff, patient and fleet travel through active travel, low emission vehicles and smarter scheduling.

Estates and facilities

Improving the environmental performance of buildings, including:

- Energy usage
- Water consumption
- Waste generation and recycling Medicines

Reducing the carbon footprint of prescribing and medicines use, including optimisation, waste reduction and lower carbon alternatives.

Medical devices

Improving procurement, reuse, maintenance and disposal of medical equipment to reduce waste and embodied carbon.

Procurement and supply chains

Working with suppliers to reduce emissions, embed social value, and align with the NHS Net Zero Supplier Roadmap.

Food and nutrition

Promoting healthier, lower carbon food choices and reducing food waste across services and facilities.

The Trust's estate team provides a quarterly update to the Trust's Green Plan delivery group and Board Committee for review and challenge. The update provides a progress update against summary of the actions being taken to deliver the Trusts Strategic Priorities.



Green Plan achievements in 2025/26 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 2026/27 and beyond.

Energy

In early 2025 the Trust secured significant investment to implement sub-metered controls across our estate utility feeds. This installation programme was completed in early 2026 and has since been mobilised to support the analysis of building level data to track and identify building anomalies. Looking ahead, we will embed this within our energy management to control our cost recovery and consumption practices.

During 2025, NCH&C secured additional funding of c.£2m to complete a significant investment in solar energy and battery storage across the estate. This programme has been completed in early 2026 and will deliver significant benefit to the Trust and wider NHS:

- 1,794 panels fitted to date
- Planned saving on electricity expected to exceed 805,680 kWh per year across the sites that we have installed panels
- Reduction in Kg CO₂e of 130,572 Kg per annum (Carbon Dioxide equivalent)
- Carbon reduction impact equal to a reduction of 187.8 tonnes based on the kWh saving per year

The Trust completed the replacement of fluorescent lighting with LED lighting across the NCH&C Estate. The benefits of these investments continue to be evaluated 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. 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

Building on last year's information campaigns, successful in person events were held for zero emission travel options from Knowles Fleet for EVs and Green Commute Initiative for e-bikes.

Of the 69 salary sacrifice vehicles in the scheme, 36 (over 50%) are now zero emission and 57 (over 80%) are below 50gCO₂/km. The salary sacrifice scheme is in line with NHSE guidance that vehicles must be zero emission unless a good reason can be given, for example a lack of home charging or high daily mileage.

The travel team continue to work with local active travel advocates. We currently have an e-cargo bike on a 2-year trial to support zero carbon logistics. We continue to work with Beryl Bikes to offer staff free access to local micromobility. The Trust has also moved to a better financial and social value Cycle to Work Scheme provider- Green Commute Initiative.

Due to a successful grant application, sufficient EV charging infrastructure is now in place to transition all Trust owned and leased vehicles to zero emission ahead of the 2027 date from the NHSE roadmap. The centrally managed pool car fleet has EVs on order to replace all fossil fuel powered vehicles. As team-owned vehicles are due for lease renewal these are replaced with EV where the financial case makes sense. The fleet looks likely to be fully zero emission on a cost beneficial basis ahead of the 2027 deadline.

As the used EV market increases it is intended to use the subject matter expert experience from the fleet electrification project to assist staff in specifying their EV requirements and supporting them to select lower emission, cost effective electric vehicles. At a strategic level we will be working with local council transport teams to advocate for on street charging at domestic energy rates to allow staff without off road parking to access the low energy costs necessary for cost effective EV adoption.



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, continues to provide 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 as digital services support and invest in technologies. In turn this is beginning to have some effects on the way our NHS estate gets used and how much is needed.

Stronger integration with CCS community teams and the social care teams from Norfolk County Council helped underpin improvement of shared use of estates across integrated care teams. This was supported by our use of Cloud booking (accommodation management software) which was implemented and is used to enable multidisciplinary working.

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.

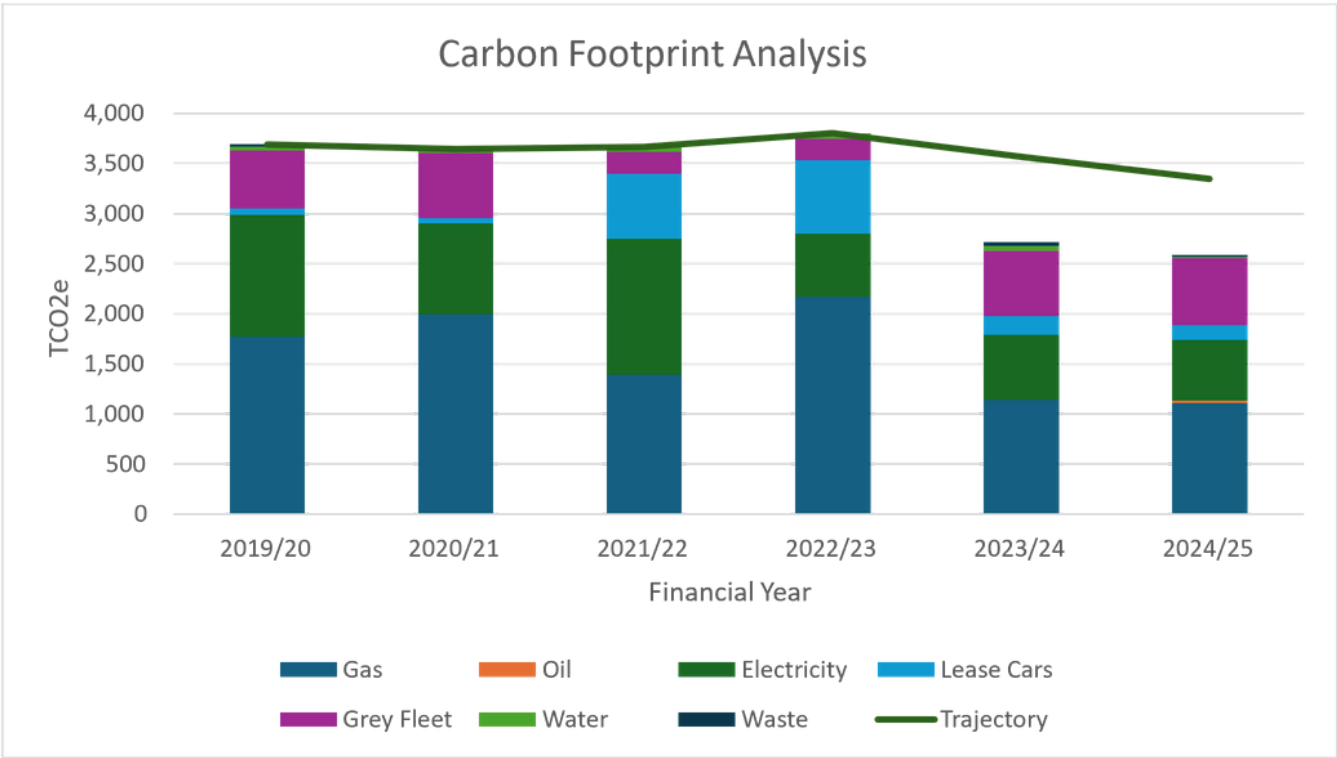
Digital Services

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 we have continued to reduce our data centre footprint / power consumption by moving our remaining systems to the cloud. We have also increased our use of national systems adoption by migration to the national Microsoft 365 platform including use of @nhs.net.

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. Reported emissions currently cover Scope 1 and Scope 2 sources in line with NHS and HM Treasury guidance. Scope 3 emissions are recognised as material for the Trust, particularly in relation to procurement and medicines, and will be disclosed progressively as part of planned reporting enhancements.

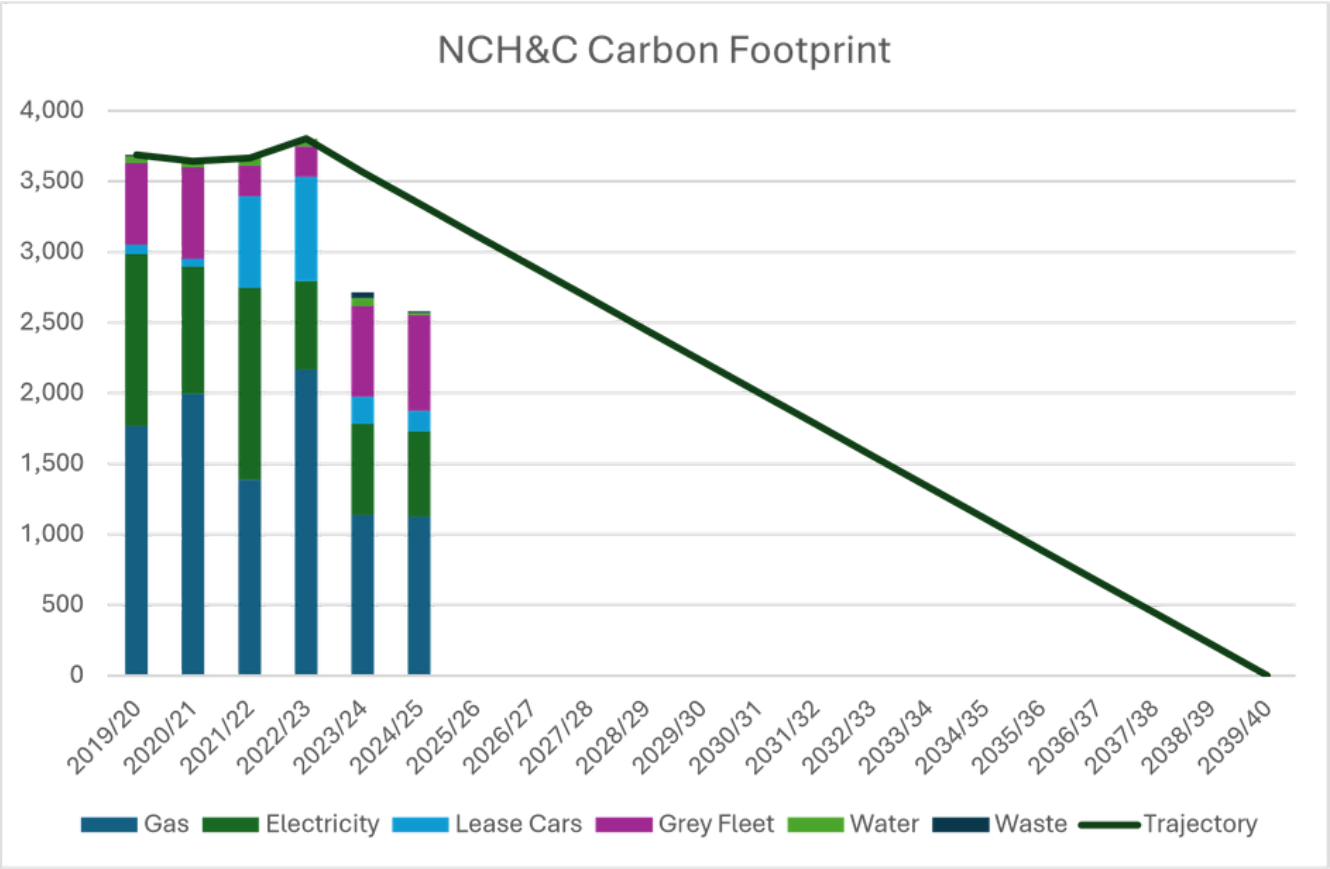
2019/20 is the point from which trajectories to Net Zero have been defined in the “Delivering a Net Zero NHS” report and have been identified as the appropriate point to measure the required average contributions from NHS trusts from a pre-COVID baseline.



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. Year-on-year variation reflects a combination of estate changes, investment impacts, data quality improvements and external factors such as weather and energy market volatility.

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 continue to see a drop in cost during future years. 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 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, risk management and integration

The Trust's approach to sustainability governance and climate-related risk management is embedded within existing corporate governance, risk and assurance arrangements. Board-level oversight is provided through the Finance and Infrastructure Committee, which receives regular updates on progress against the Green Plan and associated climate-related risks and opportunities.

Management responsibility is delegated to the Green Plan Delivery Group, which meets quarterly and includes relevant subject matter experts across estates, fleet, procurement, digital and clinical services. Outputs from this group inform capital planning, estate prioritisation and service transformation decisions.

Climate-related risks are assessed proportionately and are increasingly integrated within the Trust's wider risk management processes, including escalation where material to service resilience, financial sustainability or statutory compliance.

The outputs of these governance and risk management processes directly inform the Trust's climate-related strategy, investment decisions and assessment of long-term resilience, as set out in the Climate-Related Strategy section.

Climate-related strategy

Climate change presents both risks and opportunities for Norfolk Community Health & Care NHS Trust (NCH&C), with implications for service resilience, estate performance, workforce wellbeing, and long-term financial sustainability. In line with HM Treasury's TCFD-aligned disclosure application guidance, the Trust has begun to identify and assess climate-related risks and opportunities over the short (0–5 years), medium (5–10 years), and long term (to 2040), aligned to national NHS Net Zero milestones.



Principal climate-related risks and opportunities

Time period	Key risks	Key opportunities
Short term	Volatility in energy prices; increased frequency of heatwaves affecting community facilities; supply-chain cost pressures linked to carbon reporting requirements	Energy efficiency investment; on-site generation reducing exposure to energy markets; digital delivery reducing travel
Medium term	Increased costs of maintaining aging estate under more extreme weather conditions; workforce disruption due to climate impacts	Estate rationalisation; electrification of fleet; lower-carbon clinical models
Long term	Infrastructure adaptation requirements; service demand pressures arising from climate-related ill health	Net zero estate; resilient, digitally enabled care models; long-term cost avoidance

These risks and opportunities are most material to the Trust's estate strategy, transport and fleet plans, and capital investment decisions, reflecting the community-based nature of services and the geographically dispersed estate footprint.

Impact on strategy and financial planning

The Trust's strategic response is embedded within its Green Plan and capital programme. Investment in solar generation, LED lighting, energy monitoring and fleet electrification is intended to reduce exposure to future energy price volatility, support financial resilience, and align with NHS Net Zero trajectories. Climate considerations increasingly inform prioritisation of estate investment, recognising that failure to decarbonise and adapt could lead to higher operating costs and service disruption over time. These climate-related considerations are increasingly material to the Trust's medium-term financial planning, particularly in relation to energy costs, estate maintenance liabilities and fleet investment.

Strategic resilience and scenario considerations

The Trust has undertaken a qualitative assessment of strategic resilience under different climate futures, including a 2°C or lower global warming scenario, as recommended under TCFD Phase 3. Under this scenario, NCH&C expects increased policy, regulatory and cost pressures associated with decarbonisation, but these are largely mitigated by current and planned investment in estate efficiency, renewable energy and fleet transition. This assessment has been undertaken qualitatively and proportionately, recognising the Trust's current data maturity and the nature of community health service provision.



Under higher-warming scenarios, risks associated with physical climate impacts, particularly heat stress on facilities and increased service demand, become more pronounced, reinforcing the importance of ongoing adaptation planning.

More detailed climate scenario analysis will be developed during 2026/27, informed by national NHS guidance and improved data maturity, to further strengthen strategic decision-making and financial planning.

TCFD compliance statement

Norfolk Community Health & Care NHS Trust (NCH&C) has prepared climate-related financial disclosures in line with HM Treasury's TCFD-aligned disclosure application guidance, which interprets and adapts the Task Force on Climate-related Financial Disclosures framework for the UK public sector. This reporting period (2025/26) represents the final phase of the government's phased implementation approach, applied on a comply-or-explain basis.

The Trust considers climate change to be a primary risk due to its potential impacts on estate assets, service delivery, workforce wellbeing and long-term financial sustainability.

Summary of compliance

- **Governance:** Fully reported. Board-level oversight of climate-related risks and opportunities is provided through the Trust's Finance & Infrastructure committee, supported by the Green Plan Delivery Group and senior management accountability.
- **Risk management:** Fully reported. Climate-related risks are identified, assessed and managed through Green Plan governance arrangements and are increasingly integrated within the Trust's wider risk management processes.
- **Metrics and targets:** Partially reported. Scope 1 and Scope 2 greenhouse gas emissions are disclosed, alongside a net zero trajectory aligned to NHS requirements. Scope 3 emissions reporting remains under development and will be expanded in future reporting periods following completion of a materiality assessment.
- **Strategy:** Partially reported. The Trust has described principal climate-related risks and opportunities, qualitative impacts on strategy and financial planning, and an initial assessment of strategic resilience. Quantitative scenario analysis will be developed further during 2026/27.

Where disclosures remain under development, this reflects data maturity and proportionality considerations rather than a lack of commitment. The Trust has a clear improvement plan in place to strengthen the completeness and sophistication of future TCFD-aligned reporting.

Planned improvements to climate-related disclosures

In line with HM Treasury guidance, NCH&C is committed to continuous improvement in climate-related reporting. The following enhancements are planned:

2026/27

- Completion of a Scope 3 emissions materiality assessment, focusing on procurement, medicines and supply chains
- Expansion of Scope 3 emissions disclosures where data is available and material
- Development of a more structured qualitative climate scenario analysis aligned to NHS guidance

2027/28

- Integration of climate scenario outputs into medium-term financial planning and estate strategy
- Refinement of climate-related targets and performance monitoring at board-level

This staged approach ensures proportionate, decision specific disclosures while maintaining alignment with national NHS and HM Treasury expectations.

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 climaterelated 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 climaterelated risks and opportunities where such information is material.
Recommended disclosures				
(a)	Describe the board's oversight of climaterelated 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
(b)	Describe management's role in assessing and managing climaterelated 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 climaterelated 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 climaterelated 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. 2025/26 was again a challenging year financially for the Trust and across the whole of the health sector but we have managed to successfully deliver a £1.642 million surplus. Please note this final position was delivered following the receipt of redistributed additional £1.638 million funding from NHSE.

The continued impact of increasing activity levels and pay and non-pay cost inflation have been a real pressure to achieving this, but despite these challenges, the Trust's strong governance and financial management regime has enabled it to deliver its portfolio and maintain financial balance.

Income marginally grew by £2.5 million in 2025/26 (£16.9 million in 2024/25). The majority of this income is received from Norfolk and Waveney Integrated Care Board (ICB) for the provision of community healthcare services to the population of Norfolk.

The £7 million (£15.8 million in 2024/25) increase in staffing costs was driven by the national pay award, and overall non-pay costs have reduced by £13 million (£13.9 million increase on 2024/25) primarily due to the prior year including a material one-off cost relating to the assessed value of the Willow Therapy Unit.

The Trust continues with its aim to limit its use of temporary staff, including bank staff and the use of agency staff. The Trust is set a £1.2 million limit (£1.7 million in 2024/25) by NHSE for agency staff and during the year the Trust was within this limit, spending £400,000 on agency staff.

The Trust is required to achieve efficiencies (savings in costs or increases in income) each year. The Trust achieved efficiencies of £8.8 million in 2025/26 (£8.4 million in 2024/25) of which £2.94 million were recurrent. Efficiencies included £2 million of pay related savings driven by vacancies in year, and cost savings generated through improved procurement processes.

The Trust continues to have a small number of historic commercial debtors who owe rent to the 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 94% (95% in 2024/25) of non-NHS invoices within 30 days of receipt of a valid invoice, which was slightly below the target. 84% of NHS invoices were paid within 30 days of receipt of a valid invoice, compared to 86% in 24/25.

Financial outlook

The financial plan for East of England Community Health and Care NHS Trust has been informed by the NHS financial framework for 2026/27, the allocation and agreement of resource distribution within the Cambridgeshire and Peterborough (C&P) system and agreed contracted income from other NHS and non-NHS Commissioners.

The financial regime for 2026/27 continues to include commissioning via contracted values to inform direct allocations from NHS commissioners and the continuation of services provided to Local Authority Public Health commissioners. System allocations have been informed by a combination of the block contract funding, a reduction in and removal of non-recurrent allocations received during 2025/26, adjustments for movement to capitation-based funding, and uplifts in cost and funding for forecast growth and inflation.

The Trust's service portfolio for 2026/27 will not change materially and the overall initial expenditure budget totals £376m. On 18 March 2026, the Board approved a balanced plan for 2026/27, with a requirement to deliver a 4% efficiency target. This plan could also benefit from additional funding opportunities emerging during the financial year.

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 2026

Annual governance statement Scope of responsibility

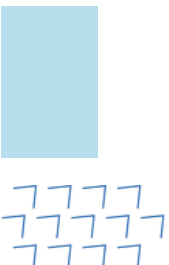
As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities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

The purpose of the system of internal control

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

Capacity to handle risk

The Board of Directors (the Board) has overall responsibility for ensuring that effective systems of risk management and internal control are in place and operating throughout the Trust. The Board provides strategic leadership and oversight, setting the tone for good governance and ensuring that risks to the delivery of the Trust's objectives are identified, assessed, and managed appropriately.



In discharging this responsibility, the Board:

Sets the strategic direction, vision, and Trust objectives, ensuring that these are aligned with the Trust's purpose and values. In doing so, the Board considers the internal and external risks that may affect the achievement of the strategy and establishes a clear risk appetite to guide decision-making.

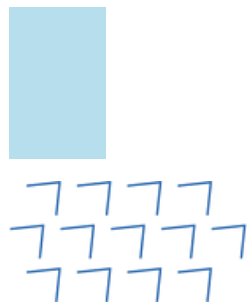
Ensures accountability for delivery of the strategy and organisational performance, holding executive management to account through regular performance reports, risk reports, and assurance processes. This includes oversight of financial sustainability, quality and safety, workforce capacity, and operational performance, ensuring that appropriate controls and mitigations are in place.

Oversees the effectiveness of the system of internal control, including arrangements for risk management, financial control, clinical and operational governance, and compliance with statutory and regulatory obligations. The Board receives assurance from its committees, including the Audit and Risk Committee, and from internal and external audit.

Promotes a positive culture of openness, integrity, and continuous improvement, fostering behaviours that support effective risk management and high-quality decision-making. The Board seeks to ensure that the Trust's culture encourages the early identification and escalation of risks, learning from incidents, and constructive challenge at all levels of the organisation.

Delegates specific responsibilities to Board committees, while retaining overall accountability. The Board regularly reviews committee effectiveness to ensure they provide robust scrutiny and assurance in relation to risk, control, and governance.

Through these arrangements, the Board gains reasonable assurance that the Trust's systems of governance, risk management, and internal control are effective in supporting the achievement of its objectives and in safeguarding public resources.



The risk and control framework

The Trust is not required to comply with the UK Corporate Governance Code. However, the Board considers strong corporate governance to be fundamental to the effective leadership and control of the organisation. Accordingly, the Trust reports on its corporate governance arrangements by drawing on recognised best practice, including those elements of the UK Corporate Governance Code that are considered relevant and proportionate to an NHS Provider Trust.

The Board operates in accordance with the Code of Governance for NHS Provider Trusts, supported by Standing Orders, Standing Financial Instructions and a Scheme of Reservation and Delegation. It demonstrates this through:

- Operating as a unitary Board with collective responsibility for the performance and governance of the Trust.

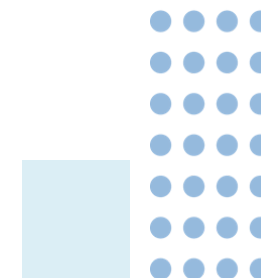
- Maintaining a strong focus on Board and committee effectiveness, supported by regular reviews of Board composition and skills, annual effectiveness evaluations, and delivery of actions arising from the well-led improvement plan.
- Providing transparency by openly considering Trust performance, quality, and risk in public Board meetings.
- Having a formal and transparent process for setting executive remuneration, in line with national guidance, overseen by a Remuneration committee.
- Effectively managing relationships with key stakeholders, including patients, staff, partners, regulators, and system colleagues.

NHS Provider Licence

The Board is satisfied that the Trust's governance arrangements are effective and meet the requirements of Section 4 of the NHS provider licence, providing appropriate leadership, oversight and accountability in support of the Trust's strategic objectives.

The Company Secretary provides ongoing advice to the Board on governance developments and emerging requirements.

Executive leadership is co-ordinated through the Executive Team, ensuring alignment between operational delivery and Board assurance.

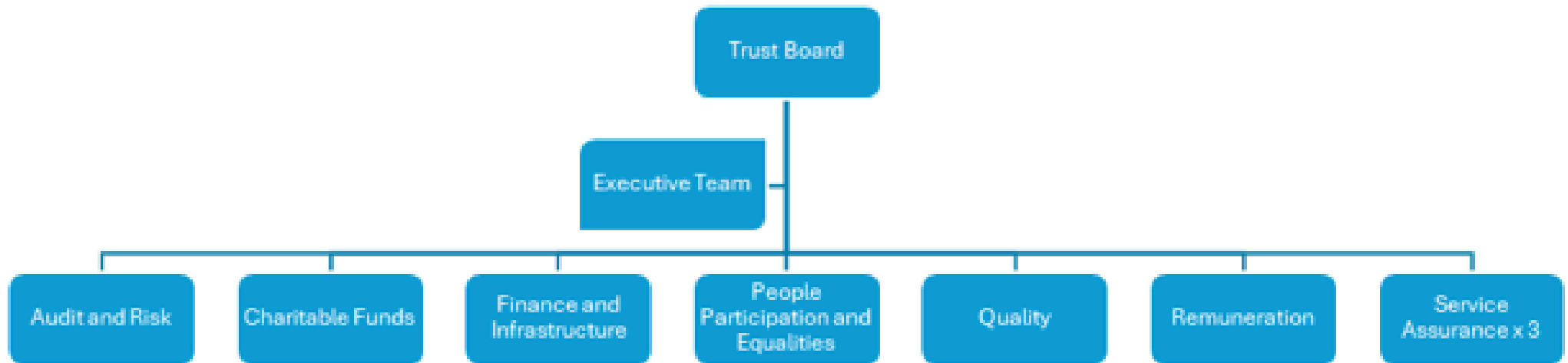


Reporting Lines and Accountability

The Trust operates a unitary Board, collectively responsible for strategy, performance, quality, risk and financial sustainability. The Board is supported by a formal committee structure, including Audit and Risk, Charitable Funds, Quality, People Participation and Equalities, Finance and Performance, and Remuneration.

Each committee operates under Board-approved terms of reference, reviewed annually, and provides assurance and escalation to the Board as appropriate.

The Trust also operates three Service Assurance Committees, through which clear reporting lines from operational, clinical and corporate functions into the Board's committees are established and routinely monitored.



Trust Board

During the year, the Trust Board met seven times in public session. In line with the Trust's commitment to openness and transparency, members of the public were able to submit questions in advance of meetings via the Trust's website and social media channels.

All Board meetings were appropriately constituted and quorate. Agendas and minutes of meetings were published and made publicly available on the Trust's website.

Attendance by individual directors at Trust Board and Board Committee meetings is set out on page 72 and 73 of this Annual Governance Statement and demonstrates appropriate engagement and participation throughout the year.

The Board comprises the Chair, the Senior Independent Director, and six other Non-Executive Directors, together with the Chief Executive and seven Executive Directors.

All Directors are required to meet the requirements of the Fit and Proper Person Test Framework, both on appointment and on an ongoing basis. The Trust has processes in place to provide assurance of continued compliance. Details of each Director's skills, experience and expertise are published on the Trust's public website:

<https://www.eastofenglandcommunityhealthandcare.nhs.uk/about-us/our-board/>

The Board was satisfied that it operated effectively during the year and discharged its responsibilities in accordance with its Standing Orders and governance arrangements.

Attendance at Board meetings and its Committees

The table below sets out the number of meetings attended by each Board member during 2025/26. Where membership of Board committees changed during the year, these are reflected in the attendance levels shown below indicating that individuals may not have been members of committees for the full year, or where directors attended meetings on an ad-hoc basis as 'ex-officio' members.

Name and Position	Board Meetings in public	Audit & Risk	Charitable funds	Finance and infrastructure	People participation &	Quality	Remuneration	Children and Young	Luton & Beds Adults	Norfolk adults service
Lynda Thomas (Trust Chair)	7(7)	-	2(2)	1*	-	1*	2(2)	1*	1*	1*
Charlotte Black (Non-Executive Director) from 1 September 2025	4(4) **	-	-		-	2(2)	-	-	4(4) **	-
Sarah Buchan (Chief Information Officer)	7(7)	-	-	6(6)	-	-	-	-	-	-
Laura Clear (Director of Strategy and Transformation)	6(7)	-	-	5(6)	-	-	-	5(6)	-	-
David Crawford (Non-Executive Director)	5(7)	4(4)	-	5(6)	-	-	-	-	5(6)	-
Steve Crowe (Non-Executive Director) until 21 May 2025	0(1)	-	-	1(1) **	-	-	-	0(1) **	-	-

Name and Position	Board Meetings in	Audit & Risk	Charitable funds	Finance and infrastructure	People participation &	Quality	Remuneration	Children and Young	Luton & Beds Adults	Norfolk adults service
Anna Gill (Non-Executive Director and Vice Chair)	6(7)	2(2) **	-	-	1(2)	5(5)	2(2)	6(6)	3(3) **	3(3) **
Rachel Hawkins (Director of Corporate Affairs)	6(7)	4(4)	1(2)	-	-	-	-	-	-	-
Kate Howard (Chief Nursing and Allied Health Professional Officer)	7(7)	-	-	-	1(2)	5(5)	-		3(6)	4(6)
Dr Caroline Kavanagh (Chief Medical Officer)	6(7)	-	-		-	4(5)	-	6(6)	-	5(6)
John Kennedy (Non-Executive Director; Senior Independent Director from 15 October 2025)	7(7)	4(4)	2(2)	2(3) **	-	-	-	-	-	-

Name and Position	Board Meetings in	Audit & Risk	Charitable funds	Finance and infrastructure	People participation &	Quality	Remuneration	Children and Young	Luton & Beds Adults	Norfolk adults service
Angela Moodie (Chief Finance and Resources Officer) from 21 July 2025	4(4) **	3(4) **	1(1) **	4(4) **	-	-	-	-	-	-
Graham Nice (Non-Executive Director, Vice Chair and Senior Independent Director) until 14 October 2025	4(4) **	1(2) **	-	-	-	4(4) **	-	-	-	2(3) **
Anita Pisani (Chief People Officer and Deputy Chief Executive)	5(7)	-	-	-	2(2)	5(5)	2(2)	-	6(6)	-
Jayne Sharma (Associate Non-Executive Director) from 1st October 2025	2(3) **	-	-	3(3) **	-	-	-	-	-	3(3) **

Name and Position	Board Meetings in	Audit & Risk	Charitable funds	Finance and infrastructure	People participation &	Quality	Remuneration	Children and Young	Luton & Beds Adults	Norfolk adults service
Mani Sharma (Non-Executive Director) from 1 September 2025	2(4) **	-	-	4(4) **	-	-	-	4(4) **	-	-
Matthew Winn (Chief Executive Officer)	7(7)	-	-	-	-	-	2(2)	-	-	5(6)
Njoki Yaxley (Non-Executive Director)	7(7)	-	-	-	2(2)	3(5)	2(2)	-	-	6(6)

Figures in brackets show total number of meetings members could have attended in year.

* Denotes attendance to observe only.

** Denotes appointment or committee membership either ended or started during the financial year.

NAMES	TITLE	COMMITTEE MEMBERS (* Indicates Chairs of that committee)
Lynda Thomas (Chair)	Trust Chair	Charitable Funds Committee; Remuneration Committee.
Charlotte Black	Non-Executive Director	Quality Committee; Luton & Bedfordshire Adults, and Ambulatory Service Assurance Committee* (both from 1 September 2025 as Associate Non-Executive Director, then as NonExecutive Director from 15 October 2025).
Sarah Buchan	Chief Information Officer	Finance & Infrastructure Committee.
Laura Clear	Director of Strategy and Transformation	Finance & Infrastructure Committee; Children & Young People's Service Assurance Committee.
David Crawford	Non-Executive Director	Finance & Infrastructure Committee; Audit & Risk Committee; Luton & Bedfordshire Adults, and Ambulatory Service Assurance Committee.
Steve Crowe	Non-Executive Director	Finance & Infrastructure Committee*; Children & Young People's Service Assurance Committee (both until 21 May 2025)

NAMES	TITLE	COMMITTEE MEMBERS (* Indicates Chairs of that committee)
Anna Gill	Non-Executive Director and Vice Chair	Quality Committee*; Children & Young People's Service Assurance Committee*; Norfolk Adults Service Assurance Committee* (from 15 October 2025); Luton & Bedfordshire Adults, and Ambulatory Service Assurance Committee* (from 1 April 2025 to 14 October 2025); Audit & Risk Committee (from 15 October 2025); People Participation & Equalities Committee; Remuneration Committee.
Rachel Hawkins	Director of Corporate Affairs	Audit & Risk Committee; Charitable Funds Committee.
Kate Howard	Chief Nursing and Allied Health Professional Officer	Quality Committee; Norfolk Adults Service Assurance Committee; Luton & Bedfordshire Adults, and Ambulatory Service Assurance Committee; People Participation & Equalities Committee.
Dr Caroline Kavanagh	Chief Medical Officer	Quality Committee, Children & Young People's Service Assurance Committee; Norfolk Adults Service Assurance Committee.
John Kennedy	Non-Executive Director and Senior Independent Director	Audit & Risk Committee*; Finance & Infrastructure Committee (from 1 April 2025 to 31 August 2025); Charitable Funds Committee*.

NAMES	TITLE	COMMITTEE MEMBERS (* Indicates Chairs of that committee)
Angela Moodie	Chief Finance & Resources Officer	Audit & Risk Committee; Finance & Infrastructure Committee; Charitable Funds Committee (all from 21 July 2025)
Graham Nice	Non-Executive Director and Vice Chair	Audit & Risk Committee; Quality Committee*; Norfolk Adults Service Assurance Committee* (all up to 14 October 2025);
Anita Pisani	Chief People Officer and Deputy Chief Executive	Quality Committee; People Participation & Equalities Committee; Luton & Bedfordshire Adults, and Ambulatory Service Assurance Committee.
Jayne Sharma	Associate Non-Executive Director	Finance & Infrastructure Committee; Norfolk Adults Service Assurance Committee (both from 1 October 2025).
Mani Sharma	Non-Executive Director	Finance & Infrastructure Committee*; Children & Young People's Service Assurance Committee (both from 1 September 2025)
Matthew Winn	Chief Executive	Norfolk Adults Service Assurance Committee.
Njoki Yaxley	Non-Executive Director	People Participation & Equalities Committee*; Remuneration Committee; Quality Committee; Norfolk Adults Service Assurance Committee.

Trust Board Development

Theme	Areas of Focus
Patient experience and engagement	• Briefing for Non-Executive Directors on the Patient Safety Incident Investigation process and learning • Application of the 15 Steps challenge approach by Non-Executive Directors to assess care quality and patient experience
Staff experience and engagement	• Freedom to Speak Up Guardian annual report and self-assessment • Board discussion of staff experience metrics and workforce culture indicators
Strategic issues	• Review of the Trust Strategy 2023-26 and the five supporting strategies and strategic ambitions • Overview of clinical services across the Group • Development of the Clinical and Care Strategy and Organisational Development Plan for the new merged Trust • (with effect from 1 April 2026), including Mission and Values, and the Full Business Case • Agreed parameters for business development and service growth • Financial strategy, efficiency plans and medium-term financial outlook for 2025/26 and future years • Collaborative working arrangements • Integrated Care System priorities and system-level developments • Group Model and Building Trust programme development • Review of risk appetite and strategic risks contained within the Board Assurance Framework • Consideration of emerging risks through the Board's risk radar • Well-led governance and leadership assurance • Digital transformation, including developments in artificial intelligence and cyber security • Review of its own effectiveness

The Audit and Risk Committee is an independent committee of the Board and provides assurance that the organisation has effective governance, risk management and internal control arrangements in place. The committee supports the Board in discharging its statutory duties by reviewing the comprehensiveness, reliability and integrity of assurances on the effectiveness of these systems.

The committee maintains oversight of the organisation's principal risks, including clinical, strategic, financial and emerging risks, and risks arising from delivery of the integrated business plan. It oversees the Board Assurance Framework, ensuring that risks are clearly articulated, aligned to strategic objectives and supported by appropriate controls and mitigating actions.

In fulfilling its role, the committee reviews the effectiveness of risk management and internal control processes, drawing assurance from the internal audit programme and from management representations. It monitors progress against agreed internal audit recommendations and reviews the adequacy of actions taken to address identified weaknesses.

The committee is constituted in accordance with the NHS Audit Committee Handbook. During 2025/26, the committee oversaw the audit of the 2025/26 financial statements and reviewed the Annual Governance Statement prior to submission to the Board. It approved and monitored delivery of the internal and external audit plans and reviewed the effectiveness of controls across the organisation, including arrangements for counter fraud.

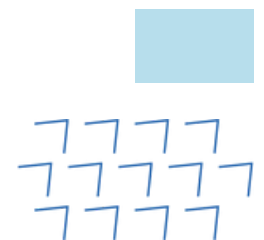
The committee met four times during the year. It reviewed reports from all internal audit assignments completed in accordance with the agreed 2025/26 audit plan. Based on the work undertaken, the committee was satisfied that it obtained appropriate assurance to inform the Board's assessment of the effectiveness of governance, risk management and internal control during the year.

Head of Internal Audit Opinion

Internal audit provided an overall reasonable level of assurance.

TIAA is satisfied that, for the areas reviewed during the year, Norfolk Community Health and Care NHS Trust have 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.



Counter fraud, anti-bribery and corruption

The Trust has established counter fraud, anti-bribery and corruption arrangements that are designed to prevent, detect and respond to fraud and bribery, and takes a zero-tolerance approach to such activity. These arrangements are aligned with the requirements and guidance of the NHS Counter Fraud Authority.

The Trust has a designated Local Counter Fraud Specialist and appropriate counter fraud resources in place to support the investigation and prevention of fraud, bribery and corruption. An anti-fraud and bribery policy is in place, supported by procedures that set out responsibilities, reporting mechanisms and standards of conduct.

Awareness-raising and preventative activity forms a key element of the Trust's counter fraud arrangements. During the year, targeted awareness sessions were delivered, including sessions for senior leaders, to reinforce staff responsibilities and promote a culture of vigilance and timely reporting.

All allegations of potential fraud or wrongdoing are treated seriously and are investigated in line with national guidance. Where appropriate, the Trust applies the full range of disciplinary, civil, regulatory and criminal sanctions, including seeking financial recovery. These arrangements provide the Board with assurance that proportionate and effective systems are in place to manage the risk of fraud, bribery and corruption as part of the Trust's overall system of internal control.

Counter fraud activity and outcomes are reported to the Audit and Risk Committee for oversight and assurance.

Charitable Funds

Norfolk Community Health and Care NHS Trust acts as the corporate trustee of its charitable funds. The Board, acting on behalf of the Trust as corporate trustee, is responsible for ensuring that charitable funds are managed, invested and applied effectively and in accordance with the Charities Act, Charity Commission guidance, NHS charity regulations and the specific wishes of donors.

The committee provides oversight of the governance arrangements for charitable funds, as delegated by the Board. This includes oversight of the management, investment and disbursement of charitable funds, and ensuring that appropriate systems of internal control and accountability are in place to support compliance with all relevant legal and regulatory requirements.

The committee met twice during the year and, through the work undertaken, provided assurance to the Board that the charitable funds were managed appropriately and in line with their stated objectives and donor intentions.

Finance and Infrastructure

The Finance and Infrastructure Committee is a joint committee of the Board and provides assurance that effective arrangements are in place to support the delivery of the Trust's financial, estates and digital strategies. The committee supports the Board by overseeing the development and implementation of these strategies and by ensuring that robust systems and structures are in place to support the delivery of high-quality and safe patient services.

The committee advises the Board on compliance with relevant legal and regulatory requirements and best practice, including health and safety, infection prevention and control, data protection, information security and sustainability. It also provides a formal route for reporting, escalation and engagement on finance, estates and digital matters between key operational groups, the Trust and commissioners.

The committee oversees finance, estates and digital risks, including risks on the strategic risk register and those captured within the Board Assurance Framework that fall within its remit. It also reviews the estates and digital risk registers to ensure that risks are appropriately identified, mitigated and escalated.

The committee was satisfied that it received appropriate assurance to inform the Board's oversight of finance, estates and digital matters.

The committee met on six occasions during the year.

People Participation and Equalities

The People Participation and Equalities Committee is a joint committee of the Board and provides assurance on the Trust's arrangements for people participation and equalities. The committee oversees the Trust's approach to engaging with service users, carers, communities and staff, and seeks assurance that this engagement informs service design, delivery and improvement.

The committee also provides oversight of the Trust's equality, diversity and inclusion arrangements, supporting the Board in understanding how the Trust promotes fairness, addresses inequalities and fosters an inclusive and 'speak-up' culture. Through its work, the committee supports continuous improvement driven by meaningful engagement and feedback.

The committee met twice during the year and provided assurance to the Board that appropriate arrangements are in place to support people participation and equalities within the Trust's overall governance framework. This includes assurance on compliance with relevant equality legislation and NHS guidance.

Quality

The Quality Committee is a committee of the Board and provides assurance on the effectiveness of the Trust's arrangements for quality, patient safety and clinical governance. The committee supports the Board in fostering a culture of continuous improvement, with patient safety at the heart of service delivery.

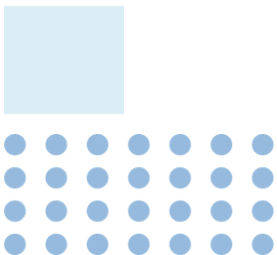
The committee oversees the systems and structures that support the delivery of high-quality, safe and effective care and provides assurance that the Trust meets its duties and responsibilities to patients, service users and staff. This includes oversight of quality standards, clinical risk management, research governance and learning from incidents and feedback.

The committee advises the Board on compliance with quality-related regulatory and accreditation requirements and contributes to the development of key clinical and quality strategies, monitoring progress against agreed objectives.

The committee also oversees arrangements to protect the health, safety and wellbeing of staff, and reviews and approves the annual clinical audit programme, ensuring that learning from audit is embedded and informs service improvement.

The committee met five times during the year and considered a range of quality improvement themes. Through its work, the committee provided assurance to the Board on the effectiveness of quality governance and the Trust's arrangements for patient safety and continuous improvement.

The committee monitored learning from incidents, complaints and patient experience to support improvement and transparency.



Remuneration Committee

The Remuneration Committee is a committee of the Board and provides assurance that the Trust's arrangements for remuneration at executive level are fair, equitable and applied consistently. The committee also supports the Board in relation to executive succession planning and appointments.

During the year, the committee met once to discharge its responsibilities. Matters considered included the review of executive remuneration, consideration of executive appointments and succession planning arrangements, and assurance that Fit and Proper Persons Test checks had been completed for all directors.

The committee also considered workforce change matters falling within its remit, including redundancies, ensuring that these were managed appropriately and in line with relevant policies and legal requirements.

Through its work, the committee provided assurance to the Board that remuneration and associated governance arrangements were applied appropriately and in accordance with best practice.

No issues of non-compliance with remuneration regulations or Fit and Proper Persons requirements were identified.

Service Assurance Committees

The following Service Assurance Committees were in place during the year:

- Norfolk Adult Services
- Children and Young People's Services
- Luton and Bedfordshire Adult and Older People's Services, and Ambulatory Care

The Service Assurance Committees are joint committees that provide service-level assurance to the Board. Each committee met six times during the year and supports the Board through integrated analysis of performance and intelligence across quality, safety and patient experience, workforce wellbeing and morale, and key risks and operational issues.

The committees identify areas of concern requiring Board attention or action and provide a structured route for escalation of exceptions, risks and issues. In addition, they support a culture of learning and continuous improvement by sharing, disseminating and recognising good and outstanding practice across services.

Through this role, the Service Assurance Committees provide the Board with assurance that robust oversight mechanisms are in place at service level and that emerging issues are identified, managed and escalated appropriately.

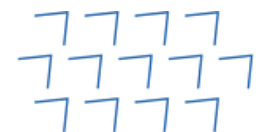
This consistent approach to service-level assurance supports the Board's oversight across all places and care groups.

Risk management and internal control

The Board is responsible for the delivery of the Trust's objectives and for ensuring that effective systems of risk management and internal control are in place. This includes oversight of risk management, counter-fraud and bribery arrangements, internal and external audit, and internal financial control.

During the year, progress has been made to strengthen risk management arrangements across the group. Key developments include the implementation of a joint Board Assurance Framework, incorporating a defined risk appetite and an emerging risk radar. The Trust also received reasonable assurance from its internal audit review of risk maturity, which confirmed there were reasonable and effective risk management, control and governance processes in place. The Trust operates a group-wide risk and issue management policy, revised in December 2025. The policy sets out the approach to identifying, assessing, recording, escalating and managing risks and issues, and reinforces the open and transparent culture expected by the Board. Standardised assessment of likelihood and consequence is applied consistently.

The Board and its committees receive regular integrated reports covering risk, quality, finance and performance, including progress against actions to mitigate principal risks. The Board Assurance Framework sets out the principal risks and issues affecting delivery of each Trust's objectives, identifies key controls and sources of assurance, and highlights gaps where further action is required. As part of its well-led improvement priorities, the Trust continues to strengthen the effectiveness and clarity of the Board Assurance Framework.



Executive leads are identified for all principal risks and are responsible for ensuring appropriate controls and mitigations are in place. The strategic risk and issue register is reviewed bi-monthly by the Board. In line with the escalation framework, all risks rated 15 or above and issues rated 5 are escalated to the Board, with lower-rated risks and issues subject to regular review through Board aligned committees.

Risks relating to fraud, bribery and corruption are managed through dedicated policies and oversight arrangements, with assurance provided to the Board via the Audit and Risk committee.

Risk is assessed at all levels of the organisation and recorded on a single, organisation-wide electronic risk register, enabling effective identification and escalation of both operational and strategic risks. Key sources of assurance include integrated performance reporting, committee oversight, internal and external audit, regulatory reviews and other external assurance mechanisms.

The principal strategic risks for 2025/26 are set out in the table below, as of 31 March 2026.

Number	Risk description	Score
3655	There is a risk that the non-executive and executive and wider senior leadership capacity and expertise required to deliver the transaction to support the move to a new/single organisation will result in failure to deliver the current quality, operational, workforce and financial performance and plans.	9
3656	If stakeholders withdraw their support, there is a risk that the group model programme and transaction could not be delivered and therefore impact the performance and delivery of the existing services of the Trust and sustainability in the future.	6
3653	There is a risk that clinical quality and patient safety could be compromised if the following areas are not managed / mitigated: gaps in staffing/staff morale, group model planning, financial pressures and cost efficiencies and compliance with regulatory bodies. The impact of this potential risk could lead to an increase in the level of 'harm', a reduction in clinical quality/safety across services and an increase in patient dissatisfaction.	12
3699	There is a risk that staff morale and engagement may be adversely affected whilst we culturally align our two organisations.	8

Number	Risk description	Score
3709	If we do not address cybersecurity threats (such as data breaches and patient privacy, ransomware, operational disruption, insider threats and third-party risks) then there is an increased likelihood of a major service disruption and possible compromise to patient care.	16
3837	There is a risk that if suppliers integrate AI (Artificial Intelligence) components or subcontract to third-party AI providers without disclosure or adequate contractual controls, then the organisation will have no visibility or assurance over how patient or operational data is processed and how AI influences clinical or business decisions, leading to potential patient harm, regulatory breaches (GDPR / DSPT), financial penalties, and reputational damage to the Group.	12
3708	If NCH&C and CCS cannot secure recurrent and long-term efficiencies and/or additional resources, it may not be able to fund increasing demand for services in future years.	12
3751	Long waits for children for diagnostic assessment from our neurodevelopmental services	16
3770	There is a risk that fraudulent activity could result in significant loss to the Trust	9
3732	NCH&C move to National Tenant – there is a risk that patients could misinterpret the signposting and not contact the new organisation / service due to the old name still being used. In addition, staff at other organisations may not be able to contact staff.	12
3707	If the Trust is not able to deliver the 2025/26 financial breakeven plan, then the Trust risks contributing to an ICS failure to break even. This will lead to a need to repay the system (and Trust) deficit in future years and will result in additional scrutiny from NHS England.	12

Compliance with the Developing Workforce Safeguards recommendations

The Trust is committed to ensuring safe, effective, and sustainable staffing arrangements and has embedded the principles of the Developing Workforce Safeguards into its governance, planning, and operational processes. The Board recognises that effective workforce safeguards are critical to the delivery of high-quality, safe patient care and to the wellbeing of staff.

Board oversight and accountability

The Board maintains clear oversight of workforce risks and safeguards through regular reporting on workforce performance, capacity, and capability. Workforce metrics, including staffing levels, turnover, sickness absence, use of temporary staffing, and staff wellbeing indicators, are routinely reviewed by the Board and its committees. Workforce risks are explicitly reflected within the Board Assurance Framework and Trust Risk Register, ensuring that strategic and operational workforce risks are identified, mitigated, and subject to appropriate assurance.

Safe and effective workforce planning

Workforce plans are developed using evidence-based tools and methodologies, including professional judgement and national guidance, to ensure that staffing models support safe care and reflect current and anticipated service need. These plans are regularly reviewed and updated to remain responsive to changes in demand, workforce availability, and system priorities.

Escalation and mitigation of staffing risks

Clear processes are in place to identify, escalate, and manage staffing risks at team/ward, departmental, and organisational levels. Where staffing shortfalls arise, mitigation actions, such as redeployment, adjusted skill mix, temporary staffing, or revised service arrangements, are implemented in line with agreed escalation policies. These arrangements ensure that risks to patient safety and staff wellbeing are promptly addressed and that learning is captured to reduce future recurrence.

Workforce capability, wellbeing, and culture

Consistent with the Developing Workforce Safeguards recommendations, the Trust places strong emphasis on workforce capability, training, and wellbeing. The Trust invests in education, professional development, and leadership capability to ensure staff are competent, supported, and able to deliver safe care. Initiatives to promote health and wellbeing, equality, diversity, and inclusion, and freedom to speak up are embedded across the organisation, supporting a positive culture in which staff feel empowered to raise concerns about safety or staffing without fear of detriment.

Use of temporary staffing

The Trust has appropriate controls in place to manage the use of temporary staffing, ensuring that agency and bank staff are used safely, effectively, and as a last resort. Governance arrangements ensure value for money, continuity of care, and maintenance of quality standards, with regular monitoring and reporting of temporary workforce usage to support assurance.

Continuous improvement and assurance

The Trust undertakes regular reviews of workforce safeguards through internal audit, committee scrutiny, and triangulation of data from quality, workforce, and finance sources. Learning from incidents, feedback from staff, and outcomes from national surveys inform continuous improvement of workforce planning and safeguards. Compliance is kept under ongoing review to ensure arrangements remain effective, proportionate, and aligned with national expectations.

Through these measures, the Trust can provide assurance that workforce safeguards are embedded within its governance arrangements and that workforce risks are actively managed in support of safe, high-quality patient care.

Care Quality Commission

The Quality Committee provides assurance on clinical governance, patient safety and quality improvement arrangements. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

Managing conflicts of interest

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. <https://www.eastofenglandcommunityhealthandcare.nhs.uk/about-us/our-board/>

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, including the completion of quality and equality impact assessments.

Green Plan

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

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

During a period of continued and significant challenge across the health sector, the Trust achieved a breakeven financial position. This outcome reflects the effectiveness of the Trust's robust financial governance arrangements and disciplined financial management, which have enabled the delivery of operational priorities while maintaining financial balance.

Key messages for the year

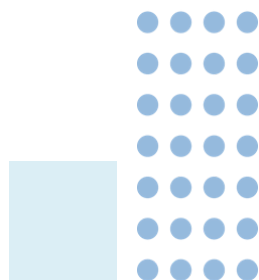
The Trust maintained financial governance, as reflected in the internal audit opinion of substantial assurance over the operation of financial systems, budgetary control, and financial improvement arrangements.

The Trust recognises its responsibility to pay suppliers in accordance with agreed payment terms. Timely payment is essential to maintaining the Trust's reputation, supporting supplier sustainability, and ensuring value for money across the wider NHS.

The Trust continues to operate in line with the NHS Better Payment Practice Code, which sets a target for at least 95% of trade payables to be settled within 30 days of receipt of a valid invoice or delivery of goods, unless alternative terms have been agreed.

During the year, the Trust's performance against this target improved for both NHS and non-NHS trade payables. Detailed performance information is set out in the annual accounts.

The Trust will continue to focus on strengthening its financial control environment, monitoring performance against national payment standards, and embedding continuous improvement to support sustainable financial management in future years.



Information governance

The Trust has not experienced any serious information governance incidents, including data loss or confidentiality breaches, that required reporting to the Information Commissioner's Office or the Department of Health and Social Care via the Data Security Incident Reporting Tool.

Data quality and governance

The Trust has established arrangements to support the accuracy and quality of clinical and performance data. Oversight is provided through the Data Quality Group, which reviews data quality assurance and reports to the Trust Board. In addition, a records management clinical audit is undertaken annually to provide assurance on compliance with records management standards.

Clinical data is subject to validation, with routine data quality reports provided to service directors and service leads. Where issues are identified, actions for improvement are agreed and monitored through the Data Quality Group.

The Trust does not provide elective services and therefore does not hold elective waiting time data. Other relevant waiting time data is monitored on a monthly basis, with exception reports provided to service leads to support review, escalation and corrective action where required.

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 and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Conclusion

A review into the Trust's policy on relationships at work provided limited assurance that the Trust's arrangements for implementing the policy and managing personal relationships are effective. Weaknesses were identified in the consistent application, recording, and oversight of declarations, and as a result, the Trust could not fully demonstrate that all potential conflicts of interest or risks of misuse of authority were being consistently identified and appropriately managed.

Since the findings, all agreed actions have been implemented agreed which have strengthened the controls and oversight. Delivery of these improvements ensure a more robust and consistent approach across the organisation.

Signed

A handwritten signature in dark ink, appearing to read 'Matthew Winn', followed by a long horizontal line extending to the right.

Matthew Winn

Chief Executive

Date: 24 June 2026

Modern Slavery Act

We fully support the Government's objectives to eradicate modern slavery and human trafficking and recognise the important role NHS Trusts play in preventing exploitation and supporting individuals who may be affected.

We are committed to acting ethically and with integrity in all our activities and to ensuring that our employment practices, procurement arrangements and supply chains uphold high ethical and labour standards.

As an NHS Trust, we take a risk-based approach to identifying, assessing and managing the potential risk of modern slavery and human trafficking, with consideration given to higher-risk areas such as workforce supply, estates and facilities services, and external contractors. Our procurement and contract management processes align with NHS Standard Contract requirements and relevant national guidance, and we expect our suppliers to share our commitment to ethical working practices.

We promote awareness of modern slavery through safeguarding arrangements and relevant staff training, and we have clear processes in place to escalate and respond to concerns. Where potential victims are identified, we work in partnership with local safeguarding teams and other statutory agencies to ensure appropriate support and referral pathways are followed.

Our Slavery and Human Trafficking Statement for 2025/26 has been approved by the Trust Board on 21 May 2025 and is published on our website as part of our commitment to transparency and continuous improvement.



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 2025/26 The following table is subject to audit.

Name	Title			2025/26				
		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)	Total Remuneration (Bands of £5,000)
Charlotte Black	Non-Executive Director	5/10/2026	1	-	-	-	5/10/2026	10/15/2026
Sarah Buchan	Chief Information Officer	65-70	4	-	-	30-32.5	100-105	170-175
Laura Clear	Director of Strategy & Transformation	55-60	5	-	-	5-7.5	60-65	115-120
David Crawford	Non-Executive Director	5/10/2026	-	-	-	-	5/10/2026	15-20
Steven Crowe	Non-Executive Director	0-5	-	-	-	-	0-5	5/10/2026
Anna Gill	Non-Executive Director	5/10/2026	3	-	-	-	10/15/2026	20-25
Rachel Hawkins	Director of Governance	45-50	-	-	-	55-57.5	105-110	150-155
Lydia Howard	Chief Nurse	70-75	3	-	-	142.5-145	215-220	285-290
Caroline Kavanagh	Medical Director	85-90	-	-	-	137.5-140	225-230	315-320
John Kennedy	Non-Executive Director	5/10/2026	1	-	-	-	5/10/2026	15-20
Emma Lunny*	Director of Finance and Performance	15-20	-	-	-	10-12.5	25-30	25-30
Angela Moodie**	Chief Finance & Resource Officer	50-55	5	-	-	17.5-20	70-75	120-125
Graham Nice	Non-Executive Director	5/10/2026	2	-	-	-	5/10/2026	10/15/2026
Anita Pisani	Chief People Officer / Deputy Chief Executive	80-85	4	-	-	152.5-155	235-240	315-320
Jade Schiebler*	Director of Finance and Performance	25-30	-	-	-	5-7.5	30-35	30-35
Jayne Sharma	Associate Non-Executive Director	5/10/2026	-	-	-	-	5/10/2026	15-20
Muneesh Sharma	Non-Executive Director	5/10/2026	-	-	-	-	5/10/2026	15-20

Name	Title			2025/26				
		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)	Total Remuneratio n (Bands of £5,000)
Lynda Thomas	Chair	25-30	3	-	-	-	25-30	55-60
Matthew Winn	Chief Executive	100-105	2	-	-	130-132.5	230-235	335-340
Njoki Yaxley	Non-Executive Director	5/10/2026	-	-	-	-	5/10/2026	15-20

*Post holders were temporary Directors of Finance and Performance for Norfolk Community Health & Care, whilst substantive post was vacant. Salary and associated benefits have been apportioned to account for duration in post 14th April - 20th July.

** Post holder commenced in post 21st July 2025.

****All post holders with the exception of those in temporary Director of Finance posts were cross charged between Norfolk Community Health & Care NHS Trust and Cambridgeshire Community Services NHS Trust. Additional column in the table represents full remuneration of members.

***** During the period 2025/26, two directors listed in the previous year (Carolyn Fowler and Andrew Hopkins) were subject to compulsory redundancy and received the following payments:

Carolyn Fowler - £21,570 compulsory redundancy plus £44,339 payment in lieu of notice Andrew Hopkins - £160,000 compulsory redundancy payment. NB: A "-" indicates nil value.

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.

Salaries and allowances of Board members in 2024/25 The following table is subject to audit.

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

* 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.

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.

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 205/26 was £102,500 (2024/25, £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 2026. 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.

2025-26	25th percentile	Median	75th percentile
Mid-point of banded remuneration of highest paid director	102,500	102,500	102,500
Total remuneration £	26,600	32,876	46,580
Salary component of total remuneration £	24,904	30,162	44,007
Pay ratio information	3.9	3.1	2.2

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
2025/26	Percentage change for highest paid director	Percentage change based on median employee	
Salary and allowances	28.20%	0.50%	
Performance pay and bonuses	-	-	
Salary, allowances, performance pay and bonuses combined	28.20%	4.50%	
2024/25	Percentage change for highest paid director	Percentage change based on median employee	
Salary and allowances	-	-1.87%	
Performance pay and bonuses	-100.00%	-	
Salary, allowances, performance pay and bonuses combined	-	-13.30%	

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”.

An outline of these follows:

a) Accounting valuation

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

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



b) Full actuarial (funding) valuation

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



	2025/26	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 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025 (to nearest £1,000)	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026 (to nearest £1,000)
Name	Title	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Sarah Buchan	Chief Information Officer	0-2.5	-	10/15/2026	0-5	154	21	195
Laura Clear**	Director of Strategy & Transformation	0-2.5	-	65-70	175-180	132	25	173
Rachel Hawkins	Director of Governance	2.5-5	2.5-5	45-50	120-125	1,062	71	1,164
Lydia Howard	Chief Nurse	5-7.5	12.5-15	50-55	125-130	967	144	1,145
Caroline Kavanagh	Medical Director	5-7.5	10-12.5	80-85	200-205	1,761	167	1,981
Emma Lunny	Director of Finance and Performance	0-2.5	2.5-5	20-25	50-55	398	39	451
Angela Moodie***	Chief Finance & Resource Officer	0-2.5	-	0-5	0-5	-	3	24
Anita Pisani	Chief People Officer / Deputy Chief Executive	7.5-10	12.5-15	70-75	175-180	1,441	177	1,663
Jade Schiebler	Director of Finance and Performance	0-2.5	-	10/15/2026	0-5	130	14	157
Matthew Winn	Chief Executive	5-7.5	10-12.5	70-75	165-170	1,394	142	1,585

*The above table discloses their full pension values.

** Laura Clear is NRA, therefore a CETV calculation is not required.

*** There are no preceding period figures, balances, or transactions to report alongside current figure

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.

Staff costs

			2025/26	2024/25			
	Permanent	Other	Total	Total			
	£000	£000	£000	£000			
Salaries and wages	92,873	4,608	97,481	93,481			
Social security costs	11,993	543	12,536	9,477			
Apprenticeship levy	478	-	478	465			
Employer's contributions to NHS pension scheme	20,720	975	21,695	20,718			
Pension cost - other	25	-	25	32			
Other post employment benefits	-	-	-	-			
Other employment benefits	0	-	0	-			
Termination benefits	-	-	-	1,087			
						386	386
Temporary staff	-			1,377		126,088	6,511
						(12)	-
Total gross staff costs			126,637			132,599	-
						126,076	6,511
						132,588	126,637
Recoveries in respect of seconded staff							
Total staff costs							
Of which							
Costs capitalised as part of assets	490	-	490	452			
Average number of employees (WTE basis)							
	Permanent	Other	2025/26	2024/25			
	Number	Number	Number	Number			
Medical and dental	15	0	15	15			
Ambulance staff	-	-	-	-			
Administration and estates	460	8	468	513			
Healthcare assistants and other support staff	666	64	729	722			
Nursing, midwifery and health visiting staff	789	33	822	773			
Nursing, midwifery and health visiting learners	-	-	-	-			
Scientific, therapeutic and technical staff	388	5	393	406			
Healthcare science staff	5	-	5	3			
Social care staff	-	-	-	-			
Other	51		51		-	7	
Total average numbers	2,374	110	2,484	2,440			
Of which:							
Number of employees (WTE) engaged on capital projects	65	-	65	7			

Exit packages

The following table is subject to audit.

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
	Mar 31, 2026	£'000	Mar 31, 2026	£'000	Mar 31, 2026	£'000	Mar 31, 2026	£'000
<£10,000								
£10,000 - £25,000			2	36	3	36		
£25,001 - £50,000			4	150	4	150		
£50,001 - £100,000	1	66	1	50	1	116		
£100,001 - £150,000								
£150,001 - £200,000	1	160			1	160		
>£200,000								
Total	2	226	7	236	9	462	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.

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF EAST OF ENGLAND COMMUNITY HEALTH AND CARE NHS TRUST IN RESPECT OF NHS NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS **Opinion ?**

We have audited the financial statements of Norfolk Community Health and Care NHS Trust ("the abolished Trust") for the year ended 31 March 2026 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the abolished Trust as at 31 March 2026 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State for Health and Social Care with the consent of HM Treasury on 23 June 2022 as being relevant to NHS Trusts in England and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended). Basis for opinion

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

Emphasis of matter – going concern

We draw attention to the disclosure made in note 1.2 to the financial statements which explains that on 1 April 2026 the abolished Trust was dissolved and its services transferred to the successor Trust. Under the continuation of service principle, the financial statements of the abolished Trust have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in this respect.



Going concern

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

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

Our conclusions based on this work:

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

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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



- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the highlevel policies and procedures to prevent and detect fraud, including the internal audit function, and the channel for “whistleblowing”, as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Assessing the incentives for management to manipulate reported financial performance as a result of the need to achieve financial performance targets delegated to the abolished Trust by NHS England.

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

As required by auditing standards and taking into account possible pressures to meet the abolished Trust’s delegated targets, we performed procedures to address the risk of management override of controls, in particular the risk that management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the abolished Trust during the year. We therefore assessed that there was limited opportunity for the abolished Trust to manipulate the income that was reported.

We also identified a fraud risk relating to the liabilities for purchases not being completely identified and recorded, being recorded where they do not exist or recorded inaccurately in response to incentives to manipulate the results of the abolished Trust to meet their adjusted performance target for the year particularly in relation to accruals.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included journal entries with unusual characteristics compared to the total journal population.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Selecting a sample of year end accruals and inspect evidence of the actual amount paid after year end and other supporting information in order to assess whether the accrual exists and has been accurately recorded.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, there are laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items. Secondly, there are many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, antibribery, employment law, contract law, climate change and environmental protection and compliance with the Care Quality Commission (CQC) recognising the nature of the abolished Trust's activities.

Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and other management and inspection of regulatory and legal correspondence, if any. Therefore, if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect noncompliance with all laws and regulations.



Other information in the Annual Report and Accounts

The Accountable Officer of the successor Trust is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2025/26.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page [X], the Accountable Officer of the successor Trust is responsible for the preparation of financial statements of the abolished Trust that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the successor Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the abolished Trust or dissolve the abolished Trust without the transfer of its services to another public sector entity.



Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS Report on the abolished Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the abolished Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page [X], the Accountable Officer is responsible for ensuring that the abolished Trust exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the abolished Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the abolished Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the abolished Trust has achieved value for money during the year.

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

Statutory reporting matters

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

- we issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the successor Trust in respect of the abolished Trust under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the abolished Trust, or an officer of the abolished Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.



The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Board of Directors of NHS East of England Community Health and Care Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of directors of the successor Trust in respect of the abolished Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of directors of the successor Trust in respect of the abolished Trust, as a body, for our audit work, for this report or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

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

Until we have completed this work, we are unable to certify that we have completed the audit of NHS Norfolk Community Health and Care Trust for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.

Jessica Hargreaves for and on behalf of KPMG LLP

Chartered Accountants

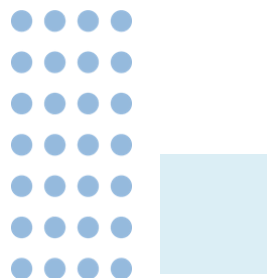
KPMG LLP

15 Canada Square

London

E14 5GL

24 June 2026



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 have 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

A handwritten signature in dark ink, appearing to read 'Matthew Winn', followed by a long horizontal flourish.

Matthew Winn

Chief Executive

Date 24 June 2026

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 policies 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
Date: 24 June 2026



Angie Moodie
Finance Director
Date: 24 June 2026

