Norfolk Community Health and Care NHS Trust

Annual Report and Accounts 2017/18

Final version 24.05.18

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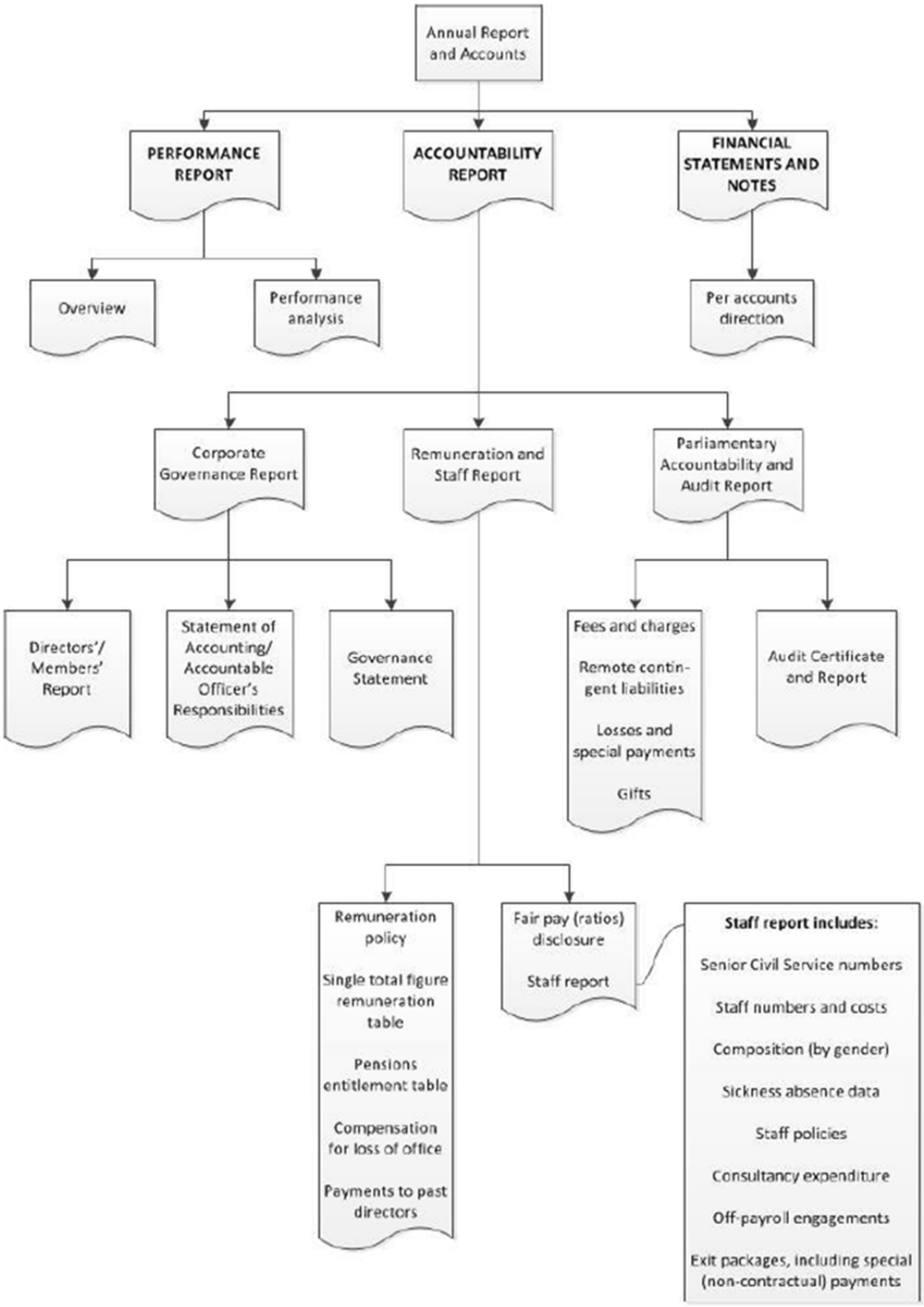
Abbreviations used in this report:
Norfolk Community Health and Care NHS Trust - NCHC
NHS England - NHSE
NHS Improvement - NHSI
Clinical Commissioning Groups - CCGs
Norfolk County Council - NCC
Care Quality Commission - CQC
Non-Executive Director - NED

In summary, the structure of the Annual Report and Accounts is determined by the Government's Financial Reporting Manual as follows:



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A. PERFORMANCE REPORT

1. Overview

This section of the Annual Report includes:

1.1 Chief Executive's statement
1.2 Statement of the purpose and activities of the Trust
1.3 Key risks and issues
1.4 Performance summary

The purpose of the overview section is to give the reader a short summary that provides 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 will be enough for the lay reader to have no need to look further into the rest of the Annual Report and Accounts unless they are interested in further detail or have specific accountability or decision-making needs to be met.

The overview includes a statement from the Chief Executive providing her perspective on the performance of the organisation over the year, a statement of the purpose and activities of the organisation, the key issues and risks that could affect the organisation in delivering its objectives, and a performance summary.

1.1 Chief Executive's statement

Team NCHC has achieved a great deal during this year in relation to all three of our strategic objectives and at the time of writing our CQC inspection has been completed and we are awaiting our outcome report and rating. We have delivered a number of efficiency changes that have contributed to our cost improvement plans and we have continued to ensure through the application of our quality impact assessment that these have not resulted in negative impact on our quality and safety. We end the year having achieved our revised financial forecast plan be it in a deficit position for the first time in the Trust's history. Doing so has been a challenge to which everyone has stepped up, working hard to ensure we met this whilst keeping improving our quality as our first and primary objective. Overall performance against our many key performance indicators has been sustained at a high level and where we put in place required improvement plans we have met these.

Improvements in patient safety are evident in year, including to our Safety Thermometer results, seeing reduced levels of new harms at 3.8%. Numbers of preventable pressure ulcers have continued to decline and the considerable work we have undertaken in relation to this has been recognised through our shortlisting for a Health Service Journal Patient Safety Award. Our Friends and Family test results are a real credit to all NCHC staff given we have continued this year to sustain these at 98%. Likewise staff's continued commitment to patient satiety is evidenced by our sustained mandatory training levels at over 90% and our staff flu vaccination rates for this year rising significantly to 76%.

Our Health Coach training has resulted in a further increase in staff with these skills

and we plan to accelerate this programme significantly next year following excellent feedback from staff and patients involved. Our Quality Champion Programme that we launched at the tail end of last year has seen over 50 staff take part in the training and undertake quality improvement projects as a result, following its recent evaluation we will be increasing the availability of the programme going forward. The Trust's PLACE (Patient Led Assessment of the Care Environment) scores have improved such that in most domains we are above the national average score. The involvement of patients and the public in these assessments and the development and delivery of our patient involvement strategy has been crucial to our making improvements, listening to, taking on board and acting upon different experiences and views. One of the consequences of this has been our focused efforts on supporting people from our communities to undertake bespoke volunteer roles within the Trust of which there are currently over 100 people supporting us to improve the quality of care and the experience of the services we provide.

Our approach to establishing a Freedom to Speak Up (F2SU) regime within NCHC has received recognition from the National Guardian through our citation in the first national F2SU annual report. Over 40 staff have made contact about their concerns through one of the many F2SU routes we have in place and all have received personal follow up from our Guardian regarding their views on the outcome achieved. Our objective of Enabling our Staff has received equal emphasis throughout this year. The "Your Voice Our Future" platform launched last year has enabled us to continue to improve upon how we engage with staff, listen to their views and action their ideas. Amongst the several "you said we did" actions was a commitment to implement a new Leadership Promise. As part of the launch all leaders in the Trust have taken facilitated time out to consider how they will improve delivery of the promise and everyone is now able to challenge where delivery on this promise is not experienced.

Our approach to talent management has been recognised both within our local health and care system where we are working with others now to support wider implementation and externally through our shortlisting for a Health Service Journal award in relation to this work. We have continued to embed our values of community, compassion and creativity that underpin all that we do as the means of supporting all in team NCHC to be the best they can be. Both our local short staff survey and national staff survey results during this year indicate a number of areas of real improvement including the increase in our overall staff engagement score. Our plans around our Enabling our Staff objective for next year are designed to build upon and keep momentum in relation to this.

Our approach to Sustaining the Future during this year has focused on working in collaboration, building upon the integrated health and social care services we have developed with Norfolk County Council for adults and using this as our joint platform to support the development of new models of care with Primary Care and other partners across Norfolk and Waveney. We have piloted and developed in partnership a number of new models of care and service delivery for example the First Response Vehicle with our paramedic colleagues from the East of England Ambulance Service that aims to prevent conveyance to hospital where other interventions can be put in place. Other examples include; in conjunction with colleagues in Primary Care, a new Supported Care Model that aims to provide care at home instead of a hospital

setting and with Primary Care, Mental Health and the Voluntary Sector an Escalation Avoidance Team that aims to avoid admissions to hospital. We have also continued to nurture and support innovation within the Trust. This year has seen us as a “come to” Trust for ideas and support on best practice and effectiveness which has seen us host 18 or so other Trust visits to NCHC as a result of our involvement in the Lord Carter work on Community and Mental Health Trusts. We have seen a large number of innovation pieces go live during this year via the use of technology, for example our Autism services is using virtual reality technology in parenting workshops to simulate the experiences of those with Autism and we have rapidly moved forward with the provision of microprocessor knees which has enabled children to run again using running blades.

This report enables us all to see Team NCHC’s progress and gives a flavour of some of the amazing contributions individuals and teams of staff are making every single day to realise our vision of: *Improving the quality of people’s lives in their homes and communities by providing the best integrated health and social care.*

There have also been a number of challenges throughout the year including the safe transfer of Suffolk community health services to another provider which has resulted in a £21m income loss to NCHC. The loss of such a significant service led the Trust to revise its financial forecast for the year, moving from a planned surplus of £2.0m, supported by a £6.2m efficiency programme to a planned deficit of £2.0m supported by a £3.0m efficiency programme. The Trust is also addressing some high risk internal control issues in IT disaster recovery, business continuity and cyber security.

The Annual Report and Accounts is usefully read in conjunction with our:

Annual Plan: describes in more detail our plans and priorities for the next two years.
Quality Account: provides more detail on the quality of our services including patient safety, the patients’ experiences, clinical effectiveness and outcomes for patients, quality governance, and our future strategy in clinical services.

These documents are available on the Trust’s website.

1.2. Statement of the purpose and activities of the Trust

NCHC 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 (NCHC reference: 2010 no. 2466). Services are commissioned by clinical commissioning groups (CCGs), Norfolk County Council (NCC) and NHS England (NHSE).

This section includes NCHC’s:

1.2.1 Vision and strategic priorities: Improving Our Quality, Enabling Our People, Securing The Future.
1.2.2 Values: Community, Compassion, Creativity
1.2.3 Services provided by NCHC.
Longer term plans:

1.2.4 Health and Care Strategy
1.2.5 Sustainability and Transformation Partnership
1.2.6 Transformation Programme
1.2.7 Integration with Adult Social Care.

Graphic showing our Vision and Values

1.2.1 Vision and strategic priorities

Our vision is to “Improve the quality of people’s lives in their homes and community, by providing the best integrated health and social care.” It will be delivered through the achievement of three longer term strategic priorities. These are: Our Quality, Our People and Securing The Future.

Improving Our Quality: through delivering harm free, clinically effective and compassionate care; involving patients and the public and delivering excellent patient experience; and integrating delivery with social and primary care and having effective partnerships with other organisations.

Enabling Our People: through inspiring staff; empowering staff to speak out and put things right; ensuring the right staff, with the right skills, are available to deliver compassionate care; transforming services; and demonstrating effective leadership.

Securing The Future: through delivering what commissioners want; delivering a financially sustainable organisation; investing in infrastructure; and growth.

1.2.2 Values

Our values of Community, Compassion and Creativity were developed following extensive consultation and engagement with our staff, patients, service users and wider stakeholders. They describe our approach to everything that we do, support our decision making and guide our interactions.

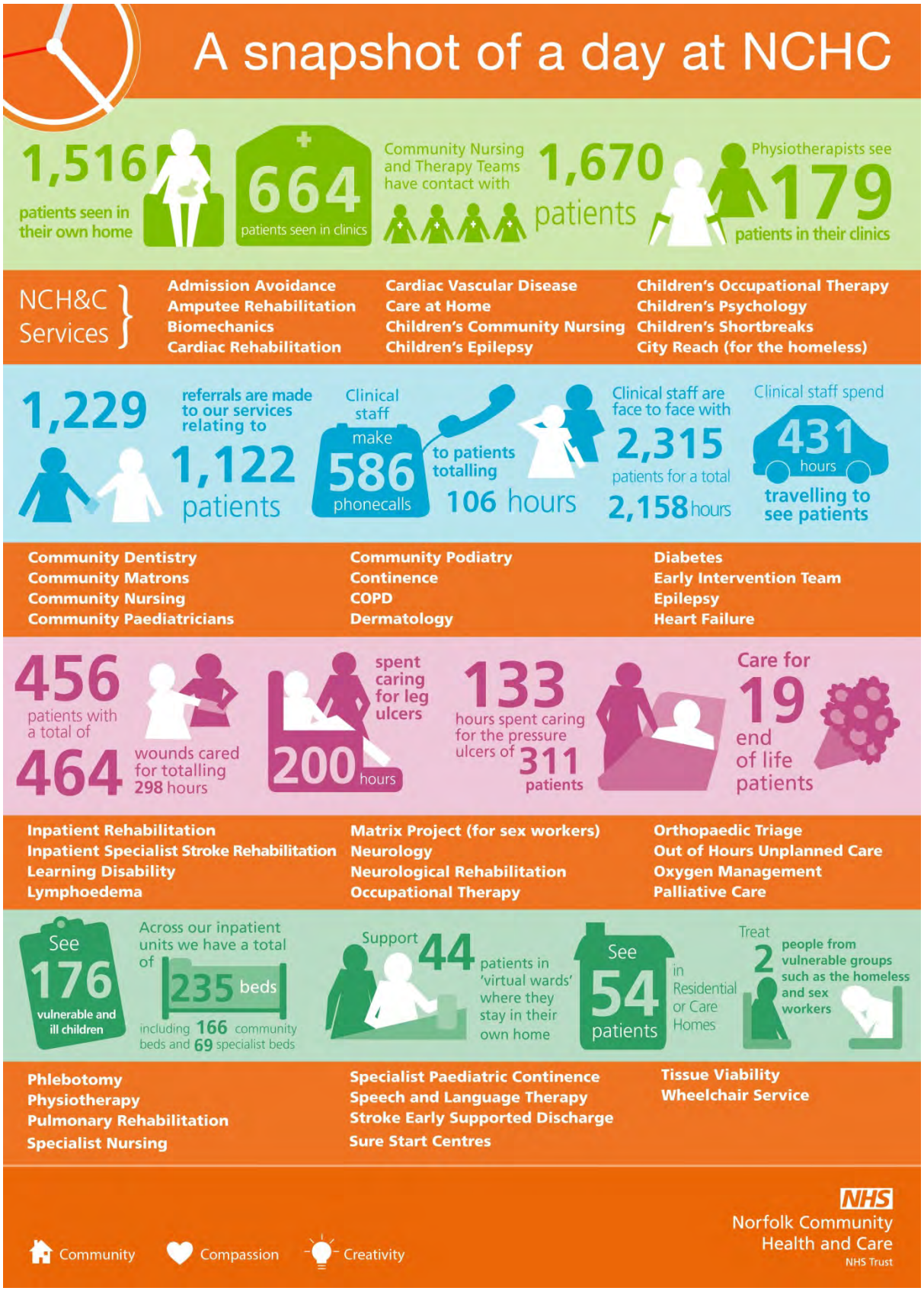
Graphic describing our Values

1.2.3 Services provided by NCHC

The graphic on the next page shows the type and location of services provided by NCHC.


NCHC is 'Looking after you locally...'
We provide our services to people where they most need them, including in patient's own homes, community clinics, care homes, and schools.
NHS
Norfolk Community Health and Care
NHS Trust
Wells-next-the-sea
Sheringham
Cromer
Hunstanton
High Kelling
Mundesley
NORTH
Fakenham
North Walsham
Aylsham
Stalham
King's Lynn
Wroxham & Hoveton
WEST
Taverham
Dereham
Acle
Brundall
Swaffham
Norwich
Great Yarmouth
Downham Market
Watton
Wymondham
Loddon
SOUTH
Attleborough
Long Stratton
Thetford
Diss
Hartismere
Bury St Edmunds
SUFFOLK
Ipswich
NCHC, the heart of the community
A number of our services, such as our Community Nursing and Therapy service, are provided right across the county, as well as many Specialist services.
Some of our services include:
Cardiac Rehabilitation
Specialist Amputee Rehabilitation
Community Neurology
Specialist and Community Palliative Care
Community Stroke Services
Community Podiatry and foot health
Community hospitals including specialist inpatient units
Continence
Falls Prevention
Infection Control
Learning Disabilities Services (adults and children)
Specialist Neurological Services
Musco Skeletal Therapy
Safeguarding (adults and children)
Services for hard to reach and vulnerable groups
Specialist Dentistry
Specialist Adult and Childrens Nursing
Speech and Language Therapy (adults and children)
Prosthetics and Reablement
Pulmonary Rehabilitation
Children's Short Breaks
Phlebotomy
Rapid Assesment Team
Starfish LD CAMHS and Starfish Plus
Neurodevelopmental Services
Sure Start Children's Centres
Occupational Therapy (adults and children)
Single Point of Contact
01603 518444
Central Booking
Referrals and bookings for Specialist Services
01603 216021
Children's Community Services Single Point of Referral
Referrals and bookings for Children's Services
01603 508958
www.nchc.nhs.uk
nchandc
@NCHC_NHS
Community
Compassion
Creativity

The graphic below shows a typical day's activity at NCHC



Longer term plans

This section includes:

1.2.4 Health and Care Strategy
1.2.5 Norfolk and Waveney Sustainability and Transformation Partnership
1.2.6 NCHC Transformation Programme
1.2.7 Health and Adult Social Care Integration

1.2.4 The Health and Care Strategy

The strategy adopts a “Levels of Care” model of service delivery which aims to provide a consistent approach to care and underpins how services will be developed and managed by NCHC. At the heart of the Levels of Care model is the needs of patients and the requirement of coordinated care to improve the patient’s experience of the care delivered. Patients will have the minimum number of separate visits and consultations that are necessary, with access to specialist advice in appropriate locations within the community.

The use of a different skill-mix and the increase in multidisciplinary working, along with maximising the use of technologies such as phone, internet, telehealth/telecare, video-conferencing, apps and email, will improve access and convenience for patients, their families and carers and enhance organisational efficiency. There will be changes over the coming years in how our workforce will deliver care in the community, which will be supported by workforce development and planning and working together with key partners. The Levels of Care model provides the basis to begin this development and planning.

Graphic showing levels of care for adult community services

Level 1 (a & b)

- L1a - Specialist units e.g. Regional Specialist Rehabilitation Services.
- L1b - Community hospital/virtual ward (approx. one third) used for this purpose, flexible agreed criteria to accept patients/service user from acute, community, and care homes, who require intensive medical and nursing rehabilitation.
- Access to 24/7 medical support available.
- Workforce – skilled with assessment capabilities, prescribing, diagnostics and advanced clinical skills.

Level 2

- Specialist services provide support to patients/service user with complex conditions who require support from specialists outpatient services e.g. community paediatrics, community dental services, older people medicine and specialist intensive nursing /case management including high users of GP/Acute services.
- Serving a small proportion of the local population with complex health and social care needs that can be predominately met in the community environment.
- Multi-disciplinary teams working across primary, secondary, tertiary and community boundaries.

Level 3

- Community hospital/virtual ward (approx. two thirds) used for this purpose, strict agreed criteria to accept patients/service user from acute.
- Nurse led service with joint management arrangements with therapy and social care.
- Workforce – skilled with assessment capability including social care, prescribing, access to regular monitoring, access to medical support, advanced discharge planning processes adopted, with use of care home beds available as required.

Level 4

- Community services delivering generic health and social care service across the four localities for adults and children.
- Working with organisations to help deliver the level of care required, empower and re-enable patients/service user, support carers and families.
- Formalise opportunities for sub-contracting, partnership working with voluntary and independent sectors to support patients/service user, carers and families.
- A less specialised Workforce and more generic in the level of support delivered (supported by training from specialists in Levels of Care 1-3).
- Signpost and work with levels 3 & 2 services and specialist hubs.

1.2.5 Sustainability and Transformation Partnership

The NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care. These proposals, called sustainability and transformation partnerships (STPs), are place-based and built around the needs of the local population. The Norfolk and Waveney Sustainability Transformation Partnership (STP) signals that a significant transformation of services is required which will see many more patients treated in primary and community care settings, thereby relieving pressure on hospital services. The following system priorities for achieving this have been identified:

- Sustainable physical and mental health, social care and prevention services out of hospital.
- Reducing acute activity, including A&E attendances, non-elective admissions and inpatient length of stay by establishing integrated locality or place-based teams responsible for physical, mental and social care.
- Improved management of planned care to meet national waiting time standards, and reduce variation and demand
- An adaptive and sustainable workforce.

1.2.6 Transformation Programme

The table on the next page describes how NCHC’s Transformation Programme aligns with the STP.

STP alignment with Trust Transformation Plans	
Keeping me at home	**To do this we will work with partners to** • Redesign Frail and Older people's services • Work with CCGs through the contractual SDIP, in conjunction with provider partners, to review Community Nursing and Therapy and Inpatient Services as core components of supporting people at home, particularly the frail older person • Review further opportunities to support technological innovation to support efficient, effective clinical service delivery
Future care and sustainability	**To do this we will work with partners to** • Develop existing and new partnerships and networks in the local health and care economy to meet the increasing patient demands, improve efficiencies, integration and minimise duplication • Work with CCGs through the contractual SDIP to review Community Nursing and Therapy and Inpatient Services as core components of delivery of future primary and community models of care, linked to FYFV • Continued implementation of the Trust's 'Connecting Community Care' 5 year IM&T plan, including enhanced sharing of information with partners
Prevention and wellbeing	**To do this we will work with partners to** • Work with NCC to lead strategic approaches to develop voluntary sector involvement in care pathways in the community • Develop new models and pathways for coordinated care to be developed within the community, addressing gaps in services by working closely with the voluntary sector and proactive support to carers. • Invest in volunteering to support quality and efficiency of service interventions • Extend self-care interventions and self-management support, focusing on prevention and wellbeing and the embedding of Health Coaching
Developing the right workforce for the future	**To do this we will work with partners to** • Actively explore opportunities for cross health system working to develop system workforce planning and recruitment strategies, joint appointments and rotation schemes, and sharing of back office personnel support functions • Refresh and refine the current Trust workforce strategy to adopt new approaches to 'grow your own' workforce and focusing on retention and successful recruitment. • Increase in retention of staff and recruitment of staff, working with system partners • Develop talent programmes and future leaders identified and trained, including consideration of Nurse/Therapy Consultants, Physician associates. • Increase band 1-4 staff across health & Social Care to support Levels of Care model.
Financial improvement	**To do this we will work with partners to** • Develop our 'middle office' function, including a review of points of access to clinical and administrative triage and resource deployment – exploring opportunities to integrate with other service providers • Develop 'corporate enablers' to optimise estates utilisation, procurement efficiencies, stock management and logistics – exploring opportunities to share benefits with provider partners

1.2.7 Integration with Adult Social Care

NCHC and NCC signed a Section 75 Agreement to enable the sharing of management arrangements and budgets across adult health and social care in order to progress the integration of services and to ensure that the patient is at the centre of care delivery. The Integration Programme is driven by project workstreams including integrated care coordinators, hospital discharge, joint therapy management and delivery roles and organisational development.

1.3 Key Risks and Issues

This section includes:

1.3.1 Strategic risks
1.3.2 Service changes
1.3.3 Policy drivers

1.3.1 Strategic risks

NCHC's main strategic risks are focused around the strategic priorities and can be summarised as:

- Risks to improving our quality mitigated through implementation of the Health and Care Strategy.
- Risks to enabling our people mitigated through staff engagement and staff deployment.
- Risks to securing the future mitigated through delivering the cost improvement programme, managing high risk cost pressures; maintaining good commissioner relations, and ensuring the sustainability of community services.

1.3.2 Service changes

There are a number of opportunities and challenges that will arise from time to time. These have included both the tendering of NCHC's existing services and those which are outside NCHC's current portfolio. NCHC's strategic focus going forward is on our contribution to the Sustainability and Transformation Partnership, and on the key assumptions set out for the achievement of a surplus including the delivery of recurrent cost improvement plans.

During the year, NCHC developed the following new services in partnership:

- Supported Care integrated support service with Norfolk First Support focused on patient re-ablement.
- Supporting North and South CCGs on the re-management of bed stock from Benjamin Court to Cranmer House.
- Worked with Norfolk CCGs to re-commission the provision of residential short breaks.

NCHC transferred the provision of community health services in Suffolk during the year to other providers.

1.3.3 Policy drivers

Local policy drivers derive from the commissioning intentions and actions of Norfolk and Suffolk CCGs, NCC and NHSE. National policy is primarily contained within NHSE and NHSI's joint publication of the Operational and Contracting Planning Guidance. This covers two financial years to provide greater stability, support transformation, and is underpinned by a two-year NHS Standard Contract. It provides local NHS organisations with an update on the national priorities as well as updating longer term financial challenges for local systems.

1.4 Performance Summary

This section includes information on:

1.4.1 CQC rating
1.4.2 Single Oversight Framework segmentation

NCHC has performed well against targets and standards set nationally and those agreed locally with commissioners. The Board receives and reviews a detailed performance report at each monthly meeting on operational performance, a monthly report on performance against quality of service measures, a bi-monthly workforce report and a monthly finance report. NCHC has been assessed by CQC and NHSI.

1.4.1 CQC rating

NCHC is registered with the Care Quality Commission (CQC) to carry out the provision of legally regulated activities without any conditions on its registration. The CQC's current rating of NCHC is 'Good' (December 2014), following its inspection of services.

CQC current rating of services

Overall rating	Safe	Caring	Effective	Responsive	Well-led
GOOD	Requires Improvement	GOOD	GOOD	GOOD	GOOD

NCHC completed the three 'must do' compliance actions within a few months of the inspection, committed itself to completing an ambitious 'should do' action plan and finally on to complete a 'could do' improvement plan. NCHC is committed to continuous quality improvement with the aim to keep our 'Good' rating, whilst progressing on the journey towards being classified as an 'Outstanding' organisation. A Good to Outstanding action plan has been developed and is being monitored at Board and committee level.

The Trust received a further inspection between 21 February and 23 March 2018 and is currently awaiting the outcome report from CQC.

1.4.2 Single Oversight Framework segmentation

NHS Improvement introduced the Single Oversight Framework (SOF) in September 2016 and the most recent update was in November 2017. It sets out a regulatory oversight process which follows an ongoing cycle of:

- Monitoring providers' performance and capability under our five themes.
- Identifying the scale and nature of providers' support needs.
- Co-ordinating support activity so that it is targeted where it is most needed.

NHSI's Strategic Objectives set the overarching aims for Trusts across five themes.

Graphic showing NHSI's five themes

Theme	Aim
Quality of care (safe, effective, caring, responsive)	To continuously improve care quality, helping to create the safest, highest quality health and care service
Finance and use of resources	For the provider sector to balance its finances and improve its productivity
Operational performance	To maintain and improve performance against core standards
Strategic change	To ensure every area has a clinically, operationally and financially sustainable pattern of care
Leadership and improvement capability (well-led)	To build provider leadership and improvement capability to deliver sustainable services

For 2017/18 NHSI had the following aims to:

- Help more providers achieve CQC 'good' or 'outstanding' ratings.
- Reduce the number of providers in special measures for quality.
- Help the sector achieve aggregate financial balance.
- Improve provider productivity.
- Help providers meet NHS Constitution standards, with a particular focus on the aggregate accident and emergency standard.

2. Performance Analysis

This section includes:

2.1 Key performance measures and analysis
  2.1.1 Operational performance against SOF metrics
  2.1.2 Patients' experience
2.2 Financial performance
2.3 Sustainability report

2.1 Key performance measures and analysis

2.1.1 Operational performance against SOF metrics

Having assessed a provider's support needs, NHSI allocate them to a support segment. NCHC has been placed in Segment 2, defined as: "Support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts)

and/or NHS Improvement considers formal action is not needed." This provides for: "Universal plus Targeted support as agreed with the provider to address issues identified and help move the provider to Segment 1".

Table showing NCHC's performance against the national SOF metrics

Quality of Care metrics

Measure	**Description**	**Standard or Target**	**Actual**
Written complaints rate	Complaints per 1000 WTE staff	4.52% community benchmark	7.67% six month average.
Staff Friends and Family Test recommended care	Count of those categorised as extremely likely or likely to recommend/Count of all responders	74% NCHC local target	83%
Never Events	Count of Never Events	0	0
Patient Safety Alerts not completed by deadline	Number of NHSE or NHSI patient safety alerts outstanding in most recent monthly snapshot	0	0
Venous thromboembolism (VTE) risk assessment	Percentage of patients admitted who have a VTE risk assessment/number of patients admitted in most recently published quarter	95%	95.8%
Mixed-sex accommodation breaches	Count of number of occasions sexes were mixed on same-sex wards	0	0
Clostridium difficile (C. difficile) plan:actual variance from	Count of trust apportioned C. difficile infections in patients aged two years and over compared to the number of planned C. difficile cases	Ceiling of 9	1
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Rolling 12-month count of trust assigned MRSA infections/Rolling 12 month average occupied bed days multiplied by 100,000	0	0
Community scores from Friends and Family Test – % positive	Count of those categorised as extremely likely or likely to recommend/Count of all responders	98% actual in 2016/17	99%
Potential under-reporting of patient safety incidents	Count of reported incidents (no harm, low harm, moderate harm, severe harm, death)/estimated total person bed days for rolling six months shown as rate per 1000 bed days	*see table below	*see table below

Table below shows the number of incidents reported monthly by category

	Fin Year Total 15/16	Fin Year Total 16/17	Fin Year To Date 17/18	RAG	April	May	June	July	August	September	October	November	December	January	February	March
Patient Safety																
Reported SIRI's - Preventable PUs	N/A	148	132	⇩	18	14	5	11	12	12	13	7	7	12	11	10
Reported SIRI's – Inpatient Falls	N/A	N/A	18	⇧	4	1	0	1	3	2	2	0	1	2	0	2
Reported SIRI's – Others – Patients / Staff / Visitors etc (excluding Patient Falls)	32	37			0	4	2	2	1	3	2	1				
Reported SIRIS – Others – **Patients only**			15	⇩	0	2	1	2	1	3	2	1	0	2	1	0
Unexpected Deaths (Inpatients only)	4	4	3	⇨	1	0	0	1	1	0	0	0	0	0	0	0
No Harm & Low Harm incidents – affecting **Patients only**			6449	⇧	587	665	632	592	660	578	471	494	407	513	372	478
Moderate & Severe Harm & community unexpected deaths	1243	1270			102	107	106	96	107	88	69	64				
Moderate & Severe Harm & community unexpected deaths- **Patients only**			912	⇧	97	108	87	85	93	78	57	52	61	75	50	69
Moderate & Severe Harm (Ex PUs)	413	548			39	35	37	29	36	32	26	26				
Moderate & Severe Harm (Ex PUs) **Patients only**			331	⇧	35	32	34	27	35	28	23	22	23	32	17	23
Duty of Candour Breaches (Discussion & Letter within 10 Days)	N/A	0	0	⇨	0	0	0	0	0	0	0	0	0	0	0	0

RAG KEY	Green	Amber	Red		Green	Amber	Red
Patient Safety							
Reported Pressure Ulcer SIRIS	0-5	6-12	12+	No Harm & Low Harm incidents	85%	80%	75%
Reported SIRIs – Inpatient Falls	0-2	3-4	5+	Moderate & Severe Harm	15%	20%	25%
Reported SIRIs – Other (Patients only)	0-2	3-4	5+	Moderate & Severe Harm (Ex PUs)	15%	20%	25%
Unexpected Deaths (Inpatients only)	0	1	2+	DOC Breaches - Letters within 10 Days	0	1-5	5+

Finance metrics

Table below explains the metrics used by NHSI to assess performance

Area	Weighting	Metric	Definition	Score			
				1	2	3	4
Financial sustainability	**0.2**	**Capital service capacity**	Degree to which the provider's generated income covers its financial obligations	≥2.5x	<2.5x - ≥1.75x	<1.75 - ≥1.25x	<1.25x
	0.2	**Liquidity (days)**	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	≥0	<0 - ≥(7)	<(7) - ≥(14)	<(14)
Financial efficiency	**0.2**	**Income and expenditure (I&E) margin**	I&E surplus or deficit / total revenue	≥1%	<1- ≥0%	<0 - ≥(1)%	<(1)%
Financial controls	**0.2**	**Distance from financial plan**	Year-to-date actual I&E margin (surplus/deficit) in comparison to Year-to-date plan I&E margin (surplus/ deficit) on a control total basis	≥0%	<0% - ≥(1)	<(1)% - ≥(2)	<(2)%
	0.2	**Agency spend**	Distance from provider's cap	≤0%	>0 - ≤25%	>25 - ≤50%	>50%

The finance score is calculated by scoring providers on a scale of 1 (best) to 4 against the following five metrics, and averaging these scores to derive an overall figure: (1) capital service capacity, (2) liquidity, (3) income and expenditure margin, (4) distance from financial plan, and (5) agency spend.

Table below provides NCHC performance on the SOF finance metrics

Indicator	Measurement	Actual			Normalised			Planned		
		Year to date	Risk Rating	Score	Year to date	Risk Rating	Score	Year to date	Risk Rating	Score
Financial Sustainability	Capital servicing capacity (times)	2	2.0	0.4	2	2.0	0.4	3	1.0	0.2
	Liquidity ratio (days)	57	1.0	0.2	56	1.0	0.2	56	1.0	0.2
Financial Efficiency	I&E margin (%)	-1.3%	4.0	0.8	-1.0%	4.0	0.8	1.4%	1.0	0.2
Financial Controls	Distance From Financial Plan	-2.7%	4.0	0.8	-2.4%	4.0	0.8	0%	1.0	0.2
	Agency Spend	-21%	1.0	0.2	-21%	1.0	0.2	13%	2.0	0.4
Weighted Score				**2.40**			**2.40**			**1.20**
Overriding rules applied:	Maximum Score of 3 due to risk ratings of 4									
Overall Score				**3**			**3**			**1**

NB: Explanation of "overriding rules applied: maximum score of 3 due to risk ratings of 4." This is because a provider's overall figure may be moderated down if it scores 4 on any individual finance metric.

Operational performance metrics

Measure	**Description**	**Standard or Target**	**Actual**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate − patients on an incomplete pathway	Percentage of patients whose clock period is less than 18 weeks during the calendar months of the return/Count of number of patients whose clock has not stopped during the calendar months of the return	92%	98.9%
Maximum 6-week wait for diagnostic procedures	Proportion of patients referred for diagnostic tests who have been waiting for less than six weeks	0%	0.5%

Organisational health metrics

Measure	**Description**	**Standard or Target**	**Actual**
Staff sickness	Level of staff absenteeism through illness in the period Numerator = number of days sickness reporting within the month. Denominator = number of days available within the month	3.7% NCHC local target	4.72%
Voluntary staff turnover	Number of Staff leavers reported within the period /Average of	7% lower limit	16%

	number of Total Employees at end of the month and Total Employees at end of the month for previous 12 month period Numerator = number of leavers within the report period. Denominator = staff in post at the start of the reporting period	17% upper limit, optimum is deemed to be 12%. NCHC local target. 13.9% in 2016/17.	
NHS Staff Survey	Staff recommendation of the organisation as a place to work or receive treatment	3.74 national score	3.64
Proportion of temporary staff (Temporary agency spend as a % of total pay bill)	Agency staff costs (as defined in measuring performance against the provider's cap) as a proportion of total staff costs. Calculated by dividing total agency spend over total pay bill.	£2,714k Absolute agency cap not %	£2,049k agency spend which represents 2.5% of total pay bill. This is a significant improvement on the prior year at 4.0%

Commentary on performance against organisational health metrics: (1) the data shows that staff sickness is above the Trust's own target, (2) staff turnover is at the higher end of the local threshold target range; an increase in the year reflects significant changes across the Trust in various services, (3) a key finding of the National Staff Survey results shows that the Trust is below the national average for recommended place to work, and (4) the Trust has remained within the NHSI cap for Agency staff costs.

2.1.2 Patients' experience

Key measures of patients' experiences are complaints, compliments and the Friends and Family Test.

This section includes:

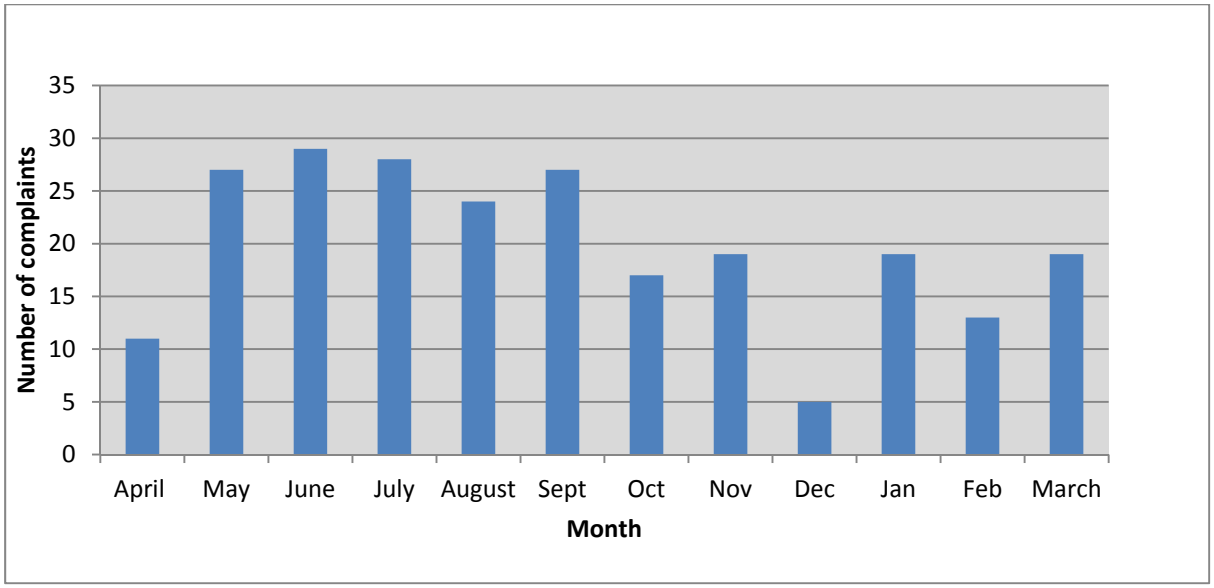
- Complaints
- Compliments
- Friends and Family Test

Complaints

NCHC received 238 complaints compared to 225 for the previous year. Themes and learning from complaints have been regularly discussed by staff and management teams, committees and at Board during the year. Of particular note are:

- Medical complaints about waits for Autistic Spectrum Disorder services, which has continued from the previous year.
- The start of the year saw the continuation of podiatry-related complaints, but these subsequently declined.
- Issues associated with implementing the Integrated Therapy Partnership service model.
- Car parking issues around parking fines at Norwich Community Hospital.

The table below shows the number of complaints received on a monthly basis



Assurance on the complaints process, themes and trends, and learning continues to be provided in a number of ways:

- A twice-yearly thematic review across all services is carried out, in addition to monthly monitoring.
- The Complaints Officer exchanges best practice with neighbouring Trusts and attends the Norfolk-wide Complaints Forum for all NHS providers and commissioners and Norfolk County Council.
- Triangulation of complaints with other quality intelligence is shared in various forums.
- Non-Executive Directors regularly undertake deep-dive exercises into individual complaints for wider organisational learning. These have confirmed that the complaints were handled well, sometimes in difficult circumstances, and there is good evidence that learning has been taken on board and shared.

Compliments

When our patients take the time to write and express their thanks or compliment a team or a service we take great pride in sharing them with our staff. We keep a record of all the compliments we receive as these are a really important measure for us when we are thinking about quality of care. This year we logged 897 compliments, compared to 1,230 last year. The fall in number is largely attributable to NCHC ceasing to be the provider of community services in Suffolk during the year.

Friends and Family Test

The NHS Friends and Family Test was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give feedback after receiving care or treatment across the NHS. The overall percentage of patients who were 'Extremely Likely' or 'Likely' to recommend our services to friends and family was 99%.

2.2 Financial performance

This section includes:

2.2.1 Efficiency programme
2.2.2 Capital
2.2.3 Balance sheet and working capital
2.2.4 Better Payments Practice Code
2.2.5 Prompt Payments Code
2.2.6 Trend analysis
2.2.7 Outlook

Summary

The original Trust financial plan for 2017/18 was to maintain the strong performance of 2015/16 through the generation of a £2.0m adjusted surplus supported by the delivery of an ambitious £6.2m efficiency programme. The original plan assumed the continuance of a significant contract for Suffolk community services. Following the cessation of this service on 1st October 2017, the Trust revised is financial projections for 2017/18 to a £(2.0m) deficit supported by a revised plan to deliver a £3.0m efficiency programme. The deficit actually delivered in 2017/18 was £(1.4m), £0.6m better than the revised projections. This was supported by efficiency savings of £3.0m (£1.9m of recurrent savings and £1.1m of non-recurrent savings). The improvement delivered compared to the revised projection was primarily driven by £0.4m of additional income received from NHS England following a redistribution of the sustainability and transformation funding incentive scheme.

One way to measure efficiency and benchmark performance with other Trusts is by using the outputs from a national reference cost data collection which is refreshed annually in arrears. The outputs for the 2016/17 data collection shows the Trust as the most efficient Community Trust nationally.

The reference cost index (RCI) is a measure of the relative cost efficiency of different NHS Providers. It shows the actual cost of a provider's casemix compared with the same casemix delivered at national average cost. A provider with costs equal to the national average will score 100. Providers with higher costs will score above 100 and providers with lower costs will score below 100. For example, a score of 110 suggests that costs are 10% above the average, while a score of 90 suggests costs are 10% below the average.

The 2016-17 reference costs were published on 24th November 2017. The Trust's

RCI adjusted for market forces* for 2016/17 is **87**, 13% below the average. The RCI has improved by four percentage points from the 2015/16 index of 91.

Out of 17 Community Trusts, NCHC has the lowest score (fifth lowest score in 2015/16), with eight in total scoring below 100 and nine above.

*The Market Force Factor (MFF) is an index used to estimate providers' unavoidable cost differences of providing healthcare, due to geographical location. The MFF for NCHC is 0.94.

2.2.1 Efficiency programme

The recurrent efficiency savings of £1.9m were achieved during the year through the Trust's Cost Improvement Programme, against a revised recurrent target of £3.0m. Much of the saving was achieved through the continued redesign and modernisation of clinical services, as well as non-clinical savings from estates rationalisation and procurement initiatives. 30 different projects generated recurrent savings during the year. The remainder was achieved by delivering non-recurrent savings during the year.

The sustainable delivery of savings continues to present a challenge to the Trust. Working in collaboration with other providers and commissioners through the Sustainability and Transformation Partnership is the key to securing the future for community services and will continue to be a major component of the Trust's long term financial strategy.

2.2.2 Capital

During the year, NCHC invested £4.1m (£4.3m in 2016/17) in capital schemes, which was an under spend of less than 4% against the plan and Capital Resource Limit agreed with the Department of Health. One key area of investment to support the efficient delivery of patient care was the maintenance programme for the Trust's estate. In addition, the Trust has invested £0.3m in new and replacement clinical equipment to support the quality of patient care and £1.2m in Information Technology which includes investment in mobile working to maximise the time staff spend with patients.

The Trust's capital investment requirement for 2018-19 is planned to be £4.0m which will be supported by a programme that will balance further investment in backlog reduction and development of new estate. Estate development and investment now forms a significant focus of attention for both the Trust's integration work with Norfolk County Council's (NCC) Adults Social Care services and the introduction of system working under the Norfolk & Waveney STP.

2.2.3 Balance sheet and working capital

With the exception of a significant drop in cash, both the balance sheet and working capital have been reasonably stable throughout the year and are consistent with 2016/17. The reduction in the cash balance £23.3m in 2016/17 to £18.2m in 2017/18 is predominantly driven by a switch from the delivery of a surplus in the prior year to the current year deficit.

2.2.4 Better Payments Practice Code

The Trust is required to pay its non-NHS and NHS trade payables in accordance with the Confederation of British Industry Better Payments Practice Code. This requires us to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later (see reference note 24 in the financial statements).

2017/18 saw a deterioration on the previous year's performance, with 81% of non-NHS trade payable invoices being paid within 30 days (85% in 2016/17). 65% of NHS payable invoices were paid within 30 days (77% in 2016/17). The reduction in performance follows the Trust's continued robust review of all payment requests which has resulted in an increase in queries and a subsequent decline in performance. This is largely a timing issue whilst the Trust waits to receive adequate information to ensure payments are appropriate. Details of compliance with the Better Payment Practice code are detailed in note 24 to the financial statements.

2.2.5 Prompt Payments Code

The Prompt Payment Code is a payment initiative developed by Government with the Institute of Credit Management to improve liquidity for small businesses. NCHC has signed up to the code and is committed to pay all invoices relating to small and medium businesses and individuals within 10 days, wherever practical.

2.2.6 Trend analysis

The table below shows the historic performance of the Trust for the period 2015/16 to 2017/18. The significant reduction in income and pay over the period is as a result of the lost Suffolk Community Services contract. This has led to the Trust being in deficit for the first time since incorporation. Over this period:

- Income levels have reduced by 7.8%.
- Pay has reduced by 9.3% and accounts for 73% (76% in 2016/17) of the cost base (excluding depreciation and public dividend capital (PDC)).
- Non-pay levels have remained on average at £30.0m.
- Depreciation and amortisation has increased by 5.4% despite capital investment remaining at fairly modest levels (average £4.2m per year). The increase is as a result of the mix of our asset base moving towards faster depreciating IT assets and away from slower depreciating estate assets.
- Public dividend capital payments have risen by 20% in line with a 20% reduction of cash balances over the period.
- In 2016/17 a Sustainability and Transformation Fund (STF) was introduced. The amount of STF is linked to how well the Trust delivers against its original plan. The Trust achieved its original plan during the first two quarters of 2017/18 and therefore received an element of STF for the year, however following the loss of Suffolk Community Services the original plan was no longer achievable and STF was not achieved in full.

NCHC has a duty to ensure it breaks even cumulatively with 2009/10 being the starting position for this calculation. 2017/18 is the first year the Trust has not achieved a surplus; it has built up sufficient reserves of £14.7m since 2009/10 to be safely within the break-even requirement.

Table below shows historic financial performance

Historic Performance	2015/16 Act	2016/17 Act	2017/18 Act
	£k	£k	£k
Income			
Patient Care	126,159	127,731	115,057
Other	3,760	5,395	4,734
Total	**129,919**	**133,126**	**119,791**
Expenditure			
Pay	92,159	94,375	83,627
Non-Pay	29,550	29,685	30,983
Total	**121,709**	**124,060**	**114,610**
EBITDA	**8,210**	**9,066**	**5,181**
%	**6.3%**	**6.8%**	**4.3%**
Depreciation and amortisation	3,930	3,891	4,144
PDC Dividend	2,037	2,310	2,444
Surplus / (Deficit) (incl ST	**2,243**	**2,865**	**(1,407)**
%	**1.7%**	**2.2%**	**(1.2%)**
Adjusted Surplus (incl STF)	**2,129**	**2,695**	**(1,275)**
STF	-	1,586	687
Surplus (excl STF)	**2,129**	**1,109**	**(1,962)**
%	**1.6%**	**0.8%**	**(1.6%)**
CIP			
Recurring	5,683	2,329	1,890
Non-recurring	1,167	2,512	1,144
Total	**6,850**	**4,841**	**3,034**
Capital expenditure	**4,396**	**4,137**	**4,088**
Cash balance	**22,956**	**23,259**	**18,213**

2.2.7 Outlook

Over the coming year NCHC will continue to work collaboratively in support of the local transformation programme in order to secure the future of community services and ongoing financial sustainability. This is known locally as the Sustainability and Transformation Partnership and brings together providers and commissioners across Norfolk and Waveney.

Estate planning for a new strategy period commenced during 2017-18 with a fresh 5-facet survey appraising the investment requirement for, and the position on, the remaining Trust estate. The Trust's investment requirement will be identified and agreed during 2018-19.

The longer term strategic approach will continue in parallel with the Trust's internal plans to continue to explore opportunities for improvements and developments in our services alongside delivering financial efficiencies, mitigating cost pressures, strengthening core business and developing new service opportunities.

2.3 Sustainability Report

The sustainability report is based on estimates at the time of writing and figures will be finalised in June 2018.

This section includes:

2.3.1 Sustainability policies
2.3.2 Sustainability partnerships
2.3.3 Sustainability performance in energy & water usage, carbon emissions, waste management and travel.

Introduction

As an NHS organisation, and as a spender of public funds, we have an obligation 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. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising costs of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

In order to fulfil our responsibilities for the role we play, NCHC has the following sustainability mission statement located in our sustainable development management plan (SDMP): ***"To sustain our health and care services and provide economic, social and environmental value to the local community for a better tomorrow."***

The NHS, public health and social care system has a duty to reduce its carbon footprint by 34% from a 1990 baseline, equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by having a 15% reduction by 2019-20 using 2007/08 as the baseline year.

2.3.1 Sustainability policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

Area	Is sustainability considered?
Travel	Yes
Business Cases	Yes
Procurement (environmental)	Yes
Procurement (social impact)	Yes
Suppliers' impact	Yes

One of the ways in which an organisation can embed sustainability is through the use of an SDMP. The board approved our SDMP in the last 12 months so our plans for a sustainable future are well known within the organisation and clearly laid out.

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Sustainable Development Assessment Tool, which replaces the Good Corporate Citizenship Assessments. As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our Board approved plans address the potential need to adapt the delivery the organisation's activities and infrastructure to climate change and adverse weather events

2.3.2 Sustainability partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms.

Strategic partnerships are already established with the following organisations: NHS Supply Chain. For commissioned services here is the sustainability comparator for our CCGs:

Organisation Name	SDMP	GCC	SD Reporting score
NHS North Norfolk CCG	No	No	Minimum
NHS Norwich CCG	No	Yes	Good
NHS South Norfolk CCG	No	No	Minimum
NHS West Norfolk CCG	No	Yes	Good

2.3.3 Sustainability performance

This section includes information on how NCHC has performed in relation to:

- Energy
- Travel
- Waste management
- Water usage
- Carbon footprint

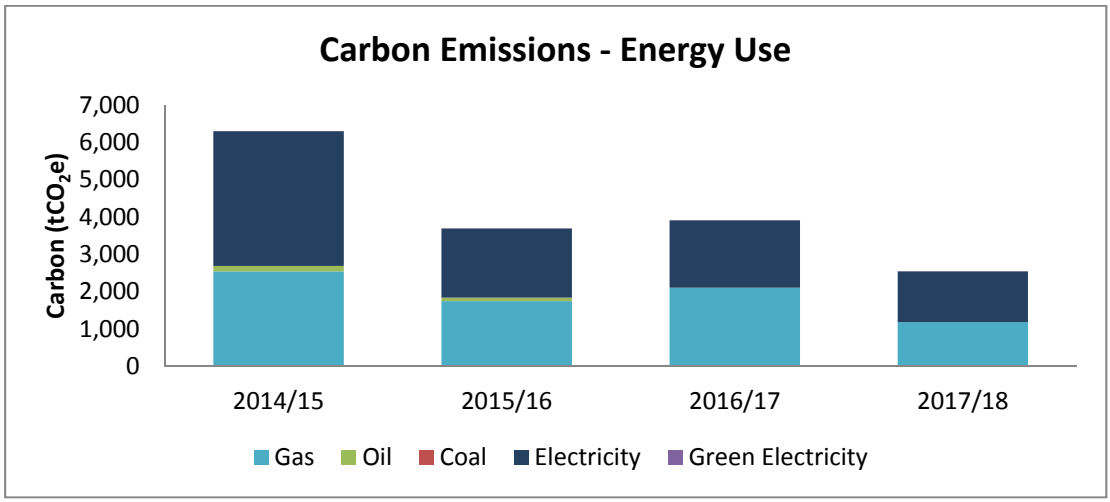
Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time.

Context info	2014/15	2015/16	2016/17	2017/18
Floor Space (m^2)	63,104	46,500	47,528	46,508
Number of Staff	2,695	2,472	2,874	2,388

In 2014 the Sustainable Development Strategy outlined an ambition to reduce the carbon footprint of the NHS by 28% (from a 2013 baseline) by 2020. We have supported this ambition as follows:

Energy

Graph below and table on next page show carbon emissions energy use



Resource		2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	12,116,536	8,327,070	10,063,392	5,566,781
	tCO2e	2,542	1,743	2,103	1,180
Oil	Use (kWh)	457,800	294,000	0	0
	tCO2e	147	94	0	0
Electricity	Use (kWh)	5,822,507	3,221,142	3,493,424	3,050,752
	tCO2e	3,606	1,852	1,805	1,360
Green Electricity	Use (kWh)	10,285	10,285	10,204	10,204
	tCO2e	6	6	5	5
Total Energy CO2e		6,301	3,694	3,914	2,545
Total Energy Spend		£ 960,054	£ 643,284	£ 498,060	£487,166

Performance summary: NCHC has now removed its oil-fueled boilers across key sites and replaced with energy efficient gas heating. This change is reflected in the energy consumption figures for the year and can account for the slight decrease in the use of gas. Please note that our energy consumption data is estimated for this report while we await confirmed information through our end of year invoices.

Travel

We can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services. Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

Table below showing performance on travel

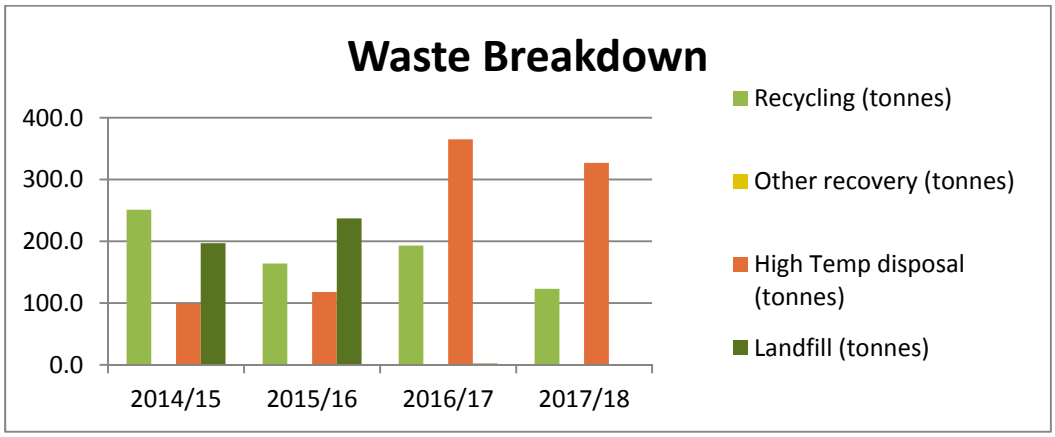
Category	Mode	2014/15	2015/16	2016/17	2017/18
Patient and visitor own travel	miles	33,433,145	32,911,340	36,407,565	34,573,163
	tCO_2e	12,284.32	11,901.92	13,158.07	12,319.28
Staff commute	miles	2,588,864	2,374,647	2,761,914	2,293,955
	tCO_2e	951.22	858.76	998.18	817.39
Business travel and fleet	miles	2,548,194	2,808,052	1,319,417	1,181,336
	tCO_2e	936.36	1,015.82	476.78	421.01
Active travel (walking and cycling) and public transport	miles	430,840	378,990	218,570	74,657
	tCO2e	38.86	32.46	20.26	6.73

Performance summary: This year NCHC has seen a natural decrease in business mileage due to staff changes and better route planning and caseload management. There were no flights in 2017/18 hence the fall in public transport figures.

Waste management

Table and graph below showing performance on waste management

Waste		2014/15	2015/16	2016/17	2017/18
Recycling	(tonnes)	251.00	164.00	193.00	123.00
	tCO_2e	5.27	3.28	4.05	2.68
High Temp disposal	(tonnes)	99.00	118.00	365.00	327.00
	tCO_2e	21.78	25.84	80.30	71.94
Landfill	(tonnes)	197.00	237.00	2.00	0.00
	tCO_2e	48.15	57.93	0.62	0.00
Total Waste (tonnes)		547.00	519.00	560.00	450.00
% Recycled or Re-used		46%	32%	34%	27%
Total Waste tCO_2e		75.20	87.05	84.97	74.62



Performance summary: NCHC has implemented Warp-It system which enables our Trust to re-use / re-cycle our furniture and equipment before considering disposal. This will further reduce the impacts for waste. Whilst implementation of Warp-it took place the Trust have also negated all landfill waste to incineration resulting in nothing scored.

Water usage

Table showing performance on water usage

Water		2014/15	2015/16	2016/17	2017/18
Mains Water	m3	55,993	31,512	34,909	29,088
	tCO2e	51	29	32	26
Water & Sewage Spend		£127,579	£78,183	£65,341	£ 77,198

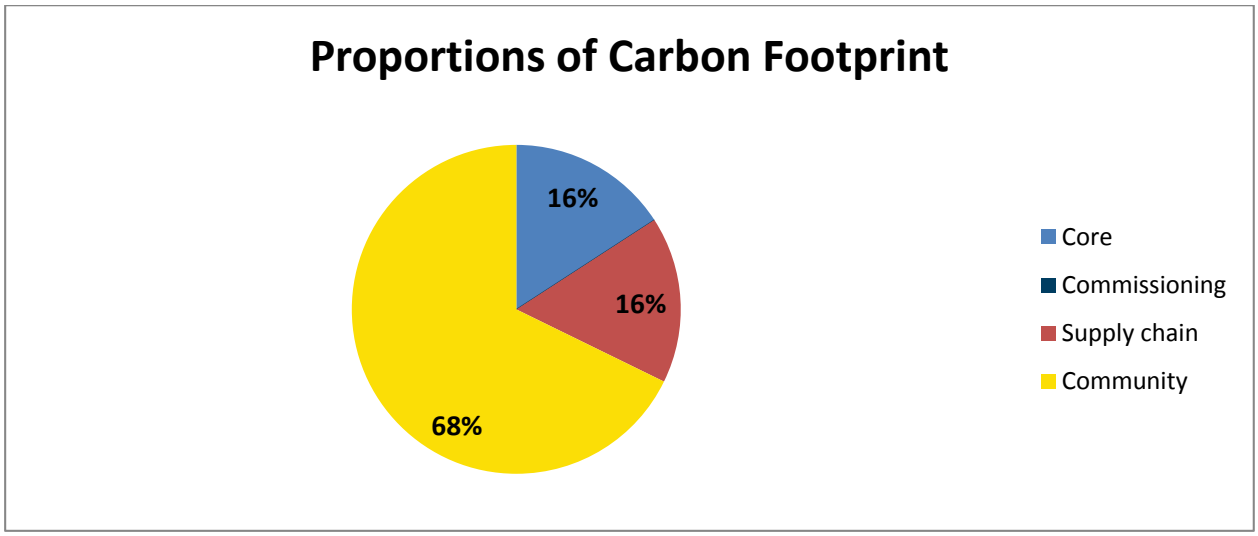
Performance summary: Work is underway with NCHC's energy and water management contractor to improve on our ability to identify leaks and problems earlier where possible.

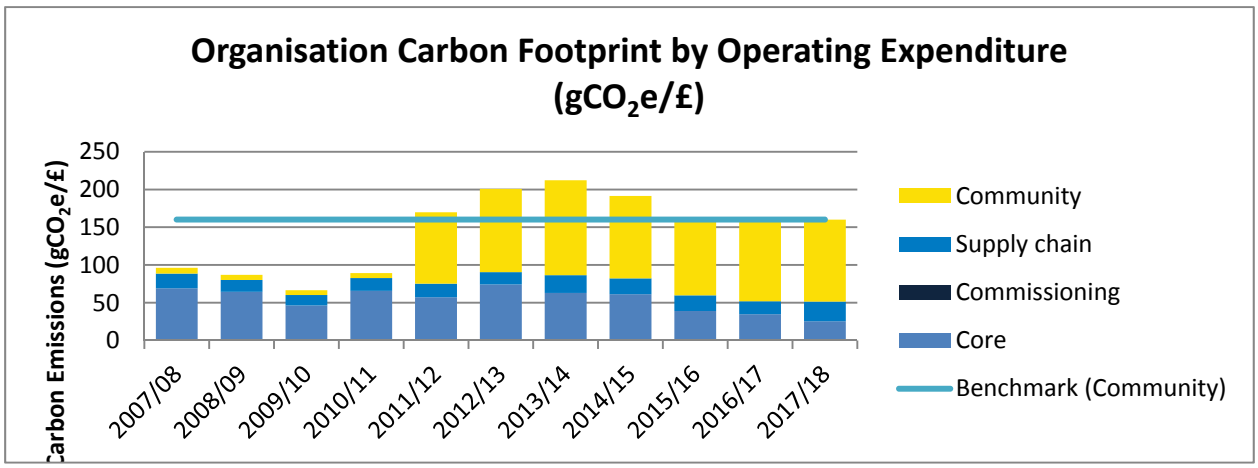
Modelled carbon footprint

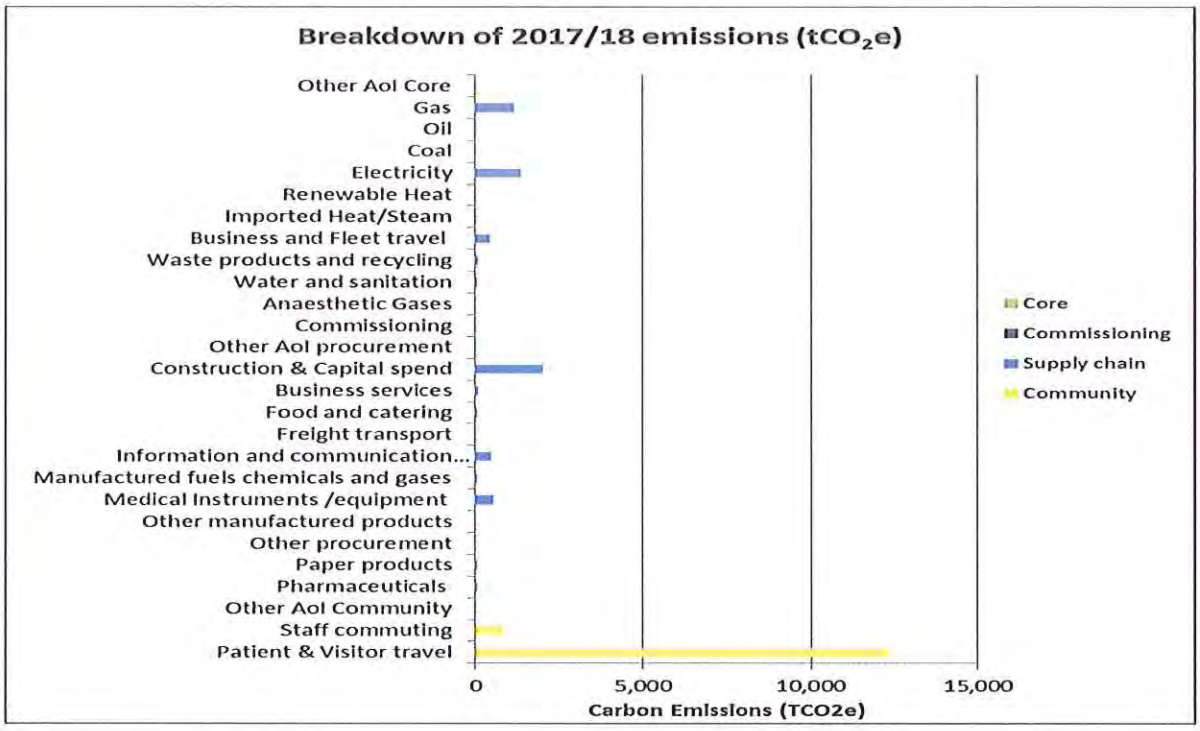
The information provided in the previous sections of this sustainability report uses the "Estates Return Information Collection" returns as its data source. However, NCHC is aware that this does not reflect its entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit in 2009/10. More information is available from their website.

Resulting in an estimated total carbon footprint of 19,388 tonnes of carbon dioxide equivalent emissions (tCO_2e). Our carbon intensity per pound is 58 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO2e/£). Average emissions for community services is 160 grams per pound.

Graphics below and on next page show performance on carbon footprint







Adaptation: Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change. To ensure that our services continue to meet the needs of our local population during such events we have developed and implemented a number of policies and protocols in partnership with other local agencies.

Performance Report signature

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.

Accountable Officer's signature

Signed:.....

Roisin Fallon-Williams
Chief Executive
Norfolk Community Health and Care NHS Trust

Date:.....

B. ACCOUNTABILITY REPORT

The Accountability Report includes:

3. Corporate Governance Report
4. Remuneration and Staff Report
5. Parliamentary and Audit Report

3. Corporate Governance Report

This section of the report includes:

3.1 Directors' report
3.2 Statement of Accountable Officer's responsibilities
3.3 Governance statement

3.1 Directors' Report

This section includes:

3.1.1 Board members and committee structure
3.1.2 Disclosure of personal data related incidents
3.1.3 Counter fraud
3.1.4 Directors' statement

3.1.1 Board members and committee structure

Below is the Register of Directors and their declared interests which shows all individuals who served on the Board of Directors at any point during the year. All Board members were in post for the whole of the year except where indicated.

Table below showing the Board of Directors and their declared interests

Name	Designation	Declared interests
Geraldine Broderick	Non-Executive Chair	Self-employed Holiday Lets and Property Development
Roisin Fallon-Williams	Executive	None
Derek Allwood (to 31.03.18)	Non-Executive	None
Heather Peck	Non-Executive	Chair, Dog Welfare Trust. Education Volunteer, Blue Cross. Adviser, Citizens Advice. Chair, LANTRA. Former Chair, Cambs Community Services NHS Trust.
Amanda Reynolds (to 27.09.17)	Non-Executive	Blend Associates Ltd – Management Consultancy, various private and public sector executive coaching contracts.

Geoff Rivers	Non-Executive	Director, Geoff Rivers Associates – local government work. Governor, Arch Bishop Sancroft High School, Harleston. Vice Chair of the Independent Monitoring Board, Norfolk HM Prison Hollesley Bay, Woodbridge, Suffolk. Treasurer, WEA (Worker Education Associations), Pulham Branch, Norfolk. Director, All Saints Multi Academy Trust.
Dr Iain Brooksby	Non-Executive	Chairman, Norfolk Heart Trust. Trustee, Norwich Consolidated Charities.
Stephen Pond (to 05.06.17)	Non-Executive (non-voting)	Aviva Insurance Limited, Managing Director Prevention & Services
John Kennedy (from 01.10.17)	Non-Executive	None
Andrew Williams (from 01.09.17)	Non-Executive (non-voting)	Co-owner and Managing Director, Options 2 Outcomes Ltd – previously providing consultancy and interim services to NHS and Local Government Organisations. Currently providing services to Dreamy Hollow Leisure Ltd campsite and woodland. Volunteer with Headway Charity.
Lorrayne Barrett	Executive	Secretary, Friends of Lowestoft Library. Host for an Norfolk County Council Care Leaver via the Benjamin Foundation.
Andrew Hopkins	Executive	Partner runs a consulting business that carry out work for the NHS on finance, contracts and commissioning
Paul Cracknell	Executive (non-voting)	Trustee, Cringleford Hub – charity sometimes working with Health Visitors and Children's Centres
Anna Morgan	Executive	Peer Reviewer for RCN Publications Review all articles that have Safeguarding/LD/Older People context. Advisor for mental health inspections for CQC, Clinical and Professional Advisor for CQC inspections. Member of the Clinical Senate for East of England.
Dr Penny Newman (to 13.08.17.)	Executive	Contracted for two days per week / Clinical Lead role / Health Coaching, Health Education East of England. Husband is CEO, Royal College of Surgeons
Dr Venu Harilal Interim MD from 01.09.17 to 31.12.17) Medical Director from 01.01.18.	Executive	Board member, East Anglian drive ability centre in Thetford, Norfolk. Clinical Lead Colman Centre for specialist rehabilitation, NCHC. Clinical input to All-Hallows Healthcare Trust, and Icanho (Community rehabilitation team in Suffolk), and Environmental Control Service, Suffolk, Bartrams.

The Board is supported by a chartered company secretary, Michael Jones.

There are five committees that support the work of the Board, each one chaired by a Non-Executive Director. The Audit Committee and Remuneration Committee comprise only NEDs. The other three committees comprise a balance of NEDs and Executives. All committees may have Executives, senior managers and clinicians in attendance to assist with the deliberations.

NCHC Committee Structure

- Quality and Risk Assurance Committee
- Finance and Performance Committee
- Charitable Funds Committee
- Remuneration and Nominations Committee
- Audit Committee

More information on the role and function of each committee is provided in the Governance Statement.

Audit Committee

Only Non-Executive Directors are members of the Audit Committee. Other Directors, such as the Director of Finance and Performance, and the Trust Secretary will normally attend at the request of the committee to assist with their deliberations. External Audit, Internal Audit and the Local Counter Fraud Specialist are also invited to attend. Committee members may also meet in private with the auditors with no officers present.

Table showing members of the Audit Committee

Name	Designation
Derek Allwood, Non-Executive Director (to 31.03.18)	Committee Chair
Amanda Reynolds, Non-Executive Director (until 27.09.17)	Deputy Chair
Andrew Williams, Associate Non-Executive Director (from 04.12.17)	Deputy Chair
Heather Peck, Non-Executive Director	Member

3.1.2 Disclosure of personal data related incidents

All data security breaches were reviewed by the Trust's Caldicott Guardian and Senior Information Risk Owner (SIRO) with appropriate actions implemented. There were two level two information governance serious incidents requiring investigation (SIRI) (defined as sufficiently high profile cases or deemed a breach of the Data Protection Act or Common Law Duty of Confidentiality, and hence reportable to the Department of Health and Information Commissioner's Office). These are described in more detail in the Governance Statement below. There were two level one

information governance SIRIs recorded (defined as a confirmed SIRI but not reportable to ICO and Department of Health). In total there were 196 incidents that were categorised as follows:

Table showing number and type of personal data related incidents

Type	Number
Loss of sensitive information	28
Confidentiality breach	78
Inappropriate disclosure of information	29
Inappropriate access of information	15
Documents not properly filed	16
Other	30

3.1.3 Counter fraud

The Local Counter Fraud Specialist (LCFS) has provided an annual report on anti-fraud, bribery and corruption work undertaken during the year. NHS Protect has developed a set of 'Standards for Providers' of NHS Services, setting out its expectations for counter fraud arrangements of any NHS or non-NHS organisation providing NHS care. The LCFS has worked with senior management to populate a self-assessment against these Standards. This assessment (the "Self-Review Toolkit" or 'SRT') was submitted to NHS Protect and confirms compliance. The Director of Finance and Performance has declared that the anti-fraud, bribery and corruption work carried out during the 2017/18 financial year has been self-reviewed against the NHS Counter Fraud Authority's fraud, bribery and corruption standards for Providers and the NHS Standard Contract, and that the rating below has been achieved.

Area of activity:	Red/Amber/Green level
Strategic Governance	Green
Inform and Involve	Green
Prevent and Deter	Amber
Hold to Account	Green
Overall rating	Green

N/A	
Behind not met	
Largely met with exceptions	
Fully Met	
Ahead of Schedule	

3.1.4 Statement of Directors' responsibilities in respect of the accounts

Model 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;
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

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 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, and 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.

By order of the Board

24/05/18 .....Date.....Chief Executive

24th May 2018 .....Date.....Finance Director

3.2 Statement of the Chief Executive's responsibilities as Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

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

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.....Chief Executive

Date 24th May 2018

3.3 Governance Statement

This section includes:

3.3.1 Scope of the Accountable Officer's responsibility
3.3.2 Capacity to handle risk
3.3.3 Risk and control framework
3.3.4 Review of effectiveness
3.3.5 Head of Internal Audit Opinion
3.3.6 Conclusion

3.3.1 Scope of the Accountable Officer's 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.

3.3.2 Capacity to handle risk

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

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

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

3.3.3 The risk and control framework

This section of the report includes:

- The Risk Management Strategy
- Strategic Risks
- Newly identified in-year and future risks
- NHS Pension Scheme
- Equality, Diversity and Human Rights
- Carbon Reduction Delivery Plans
- Information Governance
- NHS Provider Licence
- The Board and its committees
- Assessment of Board effectiveness
- Audit Committee assurance
- Corporate Governance
- Annual Quality Account
- Data Quality
- Incident reporting and learning
- Clinical Audit
- Freedom to Speak Up
- Emergency Preparedness
- Statement on discharge of statutory functions.

The Risk Management Strategy

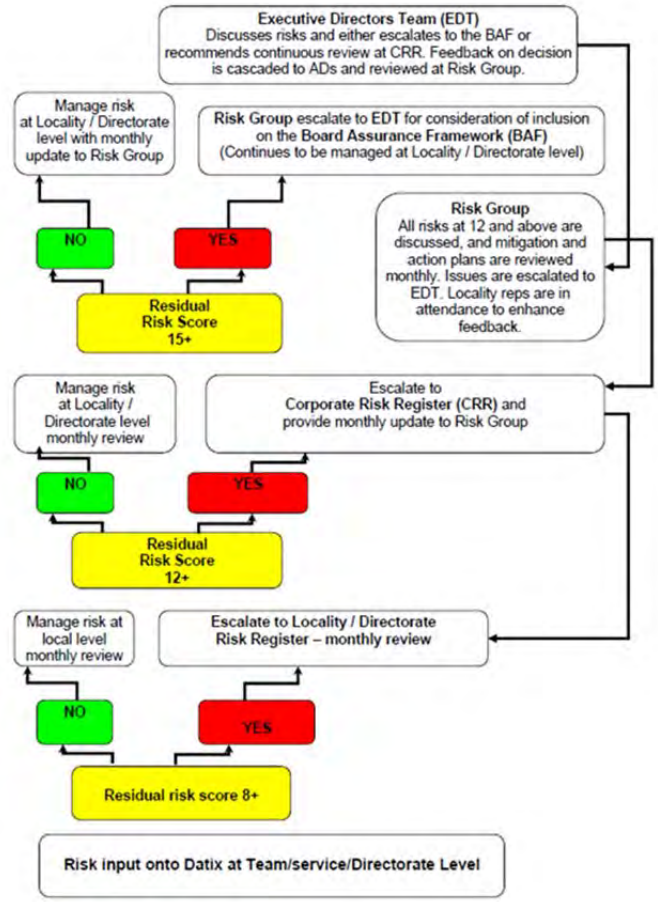
The Trust's Risk Management Strategy outlines the leadership, responsibility and accountability arrangements for risk management. The Strategy covers risk identification, evaluation, recording, control, review and assurance. It also defines the structures for the management and ownership of risk and clearly identifies the Trust's attitude and appetite for risk and at what level a risk is tolerated, clearly defining processes for Board committee review and escalation through to the Board meeting.

The Trust uses the National Patient Safety Agency risk matrix in order to assess the likelihood and severity of risks. NCHC maintains a Corporate Risk Register which is the aggregation of the local team and corporate department risk registers where the residual risk is rated at 12 and above. It maintains a Board Assurance Framework which provides a record of the principal strategic risks to the Trust achieving its objectives. The Board Assurance Framework is reported quarterly to the Board, having also undergone a detailed monthly review at both the Quality and Risk Assurance Committee and the Finance and Performance Committee.

The process for escalation and de-escalation of risks is described in the Risk Management Strategy, which also describes the process for managing risks identified through completion of the Early Warning Trigger Tool (EWTT). The EWTT captures all of the factors that could impact on the quality and safety of clinical services, identifies services that may be at risk, and helps prevent serious incidents and patient safety issues in the future.

All risk registers for the Trust are held within a centrally maintained electronic system (Datix). This system is supported through regular risk review processes led by the Lead Director. Risk register reports are then scrutinised at service level and corporate meetings. A Risk Group, comprising Trust-wide risk leads, reports to the Quality and Risk Assurance Committee. Risks that are not being successfully mitigated and controlled are escalated and discussed at executive directors' meetings in order to prioritise management action appropriately. In addition, equality impact assessments are integrated into core Trust policies through the policy approval process.

Graphic shows the risk escalation process



The Board has reviewed NHSI's Well Led Framework and undertaken a self-assessment on the CQC Well Led Key Line of Enquiry, and confirmed full compliance and is assured that services are Well Led. NCHC is fully compliant with the registration requirements of the CQC, and risks to on-going compliance have been fully assessed.

The Trust's strategic risks

The Trust's strategic risks monitored through the Board Assurance Framework were:

- Risks to improving our quality: implementation of the Health and Care Strategy.
- Risks to enabling our people: (1) staff engagement, and (2) staff deployment.
- Risks to securing the future: (1) delivering the cost improvement programme (CIP), (2) managing high risk cost pressures (HRCP), (3) maintaining good commissioner relations, and (4) ensuring the sustainability of services, including risks in relation to the Sustainability and Transformation Partnership.

At the year-end the following risks remained above the target risk rating set by the Board: CIP, HRCP, commissioner relations, and the sustainability of services. Of these two remained red rated: CIP and HRCP.

In addition, a key risk to quality has been identified as: ensuring sufficient qualified staff are in post, which is being addressed through recruitment plans and the Health and Care Strategy.

Newly identified in-year and future risks

Three new risks have been identified during the year. Significant improvements are required to improve the adequacy and effectiveness of governance, risk management and control in relation to cyber security, business continuity plans and IT disaster recovery.

NHS Pension Scheme

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.

Equality, diversity and human rights

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

Carbon reduction delivery plans

NCHC has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Information governance

There were two level two information governance serious incidents requiring investigation. These are defined as sufficiently high profile cases or deemed a breach of the Data Protection Act or Common Law Duty of Confidentiality, and hence reportable to the Department of Health and Information Commissioner's Office. A summary of the two incidents is provided below:

Loss of dental records in transit

As part of a wider project to digitise records within the dental service a number of records were lost in transit between Norfolk Community Health and Care NHS Trust (NCHC) and the third party scanning company. Transfer of these records was arranged by the scanning company and following the incident all parties were able to recover all but 13 records which were suspected to have been destroyed securely. This incident was reported to the Information Commissioners Office (ICO) and details of NCHCs response were provided. Following review by the ICO enforcement team it was decided that no further action was needed as NCHC had done all it was able to and managed to recover all but 13 records. The individuals whose records were lost were written to by the Dental Service and offered the opportunity to talk to someone within the dental service and agree a path forwards in their care.

Loss of a child's record

A record was identified as missing between Norfolk and Norwich University Hospital Foundation Trust (NNUH) and Norfolk Community Health and Care NHS Trust (NCHC). Although this loss related to a single record, it was classified as a level 2 due to the nature of the information held within the record and as a result was reported to the Information Commissioner's Office (ICO). Following root cause analysis neither NCHC nor NNUH were able to establish where the records loss was likely to have taken place although the last known location of the record was on an NCHC premises. As part of the mitigation to the loss it was established that the physical record was able to be re-created through electronically held copies of the data jointly by NCHC and NNUH. As a result of this the ICO Enforcement Team decided that no further action was needed.

NHS provider licence

As an NHS Trust, NCHC is exempt from the requirement to hold a NHS Provider Licence for the provision of NHS services under Statutory Instrument 2013 No. 2677 "The National Health Service (Licence Exemptions, etc.) Regulations 2013". The Board has self-certified compliance with the NHS Provider Licence after assessing the principal risks to compliance, particularly in relation to:

- The effectiveness of governance structures.
- The responsibilities of Directors and committees.
- The reporting lines and accountabilities between the Board, its committees and the Executive Team.
- The submission of timely and accurate information to assess risks to compliance with the conditions of the licence, and

- The degree and rigour of oversight the Board has over the trust's performance.

The Board concluded that NCHC is compliant with the NHS Provider Licence.

Board and its committees: structure, attendance, coverage

The Board comprises the Chair and five Non-Executive Directors, and one non-voting Associate Non-Executive, drawn from a variety of backgrounds, the Chief Executive and four voting and one non-voting Executive Directors who lead the organisation. The Board is supported by a qualified company secretary who attends all Board meetings. The membership, designation and roles of each Board member are set out in the table below. All Board members were in post from 1 April 2017 to 31 March 2018, except where indicated.

Table showing the designation and roles of Board directors

Name	Designation	Role
Geraldine Broderick	Non-Executive	Chair: Trust Board Chair: Remuneration Committee
Roisin Fallon-Williams	Executive	Chief Executive
Derek Allwood (to 31.03.18)	Non-Executive	Chair: Audit Committee
Heather Peck	Non-Executive	Deputy Trust Chair and Senior Independent Director. Chair: Quality and Risk Assurance Committee
Amanda Reynolds (to 27.09.17)	Non-Executive	Chair: Finance and Performance Committee
Geoff Rivers	Non-Executive	Chair: Charitable Funds Committee
Dr Iain Brooksby	Non-Executive	Deputy Chair: Quality and Risk Assurance Committee
Stephen Pond (to 05.06.17)	Non-Executive (non-voting)	Associate NED
John Kennedy (from 01.10.17)	Non-Executive	Chair: Finance and Performance Committee
Andrew Williams (from 01.09.17)	Non-Executive (non-voting)	Associate NED
Lorrayne Barrett	Executive	Director of Norfolk Adult Operations and Integration
Andrew Hopkins	Executive	Director of Finance and Performance
Paul Cracknell	Executive (non-voting)	Director of Strategy and Transformation
Anna Morgan	Executive	Director of Nursing and Quality
Dr Penny Newman (to 13.08.17)	Executive	Medical Director

Dr Venu Harilal Interim MD from 01.09.17 to 31.12.17) Medical Director from 01.01.18.	Executive	Medical Director

The Board applies the principles of integrated governance to ensure that clinical services are consistently safe, effective and experience is good, and that resources are used and managed effectively. The Board operates to a forward agenda plan that covers quality, strategy, performance & planning and corporate governance matters. The Board monitors monthly integrated performance reports, quality assurance reports and finance reports covering operational performance, quality and finance, and the Board Assurance Framework.

During the year the Board met on ten occasions, in public, and also in closed session, immediately following the meeting in public, where members of the public were excluded. The Board also held three additional extraordinary meetings in private. A report on the items discussed in closed session is presented to a subsequent meeting in public. The extraordinary meetings in private were held primarily to consider commercial-in-confidence tendering opportunities, in accordance with the Trust's Standing Financial Instructions and Tender Governance Manual.

Tables below showing attendance at Board meetings

April-September 2017

Forename	Surname	Position	26/04/17 - Public	26/04/17 - Private	31/5/17 - Public	31/5/17 - Private	28/6/17 - Public	28/6/17 - Private	26/7/17 - Public	26/7/17 - Private	27/9/17 - Public	27/9/17 - Private
Geraldine	Broderick	Chair	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Roisin	Fallon-Williams	Chief Executive	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Derek	Allwood	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lorrayne	Barrett	Director of Norfolk Adult Operations and Integration	Y	Y	APOLS	APOLS	Y	Y	Y	Y	Y	Y
Dr Iain	Brooksby	Non Executive Director	Y	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y
Paul	Cracknell	Director of Strategy and Transformation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Andrew	Hopkins	Director of Finance and Performance	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mike	Jones	Trust Secretary	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Heather	Peck	Non Executive Director	Y	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y
Dr Penny	Newman	Medical Director	Y	Y	Y	Y	APOLS	APOLS	Y	Y		
Dr Venu	Harilal	Medical Director (from 01.09.17)									Y	Y
Anna	Morgan	Director of Nursing and Quality	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Stephen	Pond	Non Executive Director Designate (finished 05.06.17)	Y	Y	Y	Y						
Amanda	Reynolds	Non Executive Director	Y	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y
Geoff	Rivers	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Andrew	Williams	Associate Non Executive Director (from 01.09.17)									Y	Y

October 2017-March 2018

Forename	Surname	Position	25/10/17 - Public	25/10/17 - Private	29/11/17 - Public	29/11/17 - Private	31/1/18 - Public	31/1/18 - Private	14/3/18 - Public	14/3/18 - Private	28/3/18 - Public	28/3/18 - Private
Geraldine	Broderick	Chair	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Roisin	Fallon-Williams	Chief Executive	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Derek	Allwood	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lorrayne	Barrett	Director of Norfolk Adult Operations and Integration	Y	Y	APOLS	APOLS	Y	Y	Y	Y	Y	Y
Dr Iain	Brooksby	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Paul	Cracknell	Director of Strategy and Transformation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Andrew	Hopkins	Director of Finance and Performance	APOLS	APOLS	APOLS	APOLS	Y	Y	Y	Y	Y	Y
Mike	Jones	Trust Secretary	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
John	Kennedy	Non Executive Director (from 01.10.17)	Y	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y
Heather	Peck	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	APOLS	APOLS
Dr Venu	Harilal	Medical Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Anna	Morgan	Director of Nursing and Quality	Y	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y
Geoff	Rivers	Non Executive Director	Y	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y
Andrew	Williams	Associate Non Executive Director (from 01.09.17)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

The Board is supported by five committees, each chaired by a Non-Executive:

- Audit Committee.
- Quality and Risk Assurance Committee.
- Finance and Performance Committee.
- Charitable Funds Committee.
- Remuneration and Nominations Committee.

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

Audit Committee

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

Table below showing Audit Committee members' attendance

Forename	Surname	Position	8/5/17	31/5/17 - EO	11/9/17	04-Dec-17	12-Mar-18
Derek	Allwood	Chair and Non Executive Director	Y	Y	Y	Y	Y
Amanda	Reynolds	Deputy Chair and NED	Y	Y	Y		
Heather	Peck	Non Executive Director	Y	Y	Y	Y	Y
Andrew	Wiliams	Associate Non Executive Director				Y	Y

Quality and Risk Assurance Committee (QRAC)

QRAC provides the leadership, supervision and monitoring of all serious incidents, complaints, claims and Coroner's inquests. It provides the overview, enquiry and challenge to ensure consistency; appropriate levels of investigation; root cause analysis and that key learning is implemented; clear responsibilities and roles within the risk management process ensure that all actions and recommendations identified as part of the process are completed; and that there are effective interfaces between the Trust's directorates, to monitor ongoing compliance. The lessons learnt from

these processes are communicated Trust-wide through clear lines of communication. QRAC reviews the content of the Quality Account before it is presented to Board. The Committee receives minutes and exception reports from sub-groups that monitor specific areas of clinical quality and risk, for example: Safeguarding; Infection Control; Patient Experience; Clinical Audit and Effectiveness. The Committee has oversight of the Trust's entire risk profile, both clinical and non-clinical and routinely escalates non-clinical risks to other committees. The Committee also monitors other areas of quality and risk, such as: Information Governance; Records Management; Health and Safety; and Equality and Diversity.

Table below showing QRAC members' attendance

Forename	Surname	Position	18/4/17	18/4/18	18/4/19	18/4/20	18/4/21	18/4/22	18/4/23	18/4/24	18/4/25	18/4/26	18/4/27	18/4/28
Lorrayne	Barrett	Director of Norfolk Adult Operations and Integration	APOLS	Y	APOLS	APOLS	APOLS	APOLS	APOLS	Y	APOLS	Y	APOLS	Y
Dr Venu	Harilal	Interim Medical Director (from 01.09.17)						Y	Y	Y	Y	Y	Y	Y
Dr Penny	Newman	Medical Director	Y	Y	Y	Y	APOLS							
Anna	Morgan	Director of Nursing and Quality	Y	Y	Y	Y	Y	APOLS	Y	Y	Y	Y	Y	Y
Derek	Allwood	Non Executive Director	Y	APOLS	Y	APOLS	Y	Y	Y	Y	Y	Y	Y	Y
Iain	Brooksby	Non Executive Director	Y	Y	APOLS*	Y	Y	Y	Y	Y	Y	APOLS	Y	APOLS
Heather	Peck	Non Executive Director and Chair	Y	Y	APOLS	Y	Y	Y	Y	Y	Y	APOLS	Y	Y

* Geoff Rivers attended as Iain's deputy 19/6/17

Finance and Performance Committee (FPC)

The FPC reviews the financial and performance strategies, policies and reports and efficiency plans of the Trust on a monthly basis.

Table below showing FPC members' attendance

Forename	Surname	Position	24/4/17	30/5/17	26/6/17	24/7/17	29/8/17	25/9/17	23.10.17	27/11/17	11/12/17	29/1/18	27/2/18	27/3/18
Lorrayne	Barrett	Director of Norfolk Adult Operations and Integration or Deputy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Andrew	Hopkins	Director of Finance and Performance	Y	Y	APOLS	Y	Y	Y	Y	Y	APOLS	Y	Y	Y
Paul	Cracknell	Director of Strategy and Transformation	Y	Y	Y	Y	APOLS	Y	Y	Y	Y	Y	Y	Y
John	Kennedy	Non Executive Director and Chair (from 01.10.17)							Y	Y	Y	Y	Y	Y
Anna	Morgan	Director of Nursing and Quality	Y	Y	Y	Y	APOLS	Y	Y	Y	Y	Y	APOLS	Y
Geoff	Rivers	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	APOLS	Y	APOLS	APOLS
Andrew	Williams	Associate Non Executive Director (from 01.09.17)									Y	Y	APOLS	Y
Stephen	Pond	Non executive Director Designate	Y	Y										
Amanda	Reynolds	Non Executive Director and Chair	Y	Y	Y	Y	Y	APOLS						

Remuneration Committee (RC)

The RC provides a forum for succession planning and considering executive pay and conditions.

Table below showing RC members' attendance

Forename	Surname	Position	18/10/17	21/3/18
Geraldine	Broderick	Chair	Y	Y
Derek	Allwood	Non Executive Director	Y	Y
Dr Iain	Brooksby	Non Executive Director	Y	APOLS
Liz	Cooke	Head of Human Resources	Y	Y
Roisin	Fallon-Williams	Chief Executive	APOLS	Y
John	Kennedy	Non Executive Director		APOLS
Amanda	Reynolds	Non Executive Director		
Heather	Peck	Non Executive Director	APOLS	APOLS
Geoff	Rivers	Non Executive Director	Y	APOLS
Andrew	Williams	Associate Non Executive Director		APOLS

Charitable Funds Committee (CFC)

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

Table below showing CFC members' attendance

Forename	Surname	Position	17.5.17	16.8.17	15.11.17	14.2.18
Derek	Allwood	Deputy Chair and Non Executive Director (to 31.03.18)	Y	Y	Y	Y
Andew	Hopkins	Director of Finance and Performance	Y	APOLS	Y	APOLS
Geoff	Rivers	Chair and Non Executive Director	Y	Y	Y	Y
Anna	Morgan	Director of Nursing and Quality	Y	Y	APOLS	Y

Assessment of Board effectiveness

The Board undertakes annual self-assessment exercises. It reviewed the outcome of its annual self-assessment evaluation at its meeting on 25 April 2018. The learning points from the Board effectiveness activities have been taken forward and implemented throughout the year. The Board Development Programme continues to embed the lessons learned from the activities undertaken during the previous year. The assessments confirm that the Board is effective and that key learning points are being taken forward. Each committee has also undertaken a self-assessment on their effectiveness and performance against its delegated responsibilities as set out

in the terms of reference. The Board reviews the annual assurance reports from each committee in May each year. These confirmed that they were effective in discharging their delegated responsibilities. The most recent external evaluation of NCHC was undertaken by the CQC during February and March 2018.

Last year the Board identified five priority areas to focus on in order to improve its effectiveness and these have shown improvements this year:

- Further improve the conciseness of Board papers including effective summaries.
- Allow sufficient challenge on each Board item.
- Involve and inform key stakeholders in the work of the Board, and take account explicitly of their views and those of staff in its strategy.
- Demonstrate more clearly the link between the time spent at Board on strategy being reflected in defined proposals for the Business Plan.
- Board diversity to be addressed through the Board's succession planning.

For the coming year the Board is focusing on measures to further improve:

- Conciseness of Board papers.
- Diversity on the Board.
- Sufficient time being spent on each agenda item.
- Board policies and strategies taking into account the views of staff and stakeholders, inform and involve stakeholders in its work, check their views and monitor this.

Audit Committee assurance report

The committees produce annual assurance reports to the Board on how they have discharged their remit throughout the year. In particular, the Audit Committee's report has confirmed to the Board that:

- The system of risk management is adequate in identifying risks and allows the Board to understand the appropriate management of those risks.
- The Board Assurance Framework is fit for purpose and the comprehensiveness of the assurances and the reliability and integrity of the sources of assurance are sufficient to support the Board's decision making and declarations.
- There are no areas of significant duplication or omission in the systems of governance that have come to the Committee's attention and not been resolved adequately.

Corporate governance

As an NHS Trust, NCHC is not required to comply with the UK Code of Corporate Governance nor the NHS Foundation Trust Code of Governance. However, The Trust's Governance Manual, incorporating Standing Orders, Standing Financial Instructions and the Scheme of Delegation and Reservation of Powers to the Board, is fully compliant with the Department of Health's model Standing Orders for NHS Trusts, as updated to comply with changing legal and regulatory requirements. The Board has also undertaken a self-assessment against the CQC's Well-led Key Lines

of Enquiry, including consideration of NHSI's Well-led Framework.

Annual Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The Board considers that the Quality Account presents a balanced picture of the Trust's performance over the reporting period, that the performance information reported in the Quality Account is reliable and accurate, that there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice, that the data underpinning the measure of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review, and that the Quality Account has been prepared in accordance with Department of Health guidance.

Data quality

NCHC assures the quality and accuracy of elective waiting time data and the risks to the quality and accuracy of this data, through review by Internal Audit and robust internal assurance processes. Improving data quality, which includes the quality of demographic, ethnicity and other equality data, should improve patient care and improve value for money. NCHC is taking the following actions to further improve data quality:

- A range of data quality reports have been designed to monitor a range of key performance indicators on a weekly and monthly basis.
- The Secondary Uses Service (SUS) dashboards are reviewed regularly in relation to a number of national key indicators.
- A selection of these indicators are also reported to the Data Quality Forum where operational services are held to account for the quality of data held on the Patient Administration System (PAS) and SystmOne (electronic patient record).
- These reports are held on a networked drive and can also be viewed on an Intranet portal to ensure they are accessible to key staff involved in the monitoring and reporting of performance and activity data.

NCHC has a Data Quality Strategy which is critical to a number of the Trust's priorities and objectives, including improving the quality of patient care, compliance with the NHS Information Governance (IG) Toolkit and the need to monitor the Community Information Data Set (CIDS). This strategy is underpinned by a Data Quality Policy which is subject to annual review. The purpose of this policy is to ensure the highest standards of data quality throughout NCHC are achieved and maintained. This policy is for all staff collecting and using data and they must adhere to the local and national standards as laid out in this policy. These procedures check the quality and accuracy of performance data including elective waiting time data and assess the risks to the quality and accuracy. This is in turn tested by Internal Audit.

Incident reporting and learning

NCHC's Incident Reporting and Management Policy draws on best practice guidance from NHS Resolution and reflects the reporting requirements of the National Reporting and Learning System, which is monitored by NHSI and the CQC.

The policy contains flow charts for reporting incident and serious incidents requiring investigation (SIRIs), (defined by the National Patient Safety Agency) and describes the process for escalation through the DATIX incident management system, assignment of an investigator and level of investigation required through to the final approval of the incident.

All incidents, including actions and learning, are reported to Board monthly. All Serious Incidents Requiring Investigation (SIRIs) are investigated using root cause analysis methodology. Initial investigation reports to commissioners are submitted within three days of reporting a SIRI and full investigation reports are submitted together with any resulting action plan to commissioners within 40 days of the SIRI being reported. Data on all incidents including SIRIs is included in the Performance Report above.

Clinical audit

NCHC participated in 71.4% of national clinical audits and national confidential enquiries which it was eligible to participate in, as follows:

- National COPD Audit Programme Pulmonary Rehabilitation.
- National Audit of Intermediate Care.
- Sentinal Stroke National Audit Programme 2017 UK Parkinson's Audit.
- Specialist Rehabilitation for patients with complex needs.
- Learning Disabilities Mortality Review.
- National Diabetes Foot Care Audit, registered under the Queen Elizabeth II Hospital NHS Foundation Trust (Kings Lynn).

NCHC was unable to register involvement for the national Audit of Inpatient Falls due to the disruption caused during the NHS Cyber-attack.

21 local Clinical Audits were completed with full action plans developed and implemented.

"Freedom to Speak Up"

NCHC Freedom to Speak Up (F2SU) guardians have a key role in helping to raise the profile of raising concerns in the Trust and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled. Guardians do not get involved in investigations or complaints, but help to facilitate the raising concerns process where needed, ensuring policies are followed correctly.

At NCHC F2SU has:

- Achieved national recognition through being featured as a good practice case study in the National Guardian for the NHS Annual Report.
- Maintained a communication plan to keep the agenda and reporting processes visible for staff.
- Provided ongoing training, development and support for our F2SU guardians and champions.
- Developed a variety of reporting options.
- Achieved full compliance against national benchmarking standards.

Emergency Preparedness

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet in relation to EPRR. These are monitored via an annual assurance process, the results of which are submitted to NHS England. NCHC was deemed to be substantially compliant after an initial review submission in September 2017 and fully compliant after further review in March 2018. A review and initial submission of the Core Standards for 2018/19 will take place in September 2018.

Statement on the discharge of statutory functions

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

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

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

3.3.4 Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have

drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality and Risk Assurance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- The Board reviewed the Board Assurance Framework quarterly, following monthly review by management and Board committees.
- The Board reviewed Trust performance against national and local clinical quality targets, as well as delivery against corporate and strategic objectives, at each Board meeting.
- The Board regularly reviewed Trust delivery against its annual priorities.
- The Audit Committee reviewed annual reports from the other Board committees, focusing on the process by which assurance was gained by these committees.
- Each Board Committee provided Annual Assurance Reports, setting out how they have discharged their delegated responsibilities in accordance with their terms of reference.
- Each Board Committee undertook their annual self-assessment of their performance and effectiveness, and identified areas for improvement, and their training needs.
- There is an effective clinical audit programme in place.
- Have taken into account the views of the Caldicott Guardian and Senior Information Risk Owner.
- The Internal Audit programme and the Head of Internal Audit Opinion.
- Performance assessed by NHS regulators. As described in the Performance Summary section above, the CQC has rated the Trust as “Good” following an inspection in 2014 and NHSI has placed the Trust into segment two of the Single Oversight Framework.

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

The following reviews were undertaken by the Trust’s Internal Auditors during the year:

- Corporate Performance including Risk Management – Medium Risk
- CPRM follow-up review – Low Risk
- Key Financial Systems – Low Risk
- Cyber Security – High Risk
- IT Disaster Recovery – High Risk
- Information Governance – Medium Risk

3.3.5 The Head of Internal Audit Opinion:

The overall opinion from internal audit is “general satisfactory with some improvements required”. However, this does not include the areas of Cyber Security and IT Disaster Recovery, in which both were found to present significant risks in the control environment.

Excluding these two areas: “Governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control.

IT processes - Cyber Security and IT Disaster Recovery. Significant improvement required: There are significant weaknesses and non-compliance in the framework of governance, risk management and control which put the achievement of organisational objectives at risk. It should be noted that these issues are considered High risk due to their ability to have a significant impact on the operations and reputation of the Trust, although the Trust considers them to be low likelihood. Significant improvements are required to improve the adequacy and effectiveness of governance, risk management and control in relation to Cyber Security and IT Disaster Recovery.”

The opinion is based on:
- All audits undertaken during the year.
- Any follow up action taken in respect of audits from previous periods.
- Any limitations which may have been placed on the scope or resources of internal audit.
- What proportion of the organisation’s audit needs have been covered to date.

Management action plans are in place to address the issues raised in the High Risk Internal Audit reports.

3.3.6 Conclusion

The significant internal control issues which have been identified in the body of the Governance Statement are IT Disaster Recovery and Cyber Security. In addition, the cost improvement programme has been a significant risk throughout the year, with 49% achievement; £3.0m against the original plan of £6.2m. The Financial Plan for 2018/19 sees the Trust remain in a £3.9m deficit. In agreeing this Financial Plan for 2018/19 the Board has set a more realistic CIP target of £3.9m and has £2.5m already identified against this target.

Accountable Officer's signature

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

Signature:.....**Date**.....

Roisin Fallon-Williams
Chief Executive
Norfolk Community Health and Care NHS Trust

4. Remuneration and Staff Report

This section includes:

4.1 Remuneration Report
4.2 Staff Report

4.1 Remuneration Report

This section includes:

4.1.1 Remuneration policy
4.1.2 Salaries and allowances
4.1.3 Fair pay disclosure
4.1.4 Pension benefits
4.1.5 Cash Equivalent Transfer Values

4.1.1 Remuneration Policy

The Secretary of State for Health 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 on the basis of 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.

4.1.2 Salaries and allowances

The following tables and narrative below have been independently audited by KPMG.

The salaries and other allowances of the senior managers who have held office for all or part of the 2017/18 financial year are disclosed in the table below. Figures for staff appointed or leaving during the financial year are for the part of the year that the individual held the position.

The tables below show salaries and allowances of Board members

Name	Title	2017/18					
		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)
Geraldine Broderick	Chair	30-35	-	-	-	-	30 - 35
Roisin Fallon-Williams	Chief Executive	140-145	-	-	-	40.0 - 42.5	180 - 185
Dr. Penny Newman *	Medical Director (Until 13/08/2017)	25-30	-	-	-	47.5 - 50	70 - 75
Anna Morgan	Director of Nursing and Quality	105-110	2	-	-	32.5 - 35	140 - 145
Andrew Hopkins	Director of Finance and Performance	115-120	-	-	-	32.5 - 35	150 - 155
Paul Cracknell	Director of Strategy and Transformation	100-105	20	-	-	22.5 - 25	125 - 130
Lorrayne Barrett	Director of Norfolk Adult Operations and Integration	105-110	-	-	-	25.0 - 27.5	135 -140
Dr Venu Harilal ** ***	Medical Director (from 01/09/2017)	110-115	3	0 - 5	-	97.5 - 100	210 - 215
Derek Allwood	Non-Executive Director	5-10	2	-	-	-	5 - 10
Amanda Reynolds *	Non-Executive Director (Until 27/09/2017)	0-5	-	-	-	-	0 - 5
Stephen Pond *	Non-Executive Director (Until 05/06/2017)	0-5	-	-	-	-	0 - 5
Dr Iain Brooksby	Non-Executive Director	5-10	-	-	-	-	5 - 10
Geoff Rivers	Non-Executive Director	5-10	-	-	-	-	5 - 10
Heather Peck	Non-Executive Director	5-10	2	-	-	-	5 - 10
John Kennedy **	Non-Executive Director	0-5	-	-	-	-	0 - 5
Andrew Williams **	Associate Non-Executive Director	0-5	-	-	-	-	0 - 5

* - Leavers, Dr. Penny Newman does not include costs that relate to a secondment and left 13.08.2017; Amanda Reynolds left at 27.09.2017; Stephen Pond left at 05.06.2017 and Derek Allwood left at 31.03.2018
** - New starters, Dr. Venu Harilal commenced post 01.09.2017; John Kennedy commenced post 01.10.2017; and Andrew Williams commenced post 01.09.2017.
*** - Dr Harilal's remuneration includes both a Clinical and Medical Director role, the salary is split £80,000 for the Clinical role and £35,000 for the Medical Director role.

A '-' indicates nil.

Name	Title	2016/17					
		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)
Ken Applegate	Chair (Until 31.05.16)	0-5	7	0	0	0	0-5
Geraldine Broderick	Chair (From 21.06.16)	20-25	21	0	0	0	25-30
Roisin Fallon-Williams	Chief Executive	140-145	6	0	0	35-37.5	175-180
Dr. Penny Newman	Medical Director *	125-130	13	0	0	7.5-10	135-140
Anna Morgan	Director of Nursing and Quality	105-110	12	0	0	30-32.5	135-140
Andrew Hopkins	Director of Finance & Performance	115-120	8	0	0	100-102.5	215-220
Paul Cracknell	Director of Strategy and Transformation	105-110	27	0	0	27.5-30	135-140
Lorrayne Barrett	Director of Integrated Care	105-110	4	0	0	25-27.5	130-135
Derek Allwood	Non-Executive Director	5-10	13	0	0	0	5-10
Heather Peck	Non-Executive Director and interim chair **	5-10	13	0	0	0	5-10
Geoff Rivers	Non-Executive Director	5-10	5	0	0	0	5-10
Stephen Pond	Designate Non-Executive Director	5-10	0	0	0	0	5-10
Amanda Reynolds	Non-Executive Director	5-10	0	0	0	0	5-10
Dr Iain Brooksby	Non-Executive Director	5-10	0	0	0	0	5-10

* Dr. Penny Newman's remuneration includes costs that relate to a secondment to Health Education England (HEE) for the following periods:
01.04.16 to 31.07.16 for 15hrs per week; and
01.08.16 to 31.10.16 for 7.5hrs per week.
Costs for the secondment have been reimbursed to the Trust by HEE.
There is £23k of pay arrears relating to 2015/16 included in the table above, which were paid during April 2016.

** Heather Peck was interim chair for the period between Ken Applegate leaving and Geraldine Broderick joining the Trust.

4.1.3 Fair pay disclosure

The narrative below has been independently audited by KPMG.

NHS organisations are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director in NCHC in the financial year was £140-£145k (£140-£145k in 2016/17). The mid-point of this band was 5.6 times (5.4 in 2016/17) the median remuneration of the workforce, which was £25,551 (£26,302 in 2016/17). In 2017/18, no employees (no employees in 2016/17) received whole time equivalent remuneration in excess of the highest paid director. Remuneration ranged from £6,157 to £143,924 (2016/17 £6,157- £142,360). For the purposes of this calculation, total remuneration includes salary and non-consolidated performance-related pay. It does not include severance payments or the cash equivalent transfer value of pensions.

4.1.4 Pension benefits

The following tables and narrative below have been independently audited by KPMG.

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the Government Financial Reporting Manual 2017-18 (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 at 31 March 2018 is based on valuation data at 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

(b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

Pension benefits for the executive directors are disclosed in the table below. These benefits relate to membership of the NHS Pension Scheme which is open to all employees.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Tables on next page showing pension benefits of executive members of the Board

2017/18		Real increase in pension at age 60 (bands of £2,500)	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017 (to nearest £1,000)	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018 (to nearest £1,000)	Employer's contribution to stakeholder pension
Name	**Title**	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Roisin Fallon-Williams	Chief Executive	2.5 - 5.0	7.5 - 10.	55 - 60	175 - 180	1,054	113	1,167	-
Penny Newman	Medical Director	0 - 2.5	5.0 - 7.5	25 - 30	80 - 85	505	61	566	-
Anna Morgan	Director of Nursing, Quality & Operations	0 - 2.5	0.0 - 2.5	30 - 35	40 - 45	417	52	469	-
Andrew Hopkins	Director of Finance & Performance	2.5 - 5.0	0.0 - 2.5	40 - 45	110 - 115	722	54	776	-
Paul Cracknell	Director of Strategy and Transformation	0 - 2.5	-	15 - 20	35 - 40	212	30	242	-
Lorrayne Barrett	Director of Integrated Care	0 - 2.5	-	5 - 10	0	48	26	74	-
Venu Harilal	Interim Medical Director	5.0 - 7.5	2.5 - 5.0	30 - 35	30 - 35	333	78	411	-

A '-' indicates nil.

2016/17		Real increase in pension at age 60 (bands of £2,500)	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2016 (to nearest £1,000)	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017 (to nearest £1,000)	Employer's contribution to stakeholder pension
Name	**Title**	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Roisin Fallon-Williams	Chief Executive	0 - 2.5	5 - 7.5	55 - 60	165 - 170	980	74	1054	0
Penny Newman	Medical Director	0 - 2.5	2.5 - 5	20-25	70-75	467	38	505	0
Anna Morgan	Director of Nursing, Quality & Operations	0 - 2.5	0 - 2.5	30 - 35	40 - 45	380	37	417	0
Andrew Hopkins	Director of Finance & Performance	5 - 7.5	10 - 12.5	40 - 45	110 - 115	596	126	722	0
Paul Cracknell	Director of Strategy and Transformation	0 - 2.5	0 - 2.5	15 - 20	35 - 40	189	23	212	0
Lorrayne Barrett	Director of Integrated Care	0 - 2.5	0	0 - 5	0	24	24	48	0

4.1.5 Cash Equivalent Transfer Values

The following narrative has been independently audited by KPMG.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

4.2 Staff Report

The Staff Report includes:

4.2.1 An analysis of staff numbers and costs
4.2.2 Staff composition
4.2.3 National Staff Survey
4.2.4 Examples of workforce developments
4.2.5 Staff policies on: equal opportunities, social, community and human rights issues, equality disclosures, health and safety, employee consultation
4.2.6 Staff recognition
4.2.7 Expenditure on consultancy
4.2.8 Off-payroll engagements
4.2.9 Exit packages

4.2.1 Analysis of staff numbers and costs

The number of senior managers (defined as those Bands classed Senior Management under Agenda for Change) by Band within the Trust is set out below:

Table showing number of Senior Management by pay band

Band	Headcount
Band 8 - Range A	68
Band 8 - Range B	25
Band 8 - Range C	14
Band 8 - Range D	4
Band 9	3
VSM	2

@31-MAR-2018

Table below showing staff numbers

Staff Numbers	2017-18			2016-17
	Total Number	**Permanent Employed Number**	**Other Number**	**Total Number**
Average Staff Numbers				
Medical and dental	**29**	29	0	**29**
Administration and estates	**438**	429	9	**510**
Healthcare assistants and other support staff	**691**	656	35	**725**
Nursing, midwifery and health visiting staff	**733**	703	30	**847**
Nursing, midwifery and health visiting learners	**0**	0	0	**0**
Scientific, therapeutic and technical staff	**341**	335	6	**404**
Healthcare science staff	**4**	4	0	**4**
Social care staff	**1**	1	0	**1**
Other	**7**	7	0	**7**
Total	**2,244**	**2,164**	**80**	**2,527**
Of the above - staff enaged on capital projects	**5**	5	0	**4**

Table below showing employee benefits

Employee Benefits	2017-18		
	Total £000	Permanently Employed total £000	Other total £000
Employee Benefits - Gross Expenditure			
Salaries and wages	65,955	63,555	2,400
Social security costs	6,201	5,984	217
Apprenticeship levy	319	319	0
Pension cost - employer contributions to NHS pension scheme	8,964	8,649	314
Pension cost - other	6	6	0
Other employment benefits	210	210	0
Termination benefits	177	177	0
Temporary staff - agency/contract staff	2,049	0	2,049
TOTAL STAFF COSTS	**83,880**	**78,900**	**4,981**
Included within:			
Employee Costs Capitalised	**253**	**253**	**0**
Operating expenditure analysed as:			
Gross Employee Benefits excluding Capitalised costs	**83,627**	**78,647**	**4,981**

Employee Benefits - Gross Expenditure 2016-17	2016-17		
	Total £000	Permanently Employed total £000	Other total £000
Salaries and wages	70,879	70,879	0
Social security costs	6,791	6,568	223
Pension cost - employer contributions to NHS pension scheme	9,901	9,576	325
Pension cost - other	1	1	0
Other employment benefits	231	231	0
Termination benefits	443	443	0
Temporary staff - external bank	2,552	0	2,552
Temporary staff - agency/contract staff	4,152	0	4,152
TOTAL STAFF COSTS	**94,950**	**87,698**	**7,252**
Included within:			
Employee Costs Capitalised	**575**	**152**	**423**
Operating expenditure analysed as:			
Gross Employee Benefits excluding Capitalised costs	**94,375**	**87,546**	**6,829**

"Permanently employed" refers to members of staff with a permanent (UK) employment contract directly with the Trust.

"Other" refers to any staff engaged on the objectives of the Trust that does not have a permanent (UK) employment contract with the Trust. This includes employees on short term contracts of employment, agency/temporary staff, locally engaged staff overseas, and inward secondments from other entities where the whole or majority of the employees' costs are met locally.

The figures exclude non-executive directors but include executive Board members and staff recharged by other Department of Health group bodies.

4.2.2 Staff composition

The Trust is committed to providing equal opportunities for all staff. The following table shows a breakdown of the Trust's staff, by category and gender:

Table below showing staff numbers by gender

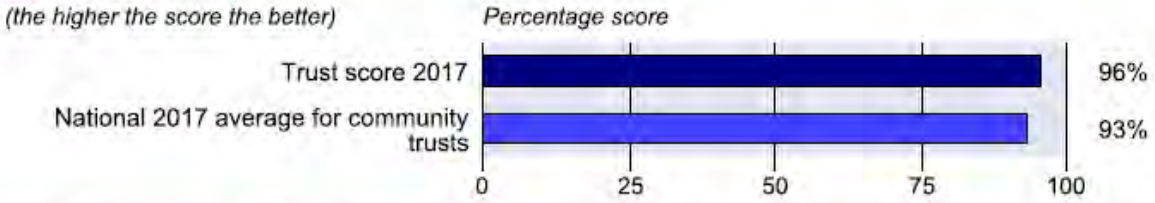
Staff Category	Female	Male	Total
Directors	5	6	11
Non-voting directors and other VSMs	0	2	2
Other staff	1924	321	2245
Total	1929	329	2258

4.2.3 National Staff Survey

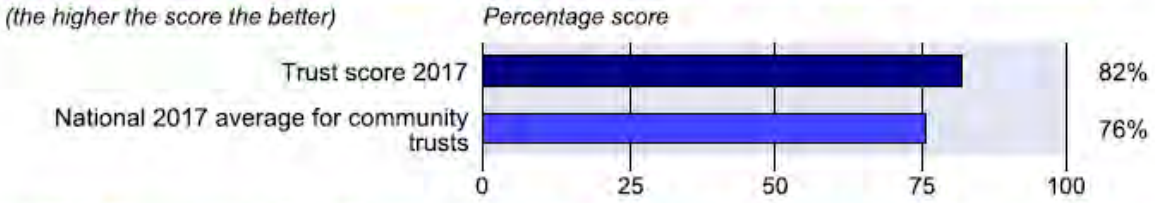
1,175 NCHC staff took part in this survey. This is a response rate of 55%, which is above average for community trusts in England (50%), and compares with a response rate of 48% in the 2016 survey.

Graphic below highlights the five key findings from the National Staff Survey for which NCHC compares most favourably with other community trusts in England.

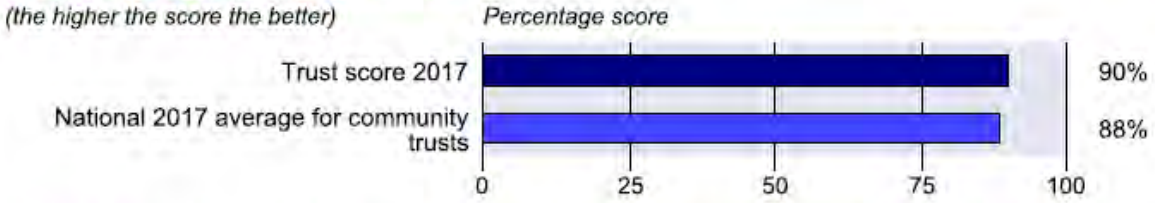
✓ KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month



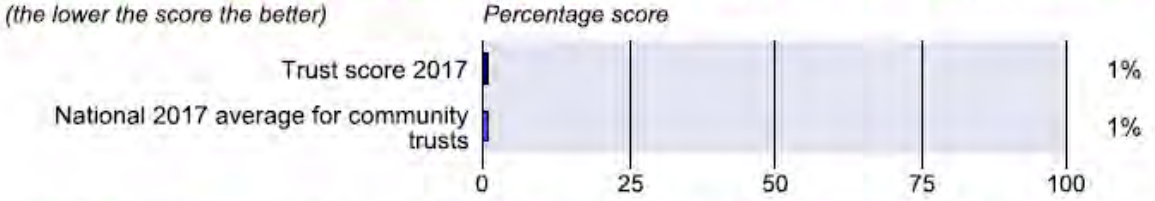
✓ KF24. Percentage of staff / colleagues reporting most recent experience of violence



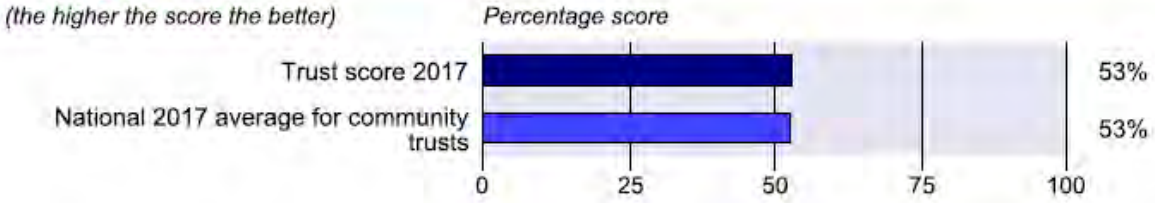
✓ KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



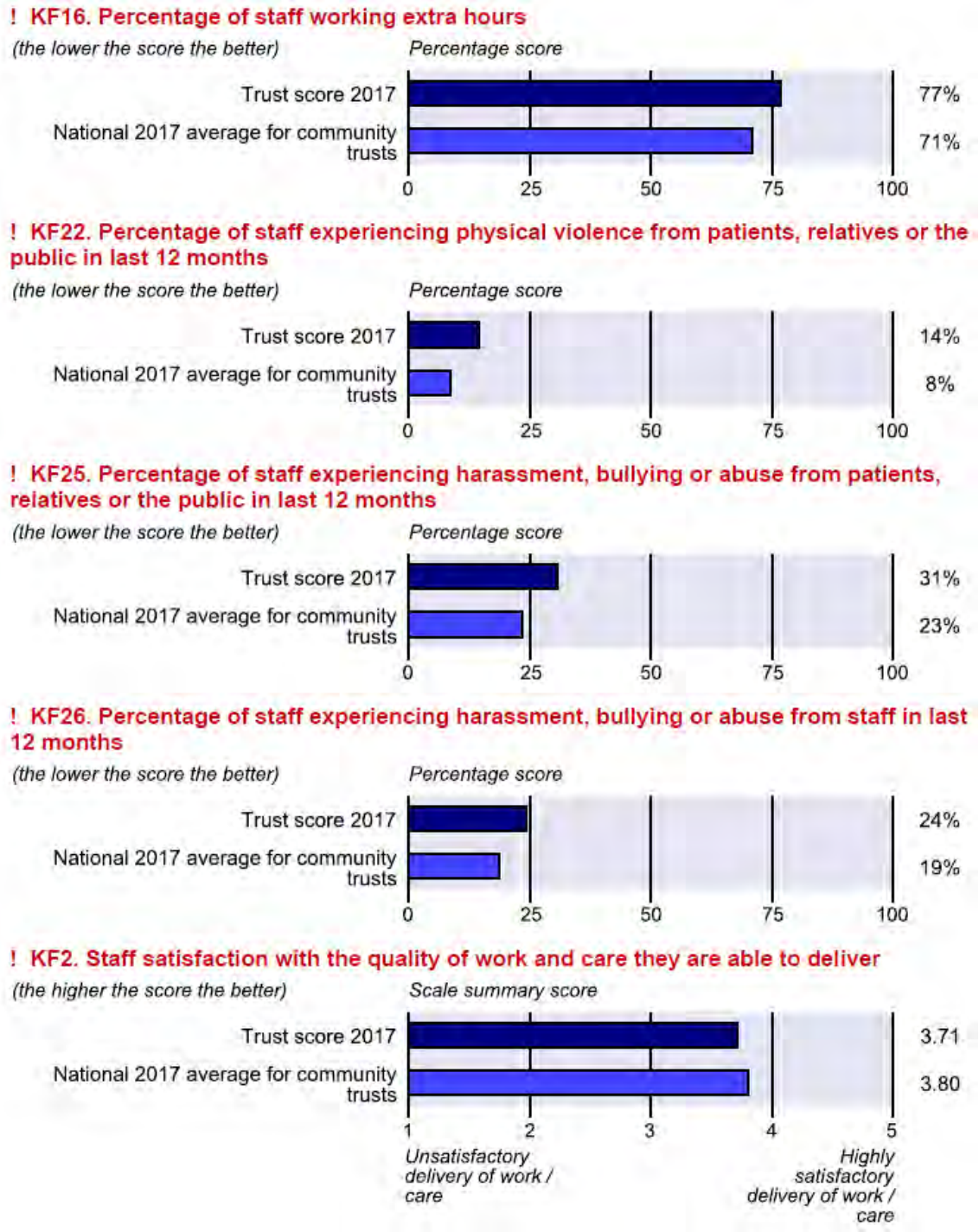
✓ KF23. Percentage of staff experiencing physical violence from staff in last 12 months



✓ KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse



Graphic below highlights the five key findings for which NCHC compares least favourably with other community trusts in England.



A Trust-wide programme of activities is underway to address the issues raised in the National Staff Survey.

4.2.4 Examples of workforce developments

This section includes:

- Tackling bullying and harassment
- Your Voice Our Future
- Quality Champions Programme
- Talent Management
- Other initiatives
- Leadership development
- Clinical apprenticeships

Tackling bullying and harassment

Working with our Trade Unions we have launched an active campaign to reduce the levels of bullying and harassment experienced by staff. The Trust takes a zero tolerance stance against bullying and harassment and the campaign has focused on addressing both staff and public behaviours. The campaign is supported by a network of “buddies”, who are members of staff who provide advice and signposting to staff who believe they are experiencing bullying.

“Your Voice Our Future”

NCHC continued to utilise its staff engagement tool called “Your Voice Our Future” which has 3 aims: (1) Stakeholder management: to build relationships with key staff groups to gather, understand and share their requirements. (2) Crowdsourcing campaign management: to design and manage targeted on-line crowdsourcing campaigns that achieve our objectives. (3) Catalysing change: to turn insight from each campaign into positive change. We have now held 7 online conversations with staff through this method covering a wide range of issues, and providing us with a wealth of information that has enabled us to increase the staff engagement score in the 2017 NHS National staff survey from 3.71 to 3.77.

Quality Champions Programme

NCHC’s Quality Champions Programme continues. This aims to give staff the opportunity to learn about quality improvement tools and techniques and put this knowledge into practice. As a champion, participants will be able to identify required improvements in their own area and then make small scale changes that can make a difference for patients and staff. Training and development is provided to improve skills at workshops and with additional coaching sessions and support available.

Talent Management

A Talent Management process is embedded into the organisation to help succession planning and support individual development needs for our leaders. To date this process has involved all band 7 and band 8 staff, and will be rolled out to other levels.

Other initiatives

Other initiatives described in detail within the Quality Account include:

- Re-validation for nurses and re-registration for Allied Health Professionals, doctors, dentists and others.
- Preceptorship.
- Apprenticeships.
- Flexible Nursing.
- Care Certificate.
- Staff Health and Wellbeing.
- Local staff surveys.

Leadership development

NCHC has completely reviewed the offer it makes to managers to support learning and development, resulting in a range of new programmes. These commence with “Leading in NCHC” for managers new to the Trust to understand our leadership approach and to provide them with a range of practical tools to be effective. REAL First Line Leader is for managers who have completed Leading in NCHC and provides key leadership skills and knowledge. Operational leader is for managers and service leads who contribute to the delivery of the Trust’s strategy and helps participants to understand themselves better, analyse business issues and create continuous improvement within their teams.

Development of Clinical Apprenticeships

NCHC has an ambitious plan as part of its “grow your own” strategy, and as outlined in its workforce strategy, to escalate significantly the number of clinical nursing and allied health professional apprenticeships it supports within the workplace, fully utilising its Apprenticeship levy over the next two years.

4.2.5 Staff policies

This section includes:

- Equal opportunities.
- Equality disclosures.
- Social, community and human rights issues.
- Employee consultation.
- Health and Safety.
- Sickness absence.

Equal opportunities

NCHC’s approach to equal opportunities is set out in the Equality and Diversity Policy and the Equality Delivery Scheme. The Board is committed to improving equal opportunities and equality performance by NCHC, making it embedded in mainstream business and for all staff to meet the evidential requirements of the

Equality Act, especially the public sector equality duty, and the statutory duty to consult and involve patients and communities and other local interests (Health and Social Care Act 2012 and Equality Act 2010). NCHC has published Equality Objectives under the following headings:

- Better health outcomes for all;
- Improved patient access and experience;
- Empowered, engaged and included staff; and
- Inclusive leadership at all levels.

Equality disclosures

The Board reaffirmed its commitment to Equality and Diversity, and approved a revised statement during the year. This statement is available on NCHC's website and is summarised below.

NCHC is committed to improving the quality of people's lives, in their homes and community by providing the best in integrated health and social care. It seeks to offer care that is compassionate and personal to individuals. This means recognising and responding to their different needs and circumstances to provide care consistently to everyone. NCHC is committed to working together with the public and its patients to overcome barriers to delivering good care. As an employer it gives equal opportunities to its staff and values the diversity of its workforce.

NCHC does not treat people less favourably because of race, age, gender, disability, religion, sexual orientation, or any other characteristic protected under law. NCHC uses Equality Delivery System 2 to help it fulfil its duties. NCHC monitors its workforce and where employees identify as having a disability or long term condition as set out in the Equality Act 2010, Access Audits are undertaken. Reasonable adjustments are then put in place to support the employees. NCHC also carries out fair and equitable access to recruitment. This means that where an applicant indicates they have a disability or long term condition as set out in the Equality Act 2010 reasonable adjustments are put in place to support the applicant.

Equality and Diversity training forms part of NCHC's induction programme and its mandatory training programme. NCHC's work in delivering equal opportunities, including support for current and potential staff with a disability, is led by NCHC's Equality and Diversity steering group and overseen by the Board of Directors.

The 2011 Census information (Norfolk) has been published and as a result, we are able to compare our ethnicity profile to the Norfolk population. The table shows a summary level comparison of the Black Minority Ethnic (BME) vs non-BME numbers. The data initially reflects that the Trust is not employing a workforce attributable to the BME population in Norfolk. However, as can be seen from the data, there is 6.76% of the organisation that has not stated what their ethnicity is.

Table below showing ethnicity of staff

Category	NCHC (%)	2011 census Norfolk (%)
Non-BME	89.44	96.3
BME	3.78	3.8
Not stated/undefined	6.76	0

Social, community and human rights issues

NCHC aims to adopt a range of good practice which helps to implement a human rights based approach in healthcare. The key messages are:

- Positive obligations - The Human Rights Act means that all health organisations have an obligation to ensure that people's rights are respected in all that they do. Our approach is based on the principles of Quality, Proportionality and Involvement.
- Quality - A human rights based approach can improve the quality of health services and prevent service failure.
- Proportionality - Any restriction of a person's human rights should be kept to a minimum.
- Involvement - The involvement of service users is an essential part of a human rights based approach based on Fairness, Respect, Equality, Dignity and Autonomy.

NCHC is committed to improving the quality of people's lives, in their homes and community by providing the best in integrated health and social care. It seeks to offer care that is compassionate and personal to individuals. This means recognising and responding to their different needs and circumstances to provide care consistently to everyone. NCHC is committed to working together with the public and its patients to overcome barriers to delivering good care. As an employer it gives equal opportunities to its staff and values the diversity of its workforce.

NCHC has carried out a range of equality analysis and human rights screening when carrying out their duties to ensure NCHC is paying 'due regard' to the three aims of the Public Sector Equality Duty and the Human Rights Act. NCHC is an early adopter of the Equality Diversity System 2 self-assessment tool. The EDS2 self-assessment was completed with the involvement of representatives from the local public sector, NHS Employers, and voluntary sector organisations such as The Guide Dogs Association for East Anglia, West Norfolk Befriending Service, Norwich Mind, and the Community Relations and Equality Board. The Board approved the self-assessment and implemented an action plan in response this assessment. All actions with a deadline during the year have been completed.

NCHC has signed up to become a Diversity Champion with Stonewall, a lobbying organisation for Lesbian, Gay, Bi-sexual and Transgender rights. Trust staff receive, as a result, support, resources and training opportunities to further promote equality and diversity across NCHC and continue to deliver fair and equitable services to all patients. We have received the results of our first assessment, which has identified a

programme of work for the Equality and Diversity Group to undertake. NCHC will submit for reassessment later in the year.

Employee consultation

NCHC has a number of ways in which it has consulted and engaged with its staff. It has held monthly staff management council meetings, to encourage two-way engagement. NCHC undertakes regular short staff surveys, in addition to the annual nation staff survey. NCHC issues a monthly newsletter to all staff, to keep staff updated and informed. A presentation on staff engagement and consultation forms part of the mandatory staff induction programme. The senior team has an open door policy allowing them to be available to staff at any time.

Specific engagement and formal consultation has taken place during the year. Staff have been involved in:

- Developing responses to service tenders.
- Transferring staff and services to alternative organisations following the cessation of a service contract in Suffolk.
- Closure of Benjamin Court and Cranmer House.
- Programme of staff engagement events across the localities.

Health and safety

NCHC recognises the importance of clear and comprehensive health and safety documentation to guide and support staff. The Trust's Health and Safety policy sets out how health and safety is managed, identifies those with specific health and safety responsibilities, and identifies the policies and procedures which must be followed. Health and Safety training forms part of NCHC's induction programme and its mandatory training programme. Health and Safety mandatory training compliance was at 97.33% for the year. There were no significant health and safety incidents reported during the year.

Sickness absence

The sickness absence rate for the year is 4.72% compared to 4.48 %for the previous year. These sickness figures are based on NCHC's internal reporting systems and cover the period 1st April 2017 to 31st March 2018. The sickness figures provided in the table below are based on information published by the Department of Health, which NCHC is required to publish. This information is based on NCHC's data, but is subject to Department of Health analysis, and covers the period 1 January 2017 to 31December 2017.

Table below showing staff sickness absence rate

Staff sickness absence	2017-18 Number	2016-17 Number
Total days lost	25,110	25,388
Total staff years	2,294	2,460
Average working days lost (per WTE)	**10.95**	**10.32**

Source: NHS Digital - Sickness Absence and Publication - based on data from the ESR Data Warehouse

4.2.6 Staff recognition

Staff were awarded or shortlisted for a number of national awards, including:

- IT Service Desk Institute winner of Best Small Service Desk.
- Rachel Keetley, shortlisted 'Championing Social Work Values' Social Worker of the Year.
- Community Neurology Service runner up with High Commendation in the Multidisciplinary Team of the Year national QuDoS (Quality in Delivery of Service).
- Winner National Smarter Travel Award, Energy Saving Trust
- HSJ awards shortlisted Workforce category for the Talent Management Programme rollout; Estates Management for delivering an enhanced patient environment; Learning Disabilities.
- Team East: LD Annual Health Checks – nominated for the Specialist Services category; Norwich Homeward for the Community Health Service redesign category.
- Community Waste Service runner-up in the annual Health Estates and Facilities Management Association awards.
- Procurement Team finalists in the National Government Opportunities Procurement Awards.
- HSJ shortlisted for Patients Safety in the Community Award

4.2.7 Expenditure on consultancy

Expenditure on consultancy services is shown in the accounts Note 5.1 Operating Expenses. The expenditure in 2017/18 was £117k (£502k in 2016/17).

4.2.8 Off-payroll engagements

Table below showing existing off-payroll payments

Engagements	Number
Existing engagements as of 31 March 2017	1
Of which, then number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	Nil
for between two and three years at the time of reporting	Nil
for between three and four years at the time of reporting	Nil
for four years or more at the time of reporting	Nil

There was 1 new off-payroll engagement during the year. Any new off-payroll engagements are subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax, and where necessary that assurance is sought, with the process being overseen by the Remuneration Committee.

Table below showing all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months.

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	1
Of which...	
No. assessed as caught by IR35	1
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	1
No. of engagements reassessed for consistency / assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Table below showing Board member and senior officer off-payroll engagements

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year. (1)	0
No. of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements. (2)	0

4.2.9 Exit packages

The following tables and narrative below have been independently audited by KPMG.

Table below showing exit packages agreed

Exit Packages agreed in 2017-18

Exit package cost band (including any special payment element)	compulsory redundancies Accounts 31 Mar 2018		redundancies Accounts 31 Mar 2018 2017/18	other departures agreed Accounts		Cost of other departures agreed	of exit packages Accounts 31 Mar 2018		exit packages Accounts 31 Mar 2018 2017/18	where special payments have been made Accounts	element included in exit packages Accounts 31 Mar 2018
	Number	£		Number	£		Number	£		No.	£000
<£10,000	3		19,053	0		0	3		19,053	0	0
£10,000 - £25,000	6		111,796	0		0	6		111,796	0	0
£25,001 - 50,000	6		213,652	0		0	6		213,652	0	0
£50,001 - £100,000	3		180,243	0		0	3		180,243	0	0
£100,001 - £150,000	0		0	0		0	0		0	0	0
£150,001 - £200,000	0		0	0		0	0		0	0	0
>£200,000	0		0	0		0	0		0	0	0
Total	18		524,744	0		0	18		524,744	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of either the NHS Agenda for Change national framework, where the exit resulted from compulsory redundancies, or the Mutually Agreed Resignation Scheme (MARS) otherwise. Exit costs in this section are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

Accountability Report signature

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

Accountable Officer's signature

Signed:..... Date.....

Roisin Fallon-Williams
Chief Executive
Norfolk Community Health and Care NHS Trust

5. Parliamentary Accountability and Audit Report

The Department of Health (DH) and bodies within the DH accounting boundary have a statutory requirement to produce an annual report and accounts following the end of the financial year. Additionally, DH must produce a consolidation of accounts data for the bodies within the accounting boundary, with individual entities referred to as DH group bodies. NCHC's Annual Report and Accounts complies with the requirement on DH group bodies to publish as a single document, a three part annual report and accounts structured as: (1) Performance Report – an overview and a performance analysis, (2) Accountability Report – Corporate Governance Report, Remuneration and Staff Report and a Parliamentary Accountability and Audit Report, and (3) Financial Statements.

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INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF 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 Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 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 with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

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

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. 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. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2017/18. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 40, the directors are responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity . As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 41 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing 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 in the statement set out on page 41, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and

related guidance. 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 issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the 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; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

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 Norfolk Community Health and Care NHS 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 the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Norfolk Community Health and Care NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

S Beavis

Stephanie Beavis
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
KPMG LLP
Dragonfly House
2 Gilders Way
Norwich
NR3 1UB

25 May 2018

Norfolk Community Health and Care NHS Trust

Annual accounts for the year ended 31 March 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	115,057	127,731
Other operating income	4	4,734	5,395
Operating expenses	5, 7	(118,754)	(127,951)
Operating surplus/(deficit)		**1,037**	**5,175**
PDC dividends payable		(2,444)	(2,310)
Net finance costs		**(2,444)**	**(2,310)**
Other gains / (losses)		-	-
Surplus / (deficit) for the year		**(1,407)**	**2,865**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	-	(700)
Revaluations	12	(671)	7,544
Total comprehensive income / (expense) for the period		**(2,078)**	**9,709**

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	11	43	23
Property, plant and equipment	12	75,114	76,853
Total non-current assets		**75,157**	**76,876**
Current assets			
Inventories	13	180	362
Trade and other receivables	14	9,967	8,997
Non-current assets held for sale	15	897	-
Cash and cash equivalents	16	18,213	23,259
Total current assets		**29,257**	**32,618**
Current liabilities			
Trade and other payables	17	(11,195)	(14,491)
Provisions	18	(257)	(861)
Deferred income		(164)	(179)
Total current liabilities		**(11,616)**	**(15,531)**
Total assets less current liabilities		**92,798**	**93,963**
Non-current liabilities			
Provisions	18	(1,146)	(233)
Total non-current liabilities		**(1,146)**	**(233)**
Total assets employed		**91,652**	**93,730**
Financed by			
Public dividend capital		15,414	15,414
Revaluation reserve		21,074	21,751
Retained earnings		55,164	56,565
Total taxpayers' equity		**91,652**	**93,730**

The notes on pages 87 to 121 form part of these accounts.

The financial statements on pages 82 to 121 were approved by the Audit Committee on 24 May 2018. The Audit Committee was acting with delegated authority from the Board. They are signed on behalf of the Board by:

Name: Roisin Fallon-Williams
Position: Chief Executive
Date: 24 May 2018

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Retained earnings	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**15,414**	**21,751**	**56,565**	**93,730**
Surplus/(deficit) for the year	-	-	(1,407)	**(1,407)**
Other transfers between reserves	-	(6)	6	**-**
Revaluations	-	(671)	-	**(671)**
Taxpayers' equity at 31 March 2018	**15,414**	**21,074**	**55,164**	**91,652**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Retained earnings	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016	**15,414**	**14,907**	**53,700**	**84,021**
Surplus/(deficit) for the year	-	-	2,865	**2,865**
Impairments	-	(700)	-	**(700)**
Revaluations	-	7,544	-	**7,544**
Taxpayers' equity at 31 March 2017	**15,414**	**21,751**	**56,565**	**93,730**

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		1,037	5,175
Non-cash income and expense:			
Depreciation and amortisation	5.1	4,144	3,891
Net impairments	6	85	(46)
(Increase) / decrease in receivables and other assets		(938)	(2,563)
(Increase) / decrease in inventories		182	85
Increase / (decrease) in payables and other liabilties		(3,130)	(349)
Increase / (decrease) in provisions		309	(160)
Net cash generated from / (used in) operating activities		**1,689**	**6,033**
Cash flows from investing activities			
Purchase of intangible assets		(64)	-
Purchase of property, plant, and equipment		(4,036)	(3,563)
Net cash generated from / (used in) investing activities		**(4,100)**	**(3,563)**
Cash flows from financing activities			
PDC dividend (paid) / refunded		(2,656)	(2,167)
Cash flows from (used in) other financing activities		21	-
Net cash generated from / (used in) financing activities		**(2,635)**	**(2,167)**
Increase / (decrease) in cash and cash equivalents		**(5,046)**	**303**
Cash and cash equivalents at 1 April - brought forward		**23,259**	**22,956**
Cash and cash equivalents at 31 March	16	**18,213**	**23,259**

Notes to the Accounts

Note 1 Summary of Significant Accounting Policies

1.1 Basis of preparation
The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of certain classes of property, plant and equipment.

1.1.2 Going Concern
These accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be a going concern where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

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

1.3 Critical accounting judgements and key sources of estimation uncertainty
In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.3.1 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Consolidation of the Norfolk Community Health & Care NHS Trust Charitable Fund
Further to Note 1.2 regarding the consolidation of charities, the Trust has determined that the Norfolk Community Health & Care NHS Trust Charitable Fund does not meet the criteria required for consolidation into the Trust accounts. This is on the basis that, although the Trust continues to exercise control of the charity through its role as sole corporate trustee, the value of the Charitable Fund's net assets, revenue and expenses are not considered material to the consolidated financial statements.

Revaluation of the Trust's land and buildings
The Trust conducts a triennial review of land and buildings valuations. Under this arrangement, the Trust has a full revaluation of its land and buildings once every three years, unless there is a significant change in fair value in an intervening year, when a revaluation will be performed in the intervening year. A revaluation was performed at 31 March 2017. Land and buildings held by the Trust were revalued and building useful economic lives were reviewed. The valuation and useful economic lives review were undertaken by the Trust's property valuer in accordance with the requirements of the RICS Valuation - Professional Standards (January 2014) and the accounting framework.

Land and buildings were revalued at 31 March 2017. The Trust has sought the advice of an external chartered surveyor and has determined there has been an immaterial change in the fair value of land and buildings in the year to 31 March 2018 when compared to the book value of these assets. The Trust has, therefore, not revalued land and buildings at 31 March 2018 (except where individual assets are revalued under accounting requirements).

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

Notes to the Accounts

1.3.2 Key source of estimation uncertainty
The following is a source of estimation uncertainty that has a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

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

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

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

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

The main source of revenue for the Trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. At the financial year end, the Trust accrues income relating to activity delivered in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued and agreed with the commissioner. Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for example by an insurer. The Trust recognises income when it receives notification from the Department of Work and Pensions Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.5 Employee benefits
Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. Leave earned but not yet taken is not accrued for at the year end, as it is not significant to the financial statements.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as if they were a defined contribution scheme: the cost to the Trust of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the schemes. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

Further details of the NHS Pensions Schemes are provided in the remuneration and staff report.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Following the government's introduction of automatic pension enrolment during 2013, the Trust has joined the government-operated National Employment Savings Trust (NEST) pension scheme. Since October 2013, a minority of Trust employees (less than 5%) have joined this scheme. As a defined contribution scheme, the cost to the Trust of participating in the NEST scheme is taken as equal to the contributions payable to the scheme for the accounting period.

1.6 Other expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Notes to the Accounts

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- Collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Items forming part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost, are capitalised.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair value is determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 *Borrowing Costs* for assets held at fair value (the Trust currently does not incur any borrowing costs). Assets are revalued and depreciation commences in the quarter after they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use. An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Useful lives

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	75
Plant & machinery	1	23
Transport equipment	7	7
Information technology	3	8
Furniture & fittings	5	8

Notes to the Accounts

1.7 Property, plant and equipment continued
Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.8 Intangible assets
Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights.

They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust, where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

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

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Software licences	3	5

1.9 Depreciation, amortisation and impairments
Freehold land, assets under construction, and assets held for sale are not depreciated / amortised.

Otherwise, depreciation and amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. The useful lives applied by the Trust are shown in the accounting notes above.

Notes to the Accounts

1.9 Depreciation, amortisation and impairments continued

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

1.10 Depreciation, amortisation and impairments continued

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.11 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases. The Trust currently does not have any finance leases.

The Trust as lessee

Operating lease payments are recognised as an expense on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value using replacement cost. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks, and using an alternative method would not have a significant effect on the financial statements.

1.13 Cash and cash equivalents

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

Cash and bank balances are recorded at current values.

1.14 Assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. They are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs are recognised in the surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets are not depreciated or amortised while they are classified as held for sale.

Notes to the Accounts

1.15 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows when discounted using HM Treasury's discount rates.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation to those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the Trust.

1.16 Clinical negligence costs

NHS Resolution (previously the NHS Litigation Authority) operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in the provisions note to these financial statements.

1.17 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.18 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is significant, contingencies are disclosed at their present value.

1.19 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The Trust classifies all of its financial assets as loans and receivables.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The carrying value of financial assets is a reasonable approximation of their fair value.

Notes to the Accounts

1.19 Financial assets continued

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible. The carrying value of financial assets is a reasonable approximation of their fair value.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset. At the end of the reporting period, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an effect on the estimated future cash flows of the asset.

The amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.20 Financial liabilities

Financial liabilities are recognised in the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

The Trust classifies all of its financial liabilities as 'other financial liabilities'. These are initially recognised at fair value.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.21 Value added tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Foreign currency

The Trust's functional currency and presentational currency is Pound Sterling. The Trust typically does not have transactions denominated in a foreign currency and does not hold any financial instruments in a foreign currency.

1.23 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

Notes to the Accounts

1.23 Public Dividend Capital (PDC) and PDC dividend continued

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the financial statements.

1.24 Losses and special payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as operating expenditure).

1.25 Subsidiaries

Entities over which the Trust has the power to exercise control are classified as subsidiaries. The Trust has control when it is exposed to or has rights to variable returns through its power over another entity.

The Trust has one subsidiary, the Norfolk Community Health & Care Charitable Fund. The Trust has not consolidated the Norfolk Community Health & Care Charitable Fund following a decision that the Fund is not significant to the Trust's consolidated financial statements.

1.26 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Income (SOCI) on a systematic basis over the period expected to benefit from the project.

1.27 Equity

1.27.1 Public dividend capital reserve

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend. This charge is reflected in the Statement of Comprehensive Income.

1.27.2 Revaluation reserve

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

1.27.3 Retained earnings reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

1.28 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2017-18.

- IFRS 15 *Revenue for Contracts with Customers* - Application is required for accounting periods beginning on or after 1 January 2018 (for the Trust, the new standard will be applied for the financial year starting 1 April 2018), but is not yet adopted by the FReM: early adoption is not therefore permitted.

Notes to the Accounts

1.28 Accounting Standards that have been issued but have not yet been adopted continued

• IFRS 9 *Financial Instruments* – Application is required for accounting periods beginning on or after 1 January 2018, but the standard is not yet adopted by the FReM: early adoption is not therefore permitted.

• IFRIC 22 *foreign currency transactions and advance consideration* – Application is required for accounting periods beginning on or after 1 January 2018.

• IFRS 16 *Leases* - Application is required for accounting periods beginning on or after 1 January 2019, but the standard is not yet adopted by the FReM: early adoption is not therefore permitted.

• IFRIC 23 *Uncertainty over Income Tax Treatments* - Application is required for accounting periods beginning on or after 1 January 2019.

• IFRS 17 *Insurance Contracts* - Application is required for accounting periods beginning on or after 1 January 2021, but the standard is not yet adopted by the FReM: early adoption is not therefore permitted.

Management are currently assessing the effect of the above standards, but does not believe they would have a material effect on the accounts for 2017-18, were they applied in that year.

Note 2 Operating Segments

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

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	Note	2017/18	2016/17
		£000	£000
Community services income from CCGs and NHS England		92,042	92,545
Income from other sources (including Local Authorities and other NHS providers)		22,745	34,668
Private patient income		26	41
Other clinical income		244	477
Total income from activities		**115,057**	**127,731**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18	2016/17
	£000	£000
NHS England	11,030	11,774
Clinical Commissioning Groups	81,012	80,771
Department of Health and Social Care	80	-
Other NHS providers	15,591	26,115
Local Authorities	7,074	8,553
Non-NHS: private patients	26	41
Non NHS: other	244	477
Total income from activities	**115,057**	**127,731**

Note 4 Other operating income

		2017/18	2016/17
		£000	£000
Research and development		244	1
Education and training		694	695
Receipt of capital grants and donations		-	162
Charitable and other contributions to expenditure		14	-
Non-patient care services to other bodies		1,391	1,450
Sustainability and transformation fund income		687	1,586
Rental revenue from operating leases	**9.1**	670	937
Other income		1,034	564
Total other operating income		4,734	5,395

During 2016/17, the Trust received donations of cash to purchase PPE additions of £162k for the completion of a multipurpose training room at North Walsham Hospital. This donation was received from the Norfolk Community Health & Care NHS Trust Charitable Fund, a related party for the Trust. No similar donation was received during 2017/18.

Note 5.1 Operating expenses

	Note	2017/18	2016/17
		£000	£000
Purchase of healthcare from NHS and DHSC bodies		2,449	1,506
Purchase of healthcare from non-NHS and non-DHSC bodies		1,174	939
Staff and executive directors costs	**7.1**	83,627	94,375
Remuneration of non-executive directors		69	68
Supplies and services - clinical (excluding drugs costs)		7,325	8,260
Supplies and services - general		9,245	7,703
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)		552	310
Consultancy costs		117	502
Establishment		1,021	1,218
Premises		2,589	2,707
Transport (including patient travel)		2,849	3,927
Depreciation on property, plant and equipment		4,132	3,885
Amortisation on intangible assets		12	6
Net impairments	**6**	85	(46)
Increase/(decrease) in provision for impairment of receivables		528	162
Change in provisions discount rate(s)		4	33
Audit fees payable to the external auditor for statutory audit:			
audit services- statutory audit		42	59
other auditor remuneration (external auditor only)	**5.2**	-	13
Internal audit costs		93	89
Clinical negligence		334	272
Legal fees, insurance, losses and ex gratia payments		3	172
Education and training		318	471
Rentals under operating leases		2,136	1,297
Car parking & security		50	23
Total		**118,754**	**127,951**

Staff, executive director and non-executive director costs see the remuneration report within this annual report for further information on staff and director costs.

Note 5.2 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
Assurance related services	-	13
Total	**-**	**13**

Note 5.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2017/18 or 2016/17.

Note 6 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	85	(46)
Total net impairments charged to operating surplus / deficit	**85**	**(46)**
Impairments charged to the revaluation reserve	-	700
Total net impairments	**85**	**654**

Note 7.1 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	65,954	73,431
Social security costs	6,201	6,791
Apprenticeship levy*	319	-
Employer's contributions to NHS pensions	8,964	9,901
Pension cost - other	6	1
Other employment benefits	210	231
Termination benefits	177	443
Temporary staff (including agency)	2,049	4,152
Total staff costs	**83,880**	**94,950**
Of which		
Employee benefits charged to operating expenses	83,627	94,375
Employee benefits capitalised as part of assets	253	575
	83,880	**94,950**

*The apprenticeship levy was introduced on 1 April 2017. The figure shown above represents the Trust's gross apprenticeship levy. The Trust utilises this by contributing towards the cost of staff apprenticeship training.

Note 7.2 Retirements due to ill-health

During 2017/18 there were 2 early retirements from the Trust agreed on the grounds of ill-health (7 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £151k (£438k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the Government Financial Reporting Manual 2017-18 (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 at 31 March 2018 is based on valuation data at 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

Note 9 Operating leases

as a lessor

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

The Trust receives rental income from a number of other healthcare providers which occupy Trust property.

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	670	937
Total	**670**	**937**

	Land	Buildings	Total
	£000	£000	£000
Future minimum lease receipts due at 31 March 2018:			
- not later than one year;	9	419	427
- later than one year and not later than five years;	33	35	68
- later than five years.	37	45	82
Total	**79**	**499**	**578**

	Land	Buildings	Total
	£000	£000	£000
Future minimum lease receipts due at 31 March 2017:			
- not later than one year;	3	1,036	1,039
- later than one year and not later than five years;	12	600	612
- later than five years.	-	-	-
Total	**15**	**1,636**	**1,651**

as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Norfolk Community Health and Care NHS Trust is the lessee.

The Trust is a lessee at a number of sites. Future minimum lease payments have been determined based on the earliest break date without incurring penalties.

Future minimum lease payments due:	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	2,136	1,297
Total	**2,136**	**1,297**

	Buildings	Other	Total
	£000	£000	£000
Future minimum lease payments due at 31 March 2018:			
- not later than one year;	578	427	1,005
- later than one year and not later than five years;	1,879	91	1,970
- later than five years.	3,203	-	3,203
Total	**5,661**	**518**	**6,179**
Future minimum sublease payments to be received			-

	Buildings	Other	Total
	£000	£000	£000
Future minimum lease payments due at 31 March 2017:			
- not later than one year;	1,032	634	1,666
- later than one year and not later than five years;	950	458	1,408
- later than five years.	974	-	974
Total	**2,956**	**1,092**	**4,048**
Future minimum sublease payments to be received			100

Note 10 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

There have been no costs incurred over £500 during 2017/18 or 2016/17 in relation to the late payment of commercial debts.

Note 11.1 Intangible assets - 2017/18

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**29**	**-**	**29**
Additions	-	32	**32**
Reclassifications	32	(32)	**-**
Gross cost at 31 March 2018	**61**	**-**	**61**
Amortisation at 1 April 2017 - brought forward	**6**	**-**	**6**
Provided during the year	12	-	**12**
Amortisation at 31 March 2018	**18**	**-**	**18**
Net book value at 31 March 2018	**43**	**-**	**43**
Net book value at 1 April 2017	**23**	**-**	**23**

All intangible assets under construction are initially classified as property, plant and equipment and are reclassified as intangible assets when ready for use.

Note 11.2 Intangible assets - 2016/17

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2016	**135**	**29**	**164**
Reclassifications	29	(29)	**-**
Disposals / derecognition	(135)	-	**(135)**
Valuation / gross cost at 31 March 2017	**29**	**-**	**29**
Amortisation at 1 April 2016	**135**	**-**	**135**
Provided during the year	6	-	**6**
Disposals / derecognition	(135)	-	**(135)**
Amortisation at 31 March 2017	**6**	**-**	**6**
Net book value at 31 March 2017	**23**	**-**	**23**
Net book value at 1 April 2016	**-**	**29**	**29**

Note 12.1 Property, plant and equipment - 2017/18

	Land	Buildings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**11,431**	**56,152**	**4,183**	**4,821**	**-**	**10,286**	**-**	**86,873**
Additions	-	-	4,056	-	-	-	-	**4,056**
Impairments	-	(85)	-	-	-	-	-	**(85)**
Revaluations	(79)	(609)	-	-	-	-	-	**(688)**
Reclassifications	-	1,259	(3,551)	1,397	-	895	-	**-**
Transfers to/ from assets held for sale	(231)	(699)	-	-	-	-	-	**(930)**
Disposals / derecognition	-	-	-	(1,560)	-	(2,330)	-	**(3,890)**
Valuation/gross cost at 31 March 2018	**11,121**	**56,018**	**4,688**	**4,658**	**-**	**8,851**	**-**	**85,336**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**20**	**-**	**3,281**	**-**	**6,719**	**-**	**10,020**
Provided during the year	**-**	**1,942**	**-**	**543**	**-**	**1,647**	**-**	**4,132**
Revaluations	-	(17)	-	-	-	-	-	**(17)**
Transfers to / from assets held for sale	-	(33)	-	-	-	-	-	**(33)**
Disposals / derecognition	-	-	-	(1,550)	-	(2,330)	-	**(3,880)**
Accumulated depreciation at 31 March 2018	**-**	**1,912**	**-**	**2,274**	**-**	**6,036**	**-**	**10,222**
Net book value at 31 March 2018	**11,121**	**54,106**	**4,688**	**2,384**	**-**	**2,815**	**-**	**75,114**
Net book value at 1 April 2017	**11,431**	**56,132**	**4,183**	**1,540**	**-**	**3,567**	**-**	**76,853**

Additions to assets under construction:	**2017/18**
	£000
Buildings excluding dwellings	1,856
Plant & machinery, and information technology	2,200
Total	**4,056**

Note 12.2 Property, plant and equipment - 2016/17

	Land	Buildings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - brought forward	**10,184**	**55,944**	**4,480**	**4,347**	**76**	**9,144**	**374**	**84,549**
Additions	-	231	4,075	-	-	-	-	**4,306**
Impairments / reversals charged to operating expenses	-	(2,342)	-	-	-	-	-	**(2,342)**
Impairments / reversals charged to reserves	-	(2,087)	-	-	-	-	-	**(2,087)**
Revaluations	1,247	1,812	-	-	-	-	-	**3,059**
Reclassifications	-	2,594	(4,372)	587	-	1,191	-	**-**
Disposals / derecognition	-	-	-	(113)	(76)	(49)	(374)	**(612)**
Valuation/gross cost at 31 March 2017	**11,431**	**56,152**	**4,183**	**4,821**	**-**	**10,286**	**-**	**86,873**
Accumulated depreciation at 1 April 2016 - brought forward	**-**	**6,321**	**-**	**3,015**	**76**	**5,216**	**370**	**14,998**
Provided during the year	**-**	**1,959**	**-**	**388**	**-**	**1,538**	**-**	**3,885**
Impairments / reversals charged to operating expenses	-	(2,342)	-	-	-	-	-	**(2,342)**
Impairments / reversals charged to reserves	-	(1,387)	-	-	-	-	-	**(1,387)**
Reversals of impairments	-	(46)	-	-	-	-	-	**(46)**
Revaluations	-	(4,485)	-	-	-	-	-	**(4,485)**
Disposals/ derecognition	-	-	-	(122)	(76)	(35)	(370)	**(603)**
Accumulated depreciation at 31 March 2017	**-**	**20**	**-**	**3,281**	**-**	**6,719**	**-**	**10,020**
Net book value at 31 March 2017	**11,431**	**56,132**	**4,183**	**1,540**	**-**	**3,567**	**-**	**76,853**
Net book value at 1 April 2016	**10,184**	**49,623**	**4,480**	**1,332**	**-**	**3,928**	**4**	**69,551**

Additions to assets under construction:	**2016/17**
	£000
Buildings excluding dwellings	2,241
Plant & machinery, and information technology	1,834
Total	**4,075**

Note 12.3 Property, plant and equipment financing - 2017/18

	Land	Buildings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018						
Owned - purchased	10,980	52,509	4,688	2,371	2,815	**73,363**
Owned - government granted	-	372	-	-	-	**372**
Owned - donated	141	1,225	-	13	-	**1,379**
Net book value total at 31 March 2018	**11,121**	**54,106**	**4,688**	**2,384**	**2,815**	**75,114**

Note 12.4 Property, plant and equipment financing - 2016/17

	Land	Buildings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017						
Owned - purchased	11,290	54,479	4,183	1,520	3,567	**75,039**
Owned - government granted	-	389	-	-	-	**389**
Owned - donated	141	1,264	-	20	-	**1,425**
Net book value total at 31 March 2017	**11,431**	**56,132**	**4,183**	**1,540**	**3,567**	**76,853**

Note 12.5 Revaluations of property, plant and equipment

The Trust's land and buildings have been independently valued at fair value with an effective date of 31 March 2017 following a full valuation exercise. The valuation was conducted by Boshier & Company Chartered Surveryors, regulated by RICS, in accordance with the Royal Institute of Chartered Surveyors Valuation Professional Standards (January 2014) insofar as these are consistent with the requirements of HM Treasury and NHS accounting requirements. Fair value has been determined for non-specialised assets as market value for existing use, and for specialised assets as depreciated replacement cost. These valuation methods are consistent with the methods used in the previous accounting period.

The Trust is satisfied the fair value of land and buildings does not materially differ from the net book value shown in note 12.

In total, £677k has been deducted from the revaluation reserve during 2017/18. This relates to the revaluation of assets on reclassification to non-current assets held for sale (see note 15) and the write down of certain buildings on reassessment of their fair value in use.

Note 13 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	1	-
Consumables	59	154
Wheelchair parts	107	99
Other	13	109
Total inventories	**180**	**362**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £4,700k (2016/17: £6,365k).

Note 14.1 Trade receivables and other receivables

	2018 £000	2017 £000
Current		
Trade receivables	7,825	5,323
Accrued income	2,931	4,059
Provision for impaired receivables	(1,447)	(931)
Prepayments	577	348
PDC dividend receivable	32	-
VAT receivable	49	198
Total current trade and other receivables	**9,967**	**8,997**
Of which receivables from NHS and DHSC group bodies:	7,622	6,386

Note 14.2 Provision for impairment of receivables

	2018 £000	2017 £000
At 1 April	**931**	**1,624**
New provision added	776	346
Amounts utilised	(12)	(855)
Unused amounts reversed	(248)	(184)
At 31 March	**1,447**	**931**

Receivables are impaired when there are indications the receivable will not be fully recovered. Indications of impairment include long overdue balances and poor creditworthiness of the counterparty.

Note 14.3 Credit quality of financial assets

	31 March 2018	31 March 2017
	Trade and other receivables	Trade and other receivables
Ageing of impaired financial assets past their due date	**£000**	**£000**
0 - 30 days	5	-
30-60 Days	26	-
60-90 days	-	-
90- 180 days	37	31
Over 180 days	2,184	1,202
Total	**2,252**	**1,233**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	1,386	744
30-60 Days	577	491
60-90 days	789	299
90- 180 days	252	850
Over 180 days	1,489	477
Total	**4,493**	**2,861**

The Trust has reviewed all financial assets past their due date and established a provision for uncollectability where appropriate. The face value of non-impaired financial assets past their due date is considered to approximate their fair value.

Note 15 Non-current assets held for sale

	2017/18	2016/17
	£000	£000
NBV of non-current assets for sale at 1 April	-	-
Assets classified as available for sale in the year	897	-
Net book value of non-current assets for sale at 31 March	**897**	-

One site held by the Trust was being actively marketed at 31 March 2018 and so has been classified as a non-current asset held for sale. Sale is expected during financial year 2018/19.

Note 16 Cash and cash equivalents movements

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

	2017/18 £000	2016/17 £000
At 1 April	**23,259**	**22,956**
Net change in year	(5,046)	303
At 31 March	**18,213**	**23,259**
Broken down into:		
Cash at commercial banks and in hand	12	22
Cash with the Government Banking Service	18,201	23,237
Total cash and cash equivalents as in SoFP	**18,213**	**23,259**
Total cash and cash equivalents as in SoCF	**18,213**	**23,259**

Note 16.1 Third party assets held by the trust

The Trust holds cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018 £000	31 March 2017 £000
Bank balances	2	2
Total third party assets	**2**	**2**

Note 17 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	3,551	6,314
Capital payables	1,550	1,551
Accruals	4,241	4,832
Social security costs	1,853	1,614
PDC dividend payable	-	180
Other payables	-	-
Total current trade and other payables	**11,195**	**14,491**
Non-current		
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	1,945	4,010

Note 18.1 Provisions for liabilities and charges analysis at 31 March 2018

	Pensions - early departure costs	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2017	**246**	**181**	**667**	**-**	**1,094**
Change in the discount rate	4	-	-	-	**4**
Arising during the year	10	116	237	693	**1,056**
Utilised during the year	(11)	(10)	(356)	-	**(377)**
Reversed unused	-	(146)	(228)	-	**(374)**
At 31 March 2018	**249**	**141**	**320**	**693**	**1,403**
Expected timing of cash flows:					
- not later than one year;	11	94	4	148	**257**
- later than one year and not later than five years;	43	-	316	545	**904**
- later than five years.	195	47	-	-	**242**
Total	**249**	**141**	**320**	**693**	**1,403**

The provision for early departure costs relates to an injury benefit claim for a former employee. Its carrying amount is the present value of the expected future cash flows discounted using the HM Treasury rate of 0.10% (2016/17: 0.24%). There is no uncertainty in respect of timings of future liabilities.

The legal claims provision relate to employer cases which are managed by the Trust, and also public liability cases which are managed on the Trust's behalf by NHS Resolution. The timings of payments are uncertain but expected to fall within the next 12 months.

The redundancy provision relates to employees whose roles have been disestablished following service reconfiguration. A small element would be expected to be paid in 2018/19 but the majority would fall for payment in 2019/20 . Costs have been identified based on the affected individuals where identifiable, or an estimate based on the most likely outcome where a group of employees are affected.

The other provision relates to two items. Firstly, an onerous lease on which payments will be made until December 2021, and secondly a dilapidation provision for Unit 20 Hellesdon Road which will crystallise on exit during 2018/19.

Note 18.2 Provisions for liabilities and charges analysis at 31 March 2018

	Pensions - early departure costs	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2016	**224**	**142**	**491**	**397**	**1,254**
Change in the discount rate	33	-	-	-	**33**
Arising during the year	-	88	677	-	**765**
Utilised during the year	(11)	(38)	(267)	-	**(316)**
Reversed unused	-	(11)	(234)	(397)	**(642)**
At 31 March 2017	**246**	**181**	**667**	**-**	**1,094**
Expected timing of cash flows:					
- not later than one year;	13	181	667	-	**861**
- later than one year and not later than five years;	42	-	-	-	**42**
- later than five years.	191	-	-	-	**191**
Total	**246**	**181**	**667**	**-**	**1,094**

Note 18.3 Clinical negligence liabilities

At 31 March 2018, £1,544k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Norfolk Community Health and Care NHS Trust (31 March 2017: £1,042k).

Note 19 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution (previously the NHS Litigation Authority) legal claims	8	20
Gross value of contingent liabilities	**8**	**20**
Net value of contingent liabilities	**8**	**20**

There were no contingent assets at 31 March 2018 and 31 March 2017.

Note 20 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	436	324
Total	**436**	**324**

Note 21 Financial instruments

Note 21.1 Financial risk management

Financial reporting standard *IFRS 7 Financial Instruments: Disclosures* requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with NHS commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust is not exposed to interest rate risk as it does not hold any borrowings or investments.

Credit risk

As the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with clinical commissioning groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 21.2 Carrying values of financial assets

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP at 31 March 2018		
Trade and other receivables excluding non financial assets	9,350	**9,350**
Cash and cash equivalents at bank and in hand	18,213	**18,213**
Total at 31 March 2018	**27,563**	**27,563**

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP at 31 March 2017		
Trade and other receivables excluding non financial assets	8,451	**8,451**
Cash and cash equivalents at bank and in hand	23,259	**23,259**
Total at 31 March 2017	**31,710**	**31,710**

Note 21.3 Carrying value of financial liabilities

	Other financial	value
	£000	£000
Liabilities as per SoFP at 31 March 2018		
Trade and other payables excluding non financial liabilities	8,058	**8,058**
Provisions under contract*	1,403	**1,403**
Total at 31 March 2018	**9,461**	**9,461**

* Previously provisions were not classed as a financial liability. This has been reassessed in 2017/18 and all provisions have been deemed to be financial liabilities.

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP at 31 March 2017		
Trade and other payables excluding non financial liabilities	12,717	**12,717**
Provisions under contract*	1,094	**1,094**
Total at 31 March 2017	**13,811**	**13,811**

Note 21.4 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	8,315	13,578
In more than one year but not more than two years	904	42
In more than two years but not more than five years	242	191
Total	**9,461**	**13,811**

Note 22 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	1	1	-	-
Bad debts and claims abandoned	6	7	-	-
Total losses	**7**	**8**	**-**	**-**
Special payments				
Ex-gratia payments	3	1	6	10
Extra-statutory and extra-regulatory payments	1	1	-	-
Total special payments	**4**	**2**	**6**	**10**
Total losses and special payments	**11**	**10**	**6**	**10**

Note 23 Related parties

The Department of Health and Social Care (the Department) is the Trust's parent department. During the 2017/18 financial year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department, as well as other entities which are part of the Crown.

These entities are:
Great Yarmouth and Waveney Clinical Commissioning Group
Ipswich and East Suffolk Clinical Commissioning Group
North Norfolk Clinical Commissioning Group
Norwich Clinical Commissioning Group
South Norfolk Clinical Commissioning Group
West Norfolk Clinical Commissioning Group
West Suffolk Clinical Commissioning Group
Cambridge and Peterborough Clinical Commissioning Group
NHS England
Norfolk and Norwich University Hospitals NHS Foundation Trust
Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
West Suffolk NHS Foundation Trust
NHS Resolution (previously the NHS Litigation Authority)
James Paget University Hospitals NHS Foundation Trust
Health Education England
NHS Improvement
NHS Property Services Limited
Community Health Partnerships
Care Quality Commission

The Trust has also had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with:
NHS Business Services Authority
HM Revenue and Customs
Norfolk County Council
Norwich City Council
North Norfolk District Council
Broadland District Council
Borough Council of Kings Lynn and West Norfolk
Breckland District Council
South Norfolk District Council

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

	2017/18	2016/17	31 March 2018	31 March 2017
	£000	£000	£000	£000
Total income received from the Charitable Fund	194	256	-	-
Accounts receivable balance due from the Charitable Fund	-	-	12	19
Total expenditure payable to the Charitable Fund	Nil	Nil	-	-
Accounts payable balance due to the Charitable Fund	-	-	Nil	Nil

Disclosure of compensation and other transactions with management and Board members is made in the Remuneration Report. All transactions with management and Board members were made within the ordinary course of the Trust's operations.

Note 24 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	16,320	52,185	17,384	33,617
Total non-NHS trade invoices paid within target	13,196	39,035	14,728	25,361
Percentage of non-NHS trade invoices paid within target	80.9%	74.8%	84.7%	75.4%
NHS Payables				
Total NHS trade invoices paid in the year	663	6,199	810	8,336
Total NHS trade invoices paid within target	431	4,499	622	7,225
Percentage of NHS trade invoices paid within target	65.0%	72.6%	76.8%	86.7%

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

Note 25 External financing

The External Financing Limit (EFL) is a control on the net cash flows of the Trust. The Trust is given an external financing limit which it is permitted to underspend. A positive EFL indicates the Trust must draw from either external resources or its own cash reserves, and a negative EFL indicates the Trust is increasing its cash reserves.

	2017/18 £000	2016/17 £000
Cash flow financing	(7,225)	(303)
External financing requirement	**(7,225)**	**(303)**
External financing limit (EFL)	(7,225)	(303)
Under / (over) spend against EFL	-	-

Note 26 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	4,088	4,303
Less: Disposals	(10)	-
Less: Donated and granted capital additions	-	(166)
Charge against Capital Resource Limit	4,078	4,137
Capital Resource Limit	4,246	4,172
Under / (over) spend against CRL	168	35

Note 27 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		-	552	637	2,683	4,630	2,628	2,129	2,695	(1,275)
Breakeven duty cumulative position	-	-	552	1,189	3,872	8,502	11,130	13,259	15,954	14,679
Operating income		-	130,709	127,725	124,843	123,266	123,796	129,920	133,126	119,791
Cumulative breakeven position as a percentage of operating income		0.00%	0.42%	0.93%	3.10%	6.90%	8.99%	10.21%	11.98%	12.25%

Paragraph 2(1) of Schedule 5 to the National Health Service Act 2006 requires each NHS Trust to ensure its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to the revenue account. This is known at the 'breakeven duty' and is deemed to have been met if the Trust's cumulative position starting from 2009/10 is not in deficit.

NHS Trusts should normally plan to meet this duty by achieving a balanced position on their income and expenditure account each and every year. However the breakeven duty includes the phrase "taking one financial year with another". This provides some flexibility on the time-scale for matching income with costs and when managing the recovery of an NHS trust in financial difficulties.

Currently the Trust has a cumulative breakeven position of £14.679m and has therefore met the breakeven duty. Should this become a negative figure in the future, there would be three years for the Trust to return to a cumulative breakeven.

A reconciliation of the surplus / (deficit) per the statement of comprehensive income to the breakeven duty in-year financial performance is shown in note 28.