Norfolk Community Health and Care NHS Trust

Annual Report and Accounts 2018/19

Final version 29.05.19

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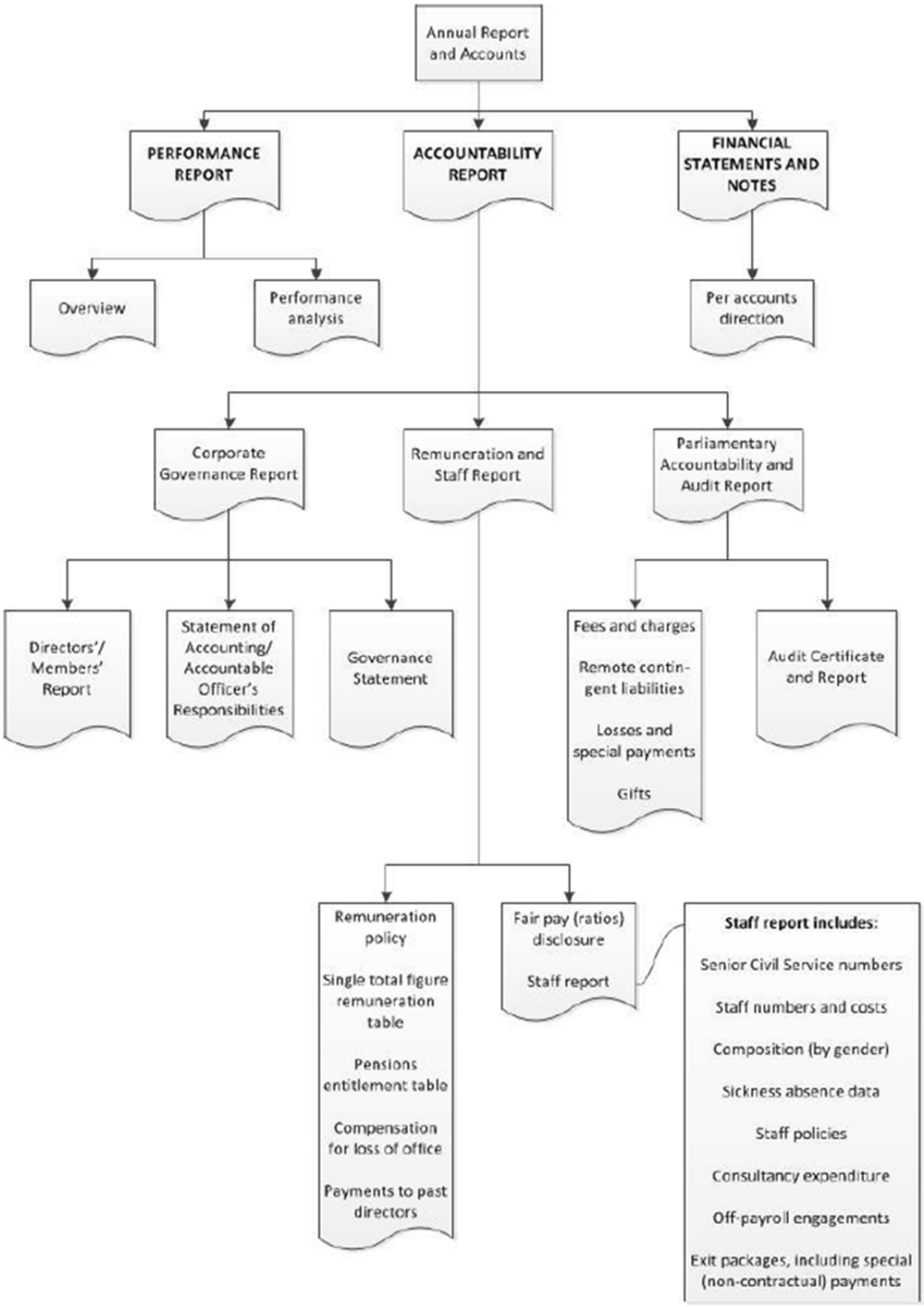
Abbreviations used in this report:
Norfolk Community Health and Care NHS Trust - NCHC
NHS England - NHSE
NHS Improvement - NHSI
Clinical Commissioning Groups - CCGs
Norfolk County Council - NCC
Care Quality Commission - CQC
Non-Executive Director - NED

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

NCHC was rated as Outstanding by the CQC in June 2018, the first community trust in the country to receive the highest possible rating. In the categories of Caring and Well Led NCHC received a rating of Outstanding, and for Safety, Effectiveness, and Responsiveness, a rating of Good was received. Within these overall ratings two service areas were rated as Requires Improvement. These were in Safety within Community Health In-patient Services, and Responsiveness within Community Health Services for Children and Young People. An action plan is in place to drive up the standards across all of the categories across all of our services.

NHS Improvement has assessed NCHC through the Single Oversight Framework (SOF) as being 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". The targeted support needs were identified in "finance and use of resources". The Trust's SOF finance rating is 3.

The latest NHS annual staff survey shows positive increases in the majority of themes and no change in the rest which demonstrates another year of continuous improvement at NCHC. It is the best performing community trust in acting fairly with regard to career progression / promotion regardless of any protected characteristic. The results showed that in the last four years the number of staff who would recommend NCHC as a place to work has increased from 42.4% to 68.3%. This is above average for community trusts in England (59.4%). Almost 80% of staff agreed

that if a friend or relative needed treatment they would be happy with the standard of care provided at NCHC which is above the national average for community trusts of 74.8%. The theme of staff engagement has significantly improved and is now above the national average. More staff took part in the survey this year and told us about their experiences. Overall the results have highlighted positive progress despite a challenging context, nationally and locally. The focus moving forward will need to be to continue to build on progress already made, and to increase the pace in some areas.

NCHC has continued to play an active and leading role in the Norfolk and Waveney STP and supporting workstreams to: (1) prevent illness and promote well-being, (2) provide care closer to home, (3) integrate working across physical, social and mental health, (4) develop sustainable hospital services, and (5) deliver cost-effective, high quality services within the funds available.

NCHC is working closely with primary care and other community colleagues to deliver the NHS Long Term Plan commitments. For example, the Long Term Plan confirms that general practices will join together to form primary care networks (groups of neighbouring practices typically covering 30–50,000 people). Practices will enter network contracts, alongside their existing contracts, which will include a single fund through which network resources will flow. Primary care networks will be expected to take a proactive approach to managing population health and from 2020/21, will assess the needs of their local population to identify people who would benefit from targeted, proactive support.

Performance measured across a range of metrics in quality and safety, operational performance, patient experience, productivity and value for money continues to be very good. However, challenges remain in improving performance in, for example, neuro-developmental services and Wheelchair Services to prevent further and prolonged deterioration in waiting times. For both services, resolving capacity issues has been key to improving performance in the short-term and providing a longer-term sustainable resource level to maintain compliance.

NCHC's original financial plan for 2018/19 was to maintain financial performance in line with 2017/18 performance and deliver a deficit of £1.9m supported by an efficiency programme of £3.9m. The actual deficit delivered was £12.6m, which was a deterioration from plan of £10.7m. These figures include an asset impairment of £5.2m following a revaluation of the Trust's land and buildings as at 31 March 2019 and a provision for potential repayment of VAT of £6.1m.

The Trust's efficiency programme of £3.9m consisted of £1.6m of recurrent savings and £2.3m of non-recurrent savings. The programme was achieved in total during the year, with the majority of the savings achieved through non-recurrent savings. 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.

NCHC is working collaboratively with all partners within the context of the jointly agreed STP-wide priorities:

Primary and community care: As a system we know we must focus on prevention wherever possible, we cannot meet our clinical priorities without focusing on primary care and community care.
Mental health: We will focus on prevention and maintaining well-being for our people to stay happy and healthy. If people are in need we will provide high quality services.
Acute transformation: Transforming our acute hospital services in a way that improves the patient experience as well as making them more financially sustainable.
Urgent and emergency care services: To address pressures on urgent and emergency care services to enable good quality care for all.
Cancer: Commitment to improving the care, treatment and support all people who have been diagnosed with cancer and ensure that cancer is diagnosed early across our footprint.
Children and young people: Ensuring our children and young people have access to high quality physical and mental health services to give them the best possible start in life.

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 for quality and 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 and Integrated Care System
1.2.6 Transformation Programme
1.2.7 Annual Priorities

Graphic above 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.

Graphic below showing our Objectives and priorities

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.

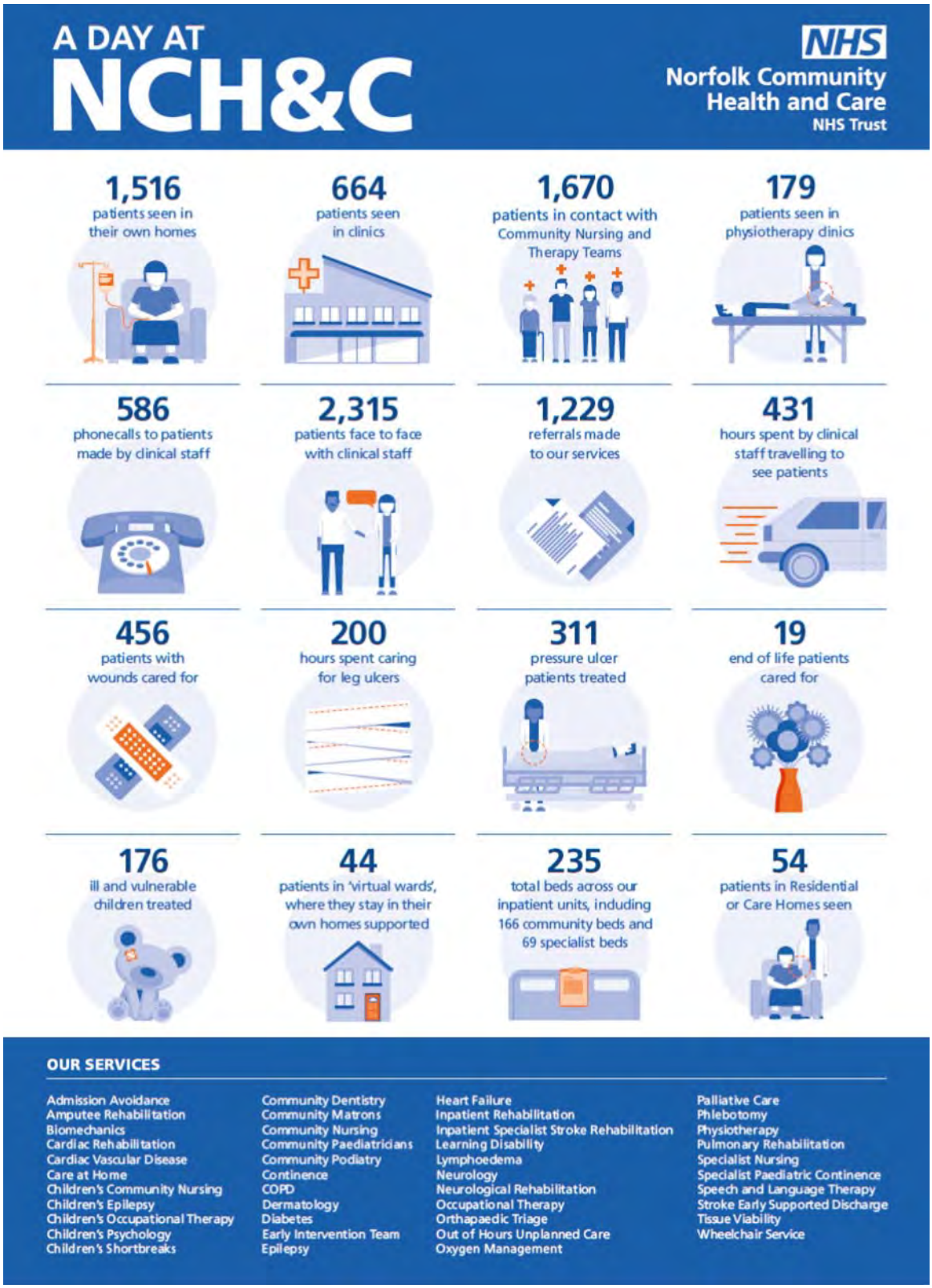
Graphic below describing our Values

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 and Integrated Care System
1.2.6 NCHC Transformation Programme
1.2.7 Annual Priorities

1.2.4 The Health and Care Strategy

Launched in 2015, the purpose of NCHC's Health and Care Strategy is to set out the four priorities that will enable us to be more innovative, collaborative and empowering in the ways we deliver care to people and to tackle the challenges of:

- Workforce
- Empowerment of our patients
- Technology
- Partnerships with volunteers

The Health and Care Strategy is:

- Helping and motivating people to help themselves, where they can.
- Making services more joined-up with visits and consultations kept to the minimum necessary.
- Shaping care around the person it is intended for.
- Providing support within the available financial budget.
- Recruiting and developing the right workforce with better career paths using their skills in the most effective ways.
- Embracing new technologies, making care more accessible, convenient and efficient.
- Allowing us to work together with carers and volunteers so they feel more valued and informed.

1.2.5 Sustainability and Transformation Partnership and Integrated Care System

Sustainability and Transformation Partnerships (STP) are areas covering all of England, where local NHS organisations and councils drew up shared proposals to improve health and care in the areas they serve. STPs were created to bring local health and care leaders together to plan around the long-term needs of local communities. They have been making simple, practical improvements like making it easier to see a GP, speeding up cancer diagnosis and offering help faster to people with mental ill health.

Norfolk and Waveney STP intends to become an Integrated Care System (ICS), which is an even closer collaboration of NHS organisations, in partnership with local councils and others, taking collective responsibility for managing resources,

delivering NHS standards, and improving the health of the population they serve. The NHS Long Term Plan set out the aim that every part of England will be covered by an ICS by 2021, replacing STPs but building on their good work to date.

Norfolk and Waveney STP have agreed the following priorities:

- Preventing illness and promoting well-being – supporting people to live longer, healthier lives by targeting lifestyle risk factors. Aligning community services with local authorities and the third sector, supporting people to live independently.
- Care closer to home – people living independently with better access to primary, and secondary care, as well as the third sector, thereby reducing demand on hospital and residential services.
- Integrated working across physical, social and mental health, delivering holistic care, improved patient experience and better outcomes. Services focusing on social care and mental health parity of esteem.
- Developing sustainable hospital services.
- Delivering cost-effective, high quality services within the funds available.

1.2.6 NCHC Transformation Programme

The health and social care system in Norfolk and Waveney is unsustainable in its current form. Commissioning health services is the responsibility of five different CCGs, which in turn work with a number of Health Trusts; three acute hospitals and a social enterprise which delivers community health care. Social care is commissioned by Norfolk County Council and delivered by more than 800 provider organisations, the majority small and community-based. The NHS Long Term Plan set out how the NHS will ‘accelerate the redesign of patient care to future-proof the NHS for the decade ahead’. NCHC has created the following themes, which are being developed over the coming year:

- **Integration**: continued working across providers within Norfolk and Waveney and developing collaborative plans which allow for the STP footprint to be operating as an Integrated Care System (ICS) by 2021.
- **Out of Hospital Care**: working with CCGs to increase capacity in community and primary care settings to ensure robust admission avoidance mechanisms are in place. Also developing pre-emergency care pathways and enhancing specialist services in a community setting to remove the need for so many acute outpatient appointments.
- **Technology**: expanding the Trust’s offer in relation to ‘digital services’, so that digital solutions can be implemented in Norfolk and Waveney, for example sourcing specific expertise in App development to facilitate better outcomes for the population.
- **Staff Empowerment and Workforce**: continue to develop our workforce in line with system need and build and expand on the success of non-medical prescribing posts (e.g. Advanced Nurse Practitioners)

The above themes are being divided into specific workstreams which will inform a programme of transformation to ensure that key milestones are delivered in order to achieve goals set out in the NHS Long Term Plan.

1.2.7 Annual Priorities

The graphic below describes the Trust's Annual Priorities.

1.3 Key Risks and Issues

This section includes:

1.3.1 Strategic risks
1.3.2 Service changes
1.3.3 Policy drivers – NHS Long Term Plan

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 delivering the Workforce Plan and the Health and Care Strategy.
- Risks to enabling our people mitigated through staff engagement and empowerment.
- Risks to securing the future mitigated through delivering the Financial Plan, ensuring the sustainability of services and developing good partner relations.

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 continued to develop partnerships through:

- Working with primary care colleagues and other partners to support the development of primary care networks.
- Working with Norfolk and Suffolk NHS Foundation Trust (NSFT) on closer working around community physical and mental health services.
- Working within an alliance of community-based providers.
- Working within and leading on STP workstreams.

1.3.3 Policy drivers – NHS Long Term Plan

Local policy drivers derive from the commissioning intentions and actions of Norfolk and Suffolk CCGs, NCC and NHSE. National policy is primarily contained within the NHS Long Term Plan. It summarises a series of improvements to be delivered in the following five key areas:

1. Improving out-of-hospital care (primary and community services).
2. Reducing pressure on emergency hospital services.
3. Delivering person-centred care.
4. Digitally enabled primary and outpatient care.
5. A focus on population health and local partnerships through ICSs.

Key measures include:

- A new NHS offer of urgent community response and recovery support: Within five years, all parts of the country will be expected to have improved the responsiveness of community health crisis response services to deliver services within two hours of referral, in line with NICE guidelines, including delivering re-ablement care within two days of referral.
- Primary care networks of local GP practices and community teams: Funding will cover expanded community multi-disciplinary teams aligned with new “primary care networks” covering 30-50,000 people. From 2019, NHS111 will start booking patients directly into GP practices, as well as referring to pharmacies. A shared savings scheme will be offered to primary care networks so they can benefit from their improvements.
- Guaranteed NHS support for people living in care homes: There will be an upgrade in NHS support for care home residents with care homes supported by a team of healthcare professionals, including named GP support. The new primary care networks will work with emergency services while care home staff will have access to NHS mail to allow a greater of information to NHS staff.
- Supporting people to age well: From 2020/21 the new primary care networks will assess local population risk and reduce hospital admissions through an increased use of preventative measures such as digital health records, population health management tools and new home-based or wearable monitoring equipment.

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 reviews a detailed integrated performance report at each monthly meeting on operational performance, a monthly report on performance against quality of service measures, a bi-monthly workforce report, a monthly finance report, and a quarterly report on the management of strategic risks, known as the Board Assurance Framework. NCHC has been assessed by CQC and NHSI.

1.4.1 CQC rating

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

Chart below shows the CQC's rating in more detail with a comparison of the current to previous ratings.

Ratings for community health services

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

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

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 below 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

NHSI has 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". The targeted support needs were identified in the category of "finance and use of resources". The Trust's SOF finance rating is 3.

Quality of Care metrics

Measure	Description	Standard or Target	Actual
Written complaints rate	Complaints per 1000 WTE staff	4.77 (six month community benchmark average) 238 actual number of complaints in 2017/18	7.62 (six month rolling average) 193 actual number of complaints in 2018/19
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%	97.2%
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	9 (ceiling)	1
Methicillin-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%	98%
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

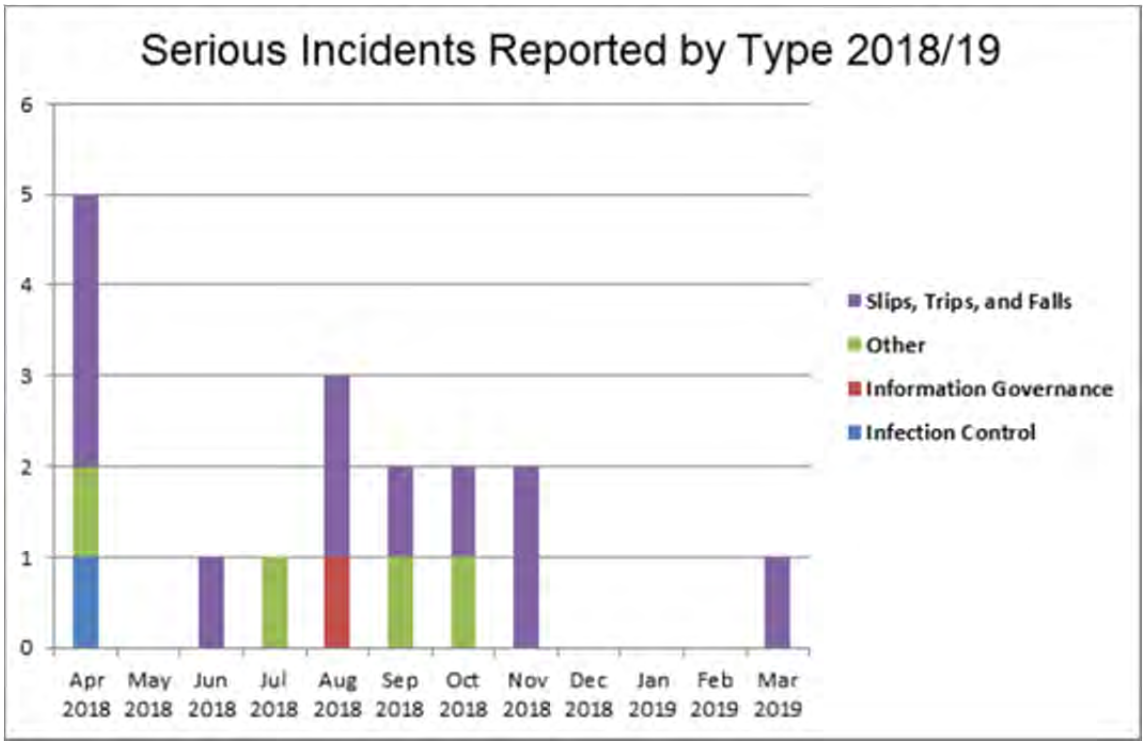
Table below shows the number of incidents reported monthly by category

	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Total
No Harm	333	303	299	288	304	279	299	343	297	263	275	307	3590
Low harm	248	247	221	277	279	253	260	287	257	274	244	296	3143
Moderate harm	46	57	47	61	47	45	53	49	34	69	64	59	631
Severe harm	7	3	4	8	4	5	2	6	5	7	4	3	58
Death not related to patient safety incident (expected death)	0	3	0	3	2	1	0	0	0	1	2	2	14
Death related to patient safety incident (unexpected death)	0	0	1	3	3	0	2	0	3	1	4	0	17
Learning Disabilities - Notifiable Death	4	1	4	1	2	1	4	2	1	1	1	6	28
Total	638	614	576	641	641	584	620	687	597	616	594	673	7481

All incidents, including actions and learning, are reported to the Board. All serious incidents requiring investigation (SIRIs) are investigated using root cause analysis (RCA) methodology. Initial investigation reports are submitted to commissioners within three days of reporting a SIRI full investigation report submitted together with any resulting action plan to commissioners within 40 days of the SIRI being reported.

Following case record reviews and investigations undertaken in line with the Trust's policy on learning from death reviews, none of the patient's deaths during the reporting period are judged to be more likely than not to have been due to problems in care provided to the patient.

A total of 17 SIRIs were reported during 2018/19 see graph below for breakdown:



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			Planned		
		Year to date	Risk Rating	Score	Year to date	Risk Rating	Score
Financial Sustainability	Capital servicing capacity (times)	- 0.51	4.0	0.8	1.71	3.0	0.6
	Liquidity ratio (days)	29	1.0	0.2	58	1.0	0.2
Financial Efficiency	I&E margin (%)	-6.7%	4.0	0.8	-1.8%	4.0	0.8
Financial Controls	Distance From Financial Plan	-4.9%	4.0	0.8	0%	1.0	0.2
	Agency Spend - Distance from plan	-51%	1.0	0.2	0%	1.0	0.2
Weighted Score				**2.80**			**2.00**
Overriding rules applied:	Maximum Score of 3 due to risk ratings of 4						
Overall Score				**3**			**3**

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

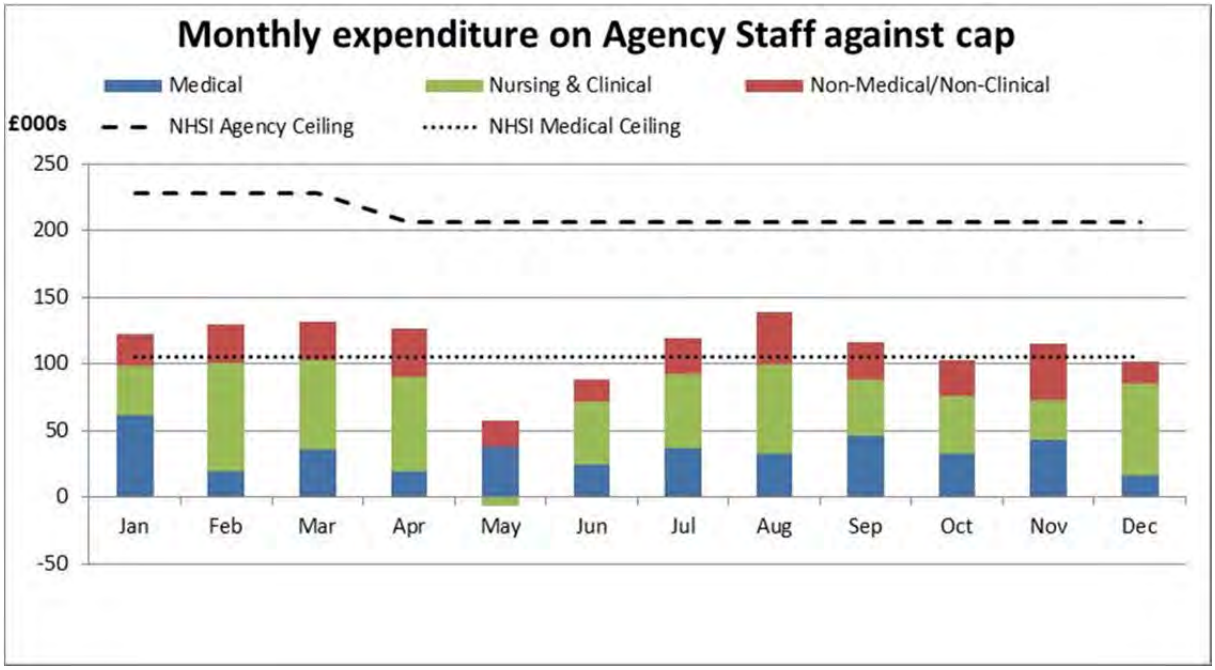
Measure	Description	Standard or Target	Actual
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate − patients on an incomplete pathway	Percentage of patients whose clock period is less than 18 weeks during the calendar months of the return/Count of number of patients whose clock has not stopped during the calendar months of the return	92%	97.3%
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

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%	4.7%
Voluntary staff	Number of Staff leavers reported	7 to 17%	12.6%

turnover	within the period /Average of 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		
NHS Staff Survey	Staff recommendation of the organisation as a place to work or receive treatment	Community trust benchmark. Place to work 59.4% Receive care 74.8%	63.6% 78.8%
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.	See table below	52.6% Total temp pay expenditure £4,108k Total pay expenditure £78,167k

Table below shows monthly expenditure against the agency staff cap



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 above the national average for recommended place to work, and (4) the Trust has remained within the NHSI cap for Agency staff costs. There was an element of May's data in the above table that was

negative – agency for nursing and clinical. This was caused by changes to accruals based on actual run rates in relation to outstanding contract variations.

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 193 complaints compared to 238 for the previous year.

This year has seen a decrease in the number of complaints from the previous year. It has also seen the introduction of a new triage process, where complaints are triaged to see whether they should be treated as a formal complaint, or can be dealt with by local resolution.

As previously reported, some complaints being received continue to be complex in nature, particularly when they relate to end of life care, and the Complaints Officer continues to support these complex cases, and any face to face meetings with complainants where required by the clinicians.

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

- Thematic reviews continue on a six-monthly basis, and the fifth review has just been completed. These are shared at the Quality and Risk Assurance Committee, and also with localities and discussed at locality meetings.
- At the request of the Quality and Risk Assurance committee, two thematic reviews have taken place around staff attitude complaints.
- A thematic review was also carried out for the Norwich locality, at the request of the Norwich Clinical Commissioning Group.
- The Trust continues to submit quarterly KO41a returns to the Health and Social Care Information Centre, and half yearly reports are produced for the Equality and Diversity meeting.
- Non-Executive Directors continue to support the complaints process with deep dives into certain complaints, and the outcome of these are shared with the Quality and Risk Assurance committee.
- Healthwatch carried out an audit of complaints in October 2018.
- Complaints and themes are triangulated by the Complaint Officer's attendance at internal quality surveillance meetings.

Other activity during the year included the Complaints Officer visiting the Colman Clinic, Wheelchair Services and home visits with a Learning Disability nurse, with the

aim to continue to understand clinical processes and therefore continue to learn and improve our processes for responding to, and managing complaints.

Handling of clinical negligence claims, and Coroner's Inquests, continues, and the Complaints Policy has been updated during the year.

Number of Complaints

During the twelve months from 1 April 2018 to 31 March 2019, 193 formal complaints were received from service users or their relatives, compared to 238 the previous year, and 225 in 2016-17. This is a decrease from previous years.

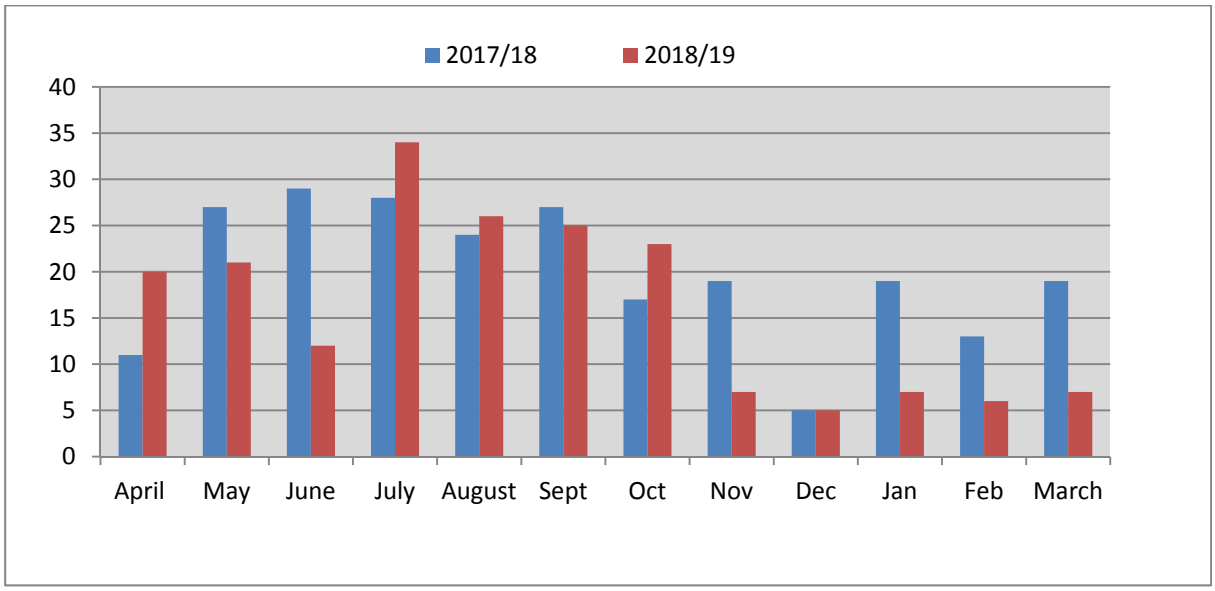
In addition to the 193 new complaints received, 33 were re-opened as the complainant was not satisfied with the first response. The Complaints Officer undertook an audit on re-opened complaints, which found that the main theme related to commissioned service changes, and the learning for the Trust has been around being more pro-active in raising public awareness when these changes are being planned by commissioners. The Quality and Risk Assurance Committee supported these findings and the actions arising from the learning.

Of the 193 complaints received during the year, 80 complaints were upheld by the Chief Executive (41.5%), compared to 45% the year before. This is reported as part of the quarterly KO41a return to the Health and Social Care Information Centre.

Themes and learning from complaints have been regularly discussed at the Quality and Risk Assurance Committee and Board during the year, and themes have been reviewed around:

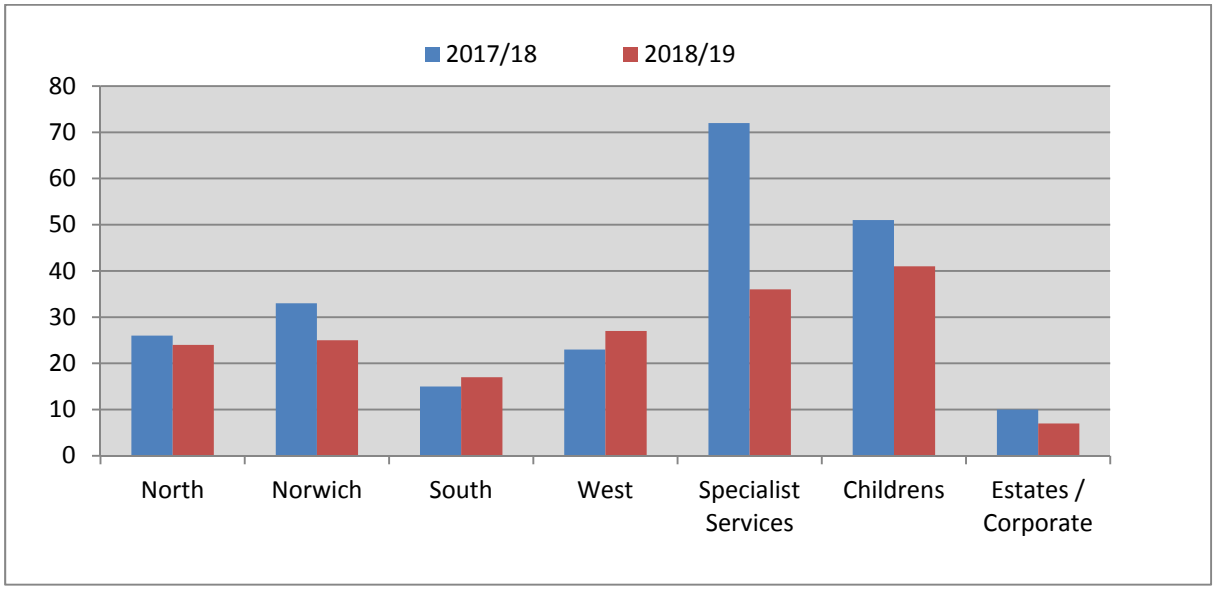
- Waiting times for the Neurodevelopmental service, which has continued since the 2016-17 and 2017-18 reporting period;
- The beginning of the year saw an increase in complaints for the Learning Disabilities service, although this did not continue;
- During the year a few complaints were received for the MSK Physiotherapy service in the West, due to increased waiting times;
- Small numbers around changes to the Diss Health Centre.

Table below shows number of complaints per month for 2018/19 compared to 2017/18



The months of May, June and September had lower numbers of complaints during the month compared to the previous year. There was an increase in July, which also happened during the previous reporting period. Since November, complaints have been lower than in the same month the previous year. The complaints pilot, which is detailed below, commenced on 1 November 2018.

Table below shows total number of complaints per locality for 2018/19 compared to 2017/18



For the last two years, the Specialist locality had the highest number of complaints, followed by Children's services, but this year both localities have seen a reduction in complaints.

In the previous year, both the South locality and West locality saw reductions in complaints, but these have slightly increased this year. The North, Norwich and Estate localities have both seen a slight reduction.

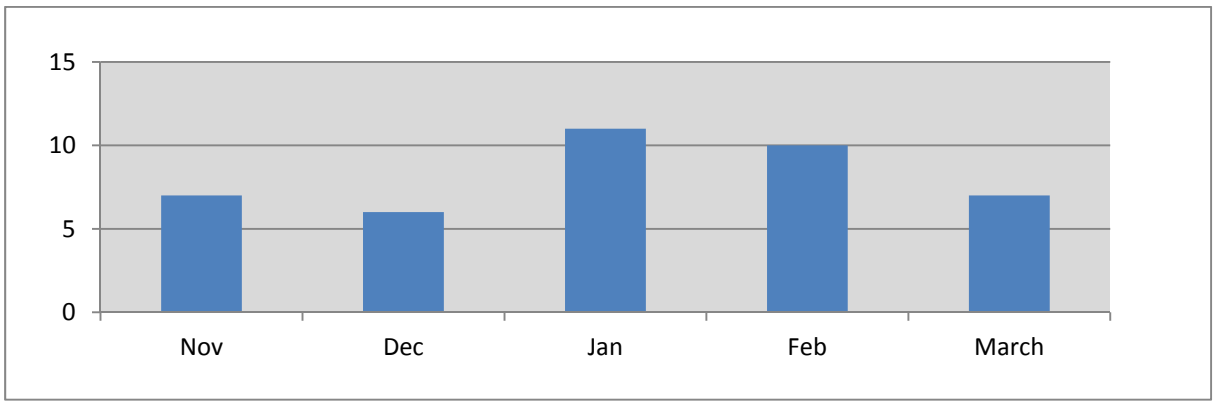
Complaints process

A new process was introduced this year to ensure a more appropriate and swifter response to complaints. This involves a triage process by clinicians to assess whether the complaint is best dealt with through the formal process or by local resolution. To ensure the appropriate clinical oversight of complaints is available, the process has also introduced a sense-check from a member of the triage team before they are passed to the Chief Executive for signing. The new process was reviewed by the Quality and Risk Assurance Committee, and it was agreed that this process should continue as it demonstrated clear benefits for patients.

As part of the process, the Complaints Officer also shares a SitRep report with Executives each week, detailing the number of complaints received, and sent, during the previous week.

The graph below shows the number of complaints received each month, since 1 November 2018, which have been locally resolved. This data will enable comparisons of numbers to be made in future reports.

Table below showing number of locally resolved complaints, November 2018 to March 2019



Healthwatch Audit

Healthwatch carried out an audit of the complaints process, and provided very helpful feedback. This concluded that the initial response to complaints was usually dealt with quickly, yet on a few occasions it was necessary to extend the investigation beyond the 25 working days limit. Healthwatch commended NCHC for making patients aware that their complaint may be submitted for auditing, and providing patients with the opportunity to refuse if they wished. They also said that the letters were mainly well written and, with one exception, dealt with the complaint in full using appropriate language and tone that matched that of the complaint.

Where NCHC was in a position to take action this was explained in the letter but in many cases there was limited evidence of the lessons learnt and the action taken to prevent a recurrence, and this is an action that is being taken forward with operational services.

Clinical Negligence and Public Liability Claims

Claims are handled on the Trust's behalf by NHS Resolution. One new potential litigation claim was received during the year. Six claims remain on-going. Two claims were settled during the year.

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 744 compliments, compared to 897 last year. The decrease is likely to be due to a reduction in the use of the Trust's electronic patient feedback form that is available for localities to record and report their own compliments.

Friends and Family Test

The NHS Friends and Family Test (FFT) 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. We received a total of 11,305 responses to the FFT with over 15,000 positive comments provided. The overall percentage of patients recommending (extremely likely or likely) was 98% which has been maintained for the last four years along with a steady increase in results year on year.

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 Trust's original financial plan for 2018/19 was to maintain financial performance in line with 2017/18 performance and deliver a deficit of £1.9m supported by an efficiency programme of £3.9m. The actual deficit delivered was £12.6m,

deterioration from plan of £10.7m. These figures include an asset impairment of £5.2m following a revaluation of the Trust's land and buildings as at 31 March 2019 and a provision for repayment of VAT of £6.1m.

The Trust's financial performance is assessed by NHS Improvement on an adjusted basis to exclude certain items, e.g. donated assets and devaluations. On an adjusted financial performance basis the Trust delivered a deficit of £7.4m, £5.5m below plan.

This deterioration is primarily due to an on-going review by HMRC into the recovery of VAT on services the Trust outsources to third party providers. The Trust continues to robustly defend its position that it was appropriate to recover the VAT on these contracts based on the VAT guidance, advice from VAT specialists and in line with how other NHS providers have treated VAT under similar circumstances, however following receipt of an initial assessment from HMRC in April the Trust was required to make a provision for the potential cost going back four years, plus associated costs, which totals £6.1m. In addition to this, making the provision has also meant, the Trust was no longer eligible to an element of Provider Sustainability Funding (PSF), that is linked to financial performance of £0.3m.

Excluding both the asset devaluation and the VAT provision the Trust would have been slightly ahead of the £1.9m deficit financial plan, achieving an underlying deficit of £1.7m.

One way to measure efficiency and benchmark performance with other Trusts is by using the outputs from a national NHS reference cost data collection which is refreshed annually in arrears. The outputs for the 2017/18 data collection shows the Trust as one of 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 case mix compared with the same case mix 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 2017-18 reference costs were published on 15th November 2018. The Trust's RCI adjusted for market forces* for 2017/18 is **95**, 5% below the average. The RCI has reduced by eight percentage points from the 2016/17 index of 87 following the cessation of the Suffolk Community services part way through 2017/18. Out of 16 Community Trusts, NCH&C has the third lowest score (lowest score in 2016/17), with nine in total scoring below 100 and seven 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 NCH&C is 0.94.

2.2.1 Efficiency programme

The Trust's efficiency programme of £3.9m consisted of £1.6m of recurrent savings and £2.3m of non-recurrent savings. The programme was achieved in total during the year, with the majority of the savings achieved through non-recurrent savings.

The main elements of recurrent savings are from the Trust's continued redesign of services and implementation of new roles within services as part of the Trust's workforce plan. 27 different projects generated recurrent savings during the year. The remainder was achieved by delivering non-recurrent savings.

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, the Trust invested £3.7m (£4.1m in 2017/18) in capital schemes. The Trust's initial plan was to invest £4.0m, however due to a national shortage of capital funding the Trust agreed to reduce this to £3.7m. This reduction was achieved by reducing project administration costs and deferring non-critical estates projects to 2019/20. One key area of investment was to continue redevelopment of Norwich Community Hospital, including the demolition of disused buildings, which totaled £1.0m. In addition, the Trust has invested £0.6m in enhancing the Trust's cyber security systems, as although the Trust was not directly impacted by the 2017 WannaCry attack it is important the Trust continues to develop these systems, and £0.4m investment in mobile working to maximise the time staff spend with patients.

The Trust's capital investment requirement for 2019-20 is planned to be £3.6m which will be supported by a programme that will balance further investment in estates and IT backlog maintenance and development of new estate. A significant element of the programme is the IT asset refresh and Windows 10 roll out to further enhance the Trust's security and provide clinical staff with refreshed devices.

2.2.3 Balance sheet and working capital

The Trust's cash position remains strong with a year-end balance of £17.4m, a small reduction from the 2017/18 balance of £18.2m. The cash balance has not been affected by the HMRC VAT issue as this is not currently payable. In addition the maintained cash position has been achieved through the introduction of dedicated credit control resource and revised processes. This has seen the recovery of debts overdue by more than 90 days totaling £1.1m during the year.

The Trust's non-current assets were revalued as at 31st March 2019 by the Trust's independent valuers, Montagu Evans. As part of this review it was identified that a number of properties had reduced in value as a result of changes in market conditions, this valuation is the primary cause of the reduction in non-current assets from £75.2m to £63.6m.

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 27 in the financial statements).

2018/19 saw a further deterioration on the previous year's performance, with 73% of non-NHS trade payable invoices being paid within 30 days (81% in 2017/18). 59% of NHS payable invoices were paid within 30 days (65% in 2017/18). 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. In addition the Trust has undertaken joint detailed reviews with a number of local NHS organisations and local government bodies of historic amounts that have resulted in delayed payments, these reviews are ongoing. 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 15 days, wherever practical.

2.2.6 Trend analysis

The table below shows the historic performance of the Trust for the period 2016/17 to 2018/19. The significant reduction in income and pay over the period is as a result of the cessation of the Suffolk Community Services contract during 2017/18. The increase in non-pay costs in 2018/19 is as a result of an estimated £6.1m VAT cost in relation to the on-going HMRC investigation. During 2018/19:

- Income from patient care reduced by 9.0%.
- The amount of Provider Sustainability Funding (PSF, formerly known as Sustainability and Transformation Funding) is linked to how well the Trust delivers against its original plan. The Trust achieved its original plan during the first three quarters of 2018/19 and therefore received an element of STF for the year, however following the recognition of estimated VAT costs the plan was no longer achievable and PSF was not achieved in the final quarter.
- Other operating income increased by £1.2m as a result of a higher PSF allocation and increased use of apprenticeship levy funding.
- Pay reduced by 6.5% and accounts for 70% (73% in 2016/17) of the cost base (excluding depreciation and public dividend capital (PDC)). Excluding the VAT provision from the total cost base brings the pay % up to 74% of this revised cost base which is in line with the prior year.
- Non-pay levels have increased by £2.6m (8.5%) as a result of the estimated VAT cost partly off-set by reduced clinical supplies following the cessation of the Suffolk Community Services contract.
- Depreciation and amortisation have increased by 1.9% despite capital investment slightly reducing. 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 13% as a result of reduced cash

balances over the period.

The Trust has a duty to ensure it breaks even cumulatively with 2009/10 being the starting position for this calculation. 2017/18 was the first year the Trust had not achieved a surplus and this continued in 2018/19. As at 31st March 2018 the Trust had built up reserves of £14.7m since 2009/10. Following the in-year deficit of £7.4m, the Trust has cumulative reserves of £7.3m.

Statement of Comprehensive Income	2016/17 Actual	2017/18 Actual	2018/19 Actual
	£000s	£000s	£000s
Operating income from patient care	£127,731	£115,057	£104,739
Other operating income	£5,395	£4,734	£5,963
Employee Benefits Expense	(£94,375)	(£83,627)	(£78,167)
Other Operating Costs	(£29,731)	(£30,898)	(£33,523)
EBITDA	**£9,020**	**£5,266**	**(£988)**
EBITDA %	**6.8%**	**4.4%**	**-0.9%**
Depreciation & amortisation	(£3,891)	(£4,144)	(£4,224)
Net impairments	£46	(£85)	(£5,230)
PDC dividend	(£2,310)	(£2,444)	(£2,119)
Other gains and losses	£0	£0	(£32)
Surplus / (deficit) for the year	**£2,865**	**(£1,407)**	**(£12,593)**
Surplus / (deficit) %	**2.2%**	**-1.2%**	**-11.4%**
Other comprehensive income:			
Revaluation	£0	(£671)	(£5,684)
Total comprehensive income / (expense) for the period	**£2,865**	**(£2,078)**	**(£18,277)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the year	£2,865	(£1,407)	(£12,593)
Remove net impairments not scoring to department expenditure limits	(£46)	£85	£5,230
Adjustments in respect of donated assets	(£124)	£47	(£36)
Adjusted financial performance surplus / (deficit)	**£2,695**	**(£1,275)**	**(£7,399)**
Adjusted financial performance surplus / (deficit) %	**2.0%**	**-1.1%**	**-6.7%**
Cost improvement programme			
Recurrent CIP	£2,329	£1,890	£817
Non-recurrent CIP	£2,512	£1,144	£3,083
Total CIP	**£4,841**	**£3,034**	**£3,900**
Capital expenditure	£4,137	£4,088	£3,682
Cash balance	£23,259	£18,213	£17,437

2.2.7 Outlook

For 2019/20 the Trust's approved financial plan is a break-even position following agreement of additional non-recurrent funding from NHS Improvement totaling £2.8m.

Over the coming year the Trust will continue to work collaboratively with commissioners and others providers to secure the future of community services and ongoing financial sustainability within the Norfolk & Waveney Sustainability and Transformation Partnership (STP). During 2019/20 the STP will be producing a revised five year financial strategy that the Trust will be part of and will help shape the future strategy for the delivery of community services in Norfolk and Waveney.

The longer term STP 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

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 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 cost 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 fulfill our responsibilities for the role we play, NCH&C has created a sustainable development management plan (SDMP). Our sustainability mission statement is: To sustain our health and care services and provide economic, social and environmental value to the local community for a better tomorrow.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to supersede this target by reducing our carbon emissions 15% by 2019/20 using 2007/08 as the baseline year.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features. One of the ways in which an organisation can embed sustainability is through the use of an SDMP. Our current SDMP was initially approved in August 2018; however a refreshed version with an action plan was approved at Trust Board in March 2019.

We engage with suppliers to understand record and track the sustainability of products and services and adherence to any related relevant contract requirements, through the tendering process when commissioning services, then through the contract management process, via tools such as the contract meetings and KPI

monitoring. 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. The organisation has identified the need for the development of a board approved plan for future climate change risks affecting our area. 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 (SDAT) tool. The last time we used the SDAT self-assessment was in 2018-19 scoring 64%.

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. Our organisation is starting to contribute to the following Sustainable Development Goals (SDGs).

Our organisation is clearly contributing to the following Sustainable Development Goals (SDGs).

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 NHS Supply Chain. For commissioned services here is the sustainability comparator for our CCGs.
Please note this is published a year in arrears.

Organisation Name	SDMP	SDAT	SD Reporting score
NHS Norwich CCG	No	n/a	Good
NHS South Norfolk CCG	No	n/a	Minimum
NHS North Norfolk CCG	No	n/a	Minimum
NHS West Norfolk CCG	No	n/a	Good
NHS Great Yarmouth and Waveney CCG	No	n/a	Good
NHS England	n/a	n/a	n/a
NHS West Suffolk CCG	No	n/a	Minimum
NHS Cambridgeshire and Peterborough CCG	No	n/a	Good

More information on these measures is available here: http://www.sduhealth.org.uk/policy-strategy/reporting/sdmp-annual-reporting.aspx

Performance

Organisation

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.
Floor space is in square metres

	2015-16	2016-17	2017-18	2018-19
Total gross internal floor space	46,500	47,528	46,508	45,767
Total no. of staff employed	2,472	2,874	2,388	2,332

Paper

The movement to a Paperless NHS can be supported by staff reducing the use of paper at all levels, this reduces the environmental impact of paper, reducing cost of paper to the NHS and can help improve information security.

Paper consumed cost is in pounds and weight in tonnes.

	2018-19
Paper spend (£)	17,427
Paper products used (tonnes)	13,106

Performance:

This is the first year we have been able to collate our paper spend figures. The paper we use is 100% recycled and mandated by NHS England.

Travel

We recognise that a Healthy Transport Plan is a foundational part of our Travel Policy and we will be putting that in place as soon as possible. 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.

Travel undertaken

All travel is shown in miles.

	2015-16	2016-17	2017-18	2018-19
Patient and visitor travel	32,911,340	36,407,565	34,573,163	41,053,363
Staff commute	2,374,647	2,761,914	2,293,955	2,241,052
Total	35,285,987	39,169,479	36,867,118	43,294,145

CO2 Emissions (tCO2e)

	2015-16	2016-17	2017-18	2018-19
Patient and visitor travel	11,901.92	13,158.07	12,319.28	15,137.00
Staff commute	858.76	998.18	817.39	798.53
Total	12,760.68	14,157.25	13,136.67	15,935.53

The increase in patient and visitor travel miles and emissions is due to more patients' contacts recorded than the previous year which drives the formula, and also data from the East of England Transport service is included for the first time this year.

Performance:

The patient and visitor mileage includes figures provided from East of England Ambulance's Patient Transport Service

Waste

Waste produced by Norfolk Community Health and Care NHS Trust. This includes waste generated by organisations that operate within our Estate.

Waste in tonnes

	2015-16	2016-17	2017-18	2018-19
Waste recycling weight	164.00	193.00	123.00	108.77
Landfill disposal weight	237.00	2.00	0.00	0.00
Incineration disposal weight	118.00	365.00	327.00	389.9
Total	519	560	450	498.67

CO2 Emissions (tCO2e)

	2015-16	2016-17	2017-18	2018-19
Recycling	3.28	4.05	2.68	2.37
Landfill	57.93	0.62	0.00	0.00
Incineration	25.84	80.30	71.94	85.78
Total	87.05	84.97	74.62	88.148

Performance:

A proportion of our incineration waste - 118.65 tonnes – is used as fuel and would generate heat used for other means which would potentially net off some of our emissions, at present we do not have an accurate way of capturing this information.

Social Value

Collectively as an organisation we recognise the contribution that commissioning, procurement and commercial can have in delivering sustainability and social value, and our duty under the Public Services Value Act.

We ensure that these obligations are met when engaging with suppliers through a rigorous tendering process, then continuing into the contract management process via tools such as contract meetings, supplier spot checks and KPI monitoring.
In June 2018, we awarded a contract to a local logistics firm to assist with the

distribution of mail and other items. Thanks to their local knowledge and expertise, we are able to demonstrate a reduction in miles travelled, and a significantly reduced cost compared to the previous service.

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 these include processes to ensure that buildings remain open, and clinical staff are able to travel to patients, even in adverse weather conditions.

Thanks to our integration with NCC, and links to other partners through initiatives such as the STP and the admittance avoidance teams, we have a strong relationship with our healthcare partners in the area and would support each other where possible.

Biodiversity Action Plan

The Trust's Health and Well-being Group, and the Trust's Patient Environment Manager monitor the performance of our biodiversity and contribute to its performance through the action set within the Trust's SDMP. NCH&C wishes to increase the amount of community green space throughout the Trust, and further explore the relationship between how these types of environments support staff with their wellbeing, and patients with recovery.

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:.....

Josie Spencer
Chief Executive
Norfolk Community Health and Care NHS Trust

Date: 29/08/19

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

Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

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

All Board members were in post between 1 April 2018 to 31 March 2019, unless otherwise stated.

Board member	Designation	Declared Interest
Geraldine Broderick Trust Chair	Non Executive	None
Heather Peck Deputy Trust Chair	Non Executive	Chair, Dog Welfare Trust. Adviser, Citizens Advice. Chair, LANTRA. Former Chair, Cambridgeshire Community Services. Trustee,

		Norfolk Citizens' Advice
Lorna Bailey	Non Executive	Self-employed Speech and Language Therapist. Director, Bailey Booth & Massingham Ltd. Director, Independent Speech & Language Therapy Services Ltd. Director and 100% shareholder, Marlingford Consulting Ltd. Director, Blossom Zone Ltd
John Kennedy	Non Executive	None
Geoff Rivers	Non Executive	Director, Geoff Rivers Associates – local government work. Governor, Archbishop Sancroft High School, Harleston , Norfolk. Vice Chair of the Independent Monitoring Board, HM Prison Hollesley Bay, Woodbridge, Suffolk. Treasurer, WEA (Worker Education Associations), Pulham Branch, Norfolk. Director, All Saints Multi Academy Trust
Graham Nice (from 15.10.18)	Non Executive	CQC specialist adviser. Managing Directors, Graham Nice Associates Ltd.
Andrew Williams Associate NED	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, Headway.
Iain Brooksby (until 09.07.18)	Non Executive	Chairman, Norfolk Heart Trust. Trustee, Norwich Consolidated Charities.
Josie Spencer Chief Executive (interim from 16.06.18, substantive from 01.03.19)	Executive	None
Venu Harilal Medical Director	Executive	Board member, East Anglian drive ability centre in Thetford, Norfolk. Clinical input to All-Hallows Healthcare Trust ,Icanho (Community rehabilitation team in Suffolk), and Environmental Control Service, Suffolk, Bartrams
Anna Morgan Director of Nursing and Quality	Executive	Peer Reviewer for RCN Publications. Clinical and Professional Advisor for CQC inspections. Member, Clinical Senate for East of England
Andrew Hopkins Director of Finance and Performance	Executive	Partner runs a consulting business that carry out work for the NHS on finance, contracts and commissioning
Laura Clear Interim Director of Community Health and Social care Operations (from 12.11.18)	Executive	None
Paul Cracknell Deputy Chief Executive (from	Executive Non-voting	None

06.11.18), Director of Strategy and Transformation (until 05.11.18) (acting Chief Executive from 01.06.18 to 15.06.18)		
Lorrayne Barrett Director of Norfolk Adult Operations and Integration (until 14.01.19)	Executive	Secretary, Friends of Lowestoft Library. Host for a Norfolk County Council Care leaver via the Benjamin Foundation
Roisin Fallon-Williams Chief Executive (until 31.05.18)	Executive	None

The Board is supported by Mike Jones, chartered governance professional and Chartered Secretary.

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
Lorna Bailey	Committee Chair, Non Executive Director
Andrew Williams	Deputy Committee Chair, Associate Non Executive Director
Heather Peck	Committee member, Non Executive Director

3.1.2 Disclosure of personal data related incidents

There were no Information Governance Serious Incidents Requiring Investigation (IG SIRI) during the year. An IG SIRI is defined as a “breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed.”

3.1.3 Counter fraud

Grant Thornton UK LLP was appointed as the Trust’s counter fraud providers from 1 April 2018 and have provided a dedicated Local Counter Fraud Specialist (LCFS), for the Trust, who is fully qualified and accredited to undertake counter fraud work. The counter fraud service provided to the Trust is divided into four areas, namely:

- Strategic governance
- Inform and involve
- Prevent and deter
- Hold to account

The LCFS reports to the Audit Committee summarising the work it has conducted in accordance with NHS Counter Fraud Authority’s (CFA) provider requirements. The LCFS found no material issues to bring to the Committee’s attention regarding counter fraud strategic governance matters that impact directly on the Trust. The LCFS has undertaken work to raise the counter fraud awareness within the Trust. As is required by the NHS CFA, the LCFS regularly summarises general NHS fraud matters for the Trust that relate to the wider NHS.

3.1.4 Modern Slavery Act 2015 – Transparency in Supply Chains

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

The Trust confirms the identities of all new employees and their right to work in the United Kingdom, and pay all its employees above the National Living Wage. In addition, its freedom to speak up, grievance and other staff policies additionally give a platform for its employees to raise concerns about poor working practices.

Consequently, whilst the Trust does not have a specific anti-slavery policy (as it is

not required to have one), it acts in accordance with the intentions of the Act with regard to its own operations and that of any sub-contractors and, therefore, the Trust's ability to deliver the contract is in no way compromised.

3.1.5 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

29/05/19 ..... Date ..... Spencer ..... Chief Executive

29/05/19 ..... 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.....Spencer.....Chief Executive

Date 29/05/19

3.3 Governance Statement

This section includes:

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.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Norfolk Community Health and Care NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Norfolk Community Health and Care NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

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

The Trust's 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 delivering the Workforce Plan and the Health and Care Strategy.
- Risks to enabling our people mitigated through staff engagement and empowerment.
- Risks to securing the future mitigated through delivering the Financial Plan, ensuring the sustainability of services and developing good partner relations.

At the year-end, risks to improving our quality and enabling our people were mitigated down to the target ratings. One of the risks to securing the future around good partner relations was mitigated to the target rating while two other risks; delivering the financial plan and service sustainability, remained above target.

Newly identified in-year and future risks

UK Withdrawal from the European Union (Brexit)

The UK triggered Article 50 of the Treaty of the European Union on 29 March 2017. As set out under that treaty, the UK has two years to negotiate a Withdrawal Agreement and framework for a future relationship with the EU before the point of the UK's exit from the EU on 31 October 2019. A no deal scenario is one where the UK leaves the EU and becomes a third country on that date without a Withdrawal Agreement and framework for a future relationship in place between the UK and the EU. In a no deal scenario there would therefore be no agreement to apply any of the elements of the Withdrawal Agreement. The UK is therefore preparing for a scenario where there is no UK-EU agreement in place on exit day.

NCHC's Brexit planning has taken full account of Government advice in its risk assessment and preparations in relation to: (1) medicines and medical devices; (2) accessing public sector contracts; data protection; (3) merger review and anti-competitive activity; exhaustion of intellectual property rights; and, (4) recognition of professional qualifications, and other workforce issues.

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

Control measures 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 has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. More detail on this is provided in section 2.3 "Sustainability Report" of the Annual Report.

Information governance

There were no Information Governance Serious Incidents Requiring Investigation (IG SIRI) during the year. An IG SIRI is defined as a: "breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed." Further information on data breaches are provided in the Performance Report of the Annual Report and Accounts.

NHS Provider Licence

As an NHS Trust, NCHC is exempt from the requirement to apply for and 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". However, while NHS Trusts are exempt, directions from the Secretary of State require NHSI to ensure that NHS Trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS Trust where necessary to ensure compliance. NHSI base their oversight, using the Single Oversight Framework, of all NHS Trusts and NHS Foundation Trusts on the conditions of the NHS Provider Licence. 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

Attendance at Board meetings

Forename	Surname	Position	25/4/18 - Public	25/4/18 - Private	30/5/18 - Public	30/5/18 - Private	27.6.18 - Public	27/6/18 - Private	25/7/18 - Public	25/7/18 - Private	8/8/18 - ExtraO	26/9/18 - Public	26/9/18 - Private
Geraldine	Broderick	Chair	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Roisin	Fallon-Williams	Chief Executive (until 31/5/18)	Y	Y	Y	Y							
Josie	Spencer	Chief Executive (from 18/6/18)					Y	Y	Y	Y	Y	Y	Y
Lorna	Bailey	Non Executive Director (from 01.04.18)	APOLS	APOLS	Y	Y	Y	Y	Y	Y	APOLS	Y	Y
Lorrayne	Barrett	Director of Norfolk Adult Operations and Integration	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Dr Iain	Brooksby	Non Executive Director (until 09.07.18)	Y	Y	APOLS	APOLS	APOLS	APOLS					
Paul	Cracknell	Director of Strategy and Transformation	Y	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y	Y
Andrew	Hopkins	Director of Finance and Performance	Y	Y	Y	Y	Y	Y	Y	Y	APOLS	Y	Y
Mike	Jones	Trust Secretary	Y	Y	Y	Y	Y	Y	Y	Y	APOLS	Y	Y
Heather	Peck	Non Executive Director	Y	Y	APOLS	APOLS	Y	Y	Y	Y	Y	Y	Y
Dr Venu	Harilal	Medical Director	Y	Y	Y	Y	Y	Y	Y	Y	APOLS	Y	Y
John	Kennedy	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Anna	Morgan	Director of Nursing and Quality	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Geoff	Rivers	Non Executive Director	Y	Y	APOLS	APOLS	Y	Y	Y	Y	APOLS	Y	Y
Andrew	Williams	Associate Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Forename	Surname	Position	26/10/18 ExtraO	31/10/18 - Public	31/10/18 - Private	28/11/18 - Public	28/11/18 - Private	30/1/19 - Public	30/1/19 - Private	18/2/19 - ExtraO	27/2/19 - Public	27/2/19 - Private	27/3/19 - Public	27/3/19 - Private
Geraldine	Broderick	Chair	Y	Y	Y	Y	Y	Y	Y	APOLS	Y	Y	Y	Y
Josie	Spencer	Chief Executive (from 18/6/18)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lorna	Bailey	Non Executive Director (from 01.04.18)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lorrayne	Barrett	Director of Community Health and Social Care Operations	APOLS	APOLS	APOLS	APOLS	APOLS							
Laura	Clear	Interim Director of Community Health and Social Care Operations (from 12/11)				APOLS	APOLS	Y	Y	APOLS	Y	Y	APOLS	APOLS
Paul	Cracknell	Director of Strategy and Transformation (until 09.11)	Y	Y	Y									
Paul	Cracknell	Deputy Chief Executive (from 9/11)				Y	Y	Y	Y	APOLS	Y	Y	Y	Y
Andrew	Hopkins	Director of Finance and Performance	Y	Y	Y	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y
Mike	Jones	Trust Secretary	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Heather	Peck	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	APOLS	Y	Y	Y	Y
Dr Venu	Harilal	Medical Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
John	Kennedy	Non Executive Director	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y	Y	Y	Y
Anna	Morgan	Director of Nursing and Quality	Y	Y	Y	APOLS	APOLS	Y	Y	Y	Y	Y	Y	Y
Geoff	Rivers	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	APOLS	Y	Y	Y	Y
Andrew	Williams	Associate Non Executive Director	APOLS	Y	Y	Y	Y	Y	Y	APOLS	Y	Y	Y	Y
Graham	Nice	Non Executive Director (from 15.10.18)	APOLS	Y	Y	Y	Y	Y	Y	APOLS	Y	Y	Y	Y

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

- 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 NHS Counter Fraud Authority.

Attendance at Audit Committee

Forename	Surname	Position	14/5/18	24/5/18 (ExtraO)	10/9/18	03-Dec-18	11-Mar-19
Lorna	Bailey	Chair and Non Executive Director	Y	Y	Y	Y	Y
Heather	Peck	Non Executive Director	Y	Y	Y	Y	Y
Andrew	Williams	Associate Non Executive Director	Y	Y	Y	Y	Y

The Director of Finance and Performance attended all Audit Committee meetings.

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.

Attendance at Quality and Risk Assurance Committee

Forename	Surname	Position	16/4/18	21/5/18	18/6/18	16/7/18	17/9/18	19-Nov-18	21-Jan-19	18-Mar-19
Lorrayne	Barrett	Director of Norfolk Adult Operations and Integration	Y	APOLS	APOLS	Y	APOLS	APOLS		
Dr Venu	Harilal	Medical Director	APOLS	Y	Y	Y	Y	Y	Y	Y
Anna	Morgan	Director of Nursing and Quality	Y	Y	Y	Y	Y	Y	Y	Y
Dr Iain	Brooksby	Non Executive Director	APOLS	Y	APOLS					
Lorna	Bailey	Non Executive Director (from 01.04.18)	APOLS	Y	APOLS	Y	Y	Y	Y	Y
Graham	Nice	Non Executive Director and Deputy Chair (from 15.10.18)						Y	Y	Y
Heather	Peck	Non Executive Director and Chair	Y	Y	Y	Y	Y	Y	Y	Y

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.

Attendance at Finance and Performance Committee

Forename	Surname	Position	24/4/18	29/5/18	26/6/18	24/7/18	25/9/18	30/10/18	27/11/18	29/1/19	26/2/19	26/3/19
Lorrayne	Barrett	Director of Norfolk Adult Operations and Integration	APOLS	APOLS	APOLS *	APOLS *	APOLS	APOLS *	APOLS*			
Andrew	Hopkins	Director of Finance and Performance	Y	Y	Y	Y	Y	Y	Y	Y	APOLS	Y
Paul	Cracknell	Director of Strategy and Transformation	Y	Y	Y	APOLS	Y	Y	Y	Y	Y	Y
John	Kennedy	Non Executive Director	Y	APOLS	Y	Y	Y	Y	Y	APOLS	Y	Y
Anna	Morgan	Director of Nursing and Quality	Y	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y
Geoff	Rivers	Non Executive Director	APOLS	APOLS	Y	APOLS						
Andrew	Williams	Associate Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

*An Assistant Director or Deputy Director attended in place of the Executive Director

Remuneration Committee (RC)

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

Attendance at the Remuneration Committee

Forename	Surname	Position	31/10/18
Geraldine	Broderick	Chair	Y
Lorna	Bailey	Non Executive Director	Y
John	Kennedy	Non Executive Director	Y
Heather	Peck	Non Executive Director	APOLS
Geoff	Rivers	Non Executive Director	Y
Graham	Nice	Non Executive Director	Y
Andrew	Williams	Associate Non Executive Director	Y

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.

Attendance at the Charitable Funds Committee

Forename	Surname	Position	16/5/18	15/8/18	14-Nov-18	13-Feb-19
Andew	Hopkins	Director of Finance and Performance	Y	APOLS*	Y	Y
Geoff	Rivers	Chair and Non Executive Director	Y	Y	Y	Y
Anna	Morgan	Director of Nursing and Quality	APOLS	Y	Y	Y
Lorna	Bailey	Non Executive Director (from 01.04.18)	Y	APOLS	Y	Y

*Deputy Director attendance in place of the Executive Director

Assessment of Board effectiveness

This is the eighth year in a row that the Board has undertaken a self-assessment using the good practice questions from the NHS Providers "Compendium of Best Practice". Board members scored each question, with 5 being good and zero being poor (or not known).

During the year the Board had made good progress in the priorities it had identified in:

- To further improve the conciseness of Board papers including effective summaries
- To allow sufficient time on each Board item
- That Board policies and strategies take into account the views of staff and stakeholders, inform and involve stakeholders in its work, check their views and monitor this.
- To address Board diversity through recruitment to the Board as vacancies arise.

For the coming year the key findings identified through the self-assessment that the following areas should receive increased focus to further improve Board effectiveness:

- Continue improvements to Board reports.
- Composition of the Board to be more representative of the community that it serves.
- Allow sufficient time to be spent on each agenda item.
- Board to ensure it has the right balance of skills, knowledge and experience to deal with current and anticipated challenges.
- Ensure key stakeholders are more informed and involved in the work of the Board.
- Confirm Board succession planning.

The Board has agreed an action plan to drive improvements in these areas.

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 considered NHS Improvement's well-led framework published at **https://improvement.nhs.uk/resources/well-led-framework/**. A self-assessment was undertaken against the framework and three areas were identified that would potentially benefit from independent external scrutiny or support, as follows:

- 360 stakeholder appraisal;
- Sharing and embedding good practice, learning, innovation and improvements consistently Trust-wide;
- Accountability Framework.

An action plan has been developed to implement these three priority areas.

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.

Developing Workforce Safeguards

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

- Sufficient suitably qualified, competent, skilled and experienced staff are deployed to meet care and treatment needs safely and effectively.
- There is a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times.
- Our approach reflects current legislation and guidance.

Meeting the National Quality Board's (NQB) requirements has helped NCHC comply with the CQC's fundamental standards on staffing, for example, in the well-led framework and related legislation.

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

- NCHC has formally embedded NQB's 2016 guidance in its safe staffing

governance.
- NCHC has ensured the three components of (1) evidence-based tools, (2) professional judgement, and (3) outcomes, are used in its safe staffing processes.

NCHC confirms that its staffing governance processes are safe and sustainable.

Managing Conflicts of Interest

NCHC has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS" guidance. The Audit Committee receives an annual report of declarations of interest, gifts and hospitality.

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 of the Annual report and Accounts.

Clinical audit

Clinical audit is a way to find out if healthcare being provided by the Trust is in line with standards and enables us as a provider, and our patients to know where their service is doing well, and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients. Clinical audits can look at care nationwide (national clinical audits) and local clinical audits can also be performed locally in Trusts wherever healthcare is provided. NCHC has participated in both national and local clinical audits, and implemented the learning from these.

"Freedom to Speak Up"

NCHC Freedom to Speak Up (FTSU) 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, FTSU 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 FTSU 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.

Statement on the discharge of statutory functions

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

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

The Governance Manual is reviewed at least annually by subject matter experts with the Audit Committee having oversight of this process. Amendments have been considered by the Committee and the Executive Team to ensure that the document remains fit for purpose as a working document. The proposed changes are then reviewed and 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 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 “Outstanding” following an inspection this year 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 Grant Thornton. 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:

Audit area	Findings
Core Financial Systems review of payroll	Significant assurance with some improvements required
Core Financial Systems review of outsourced arrangements	Significant assurance with some improvements required
Core Financial Systems review of finance monitoring processes	Significant assurance with some improvements required
Board Assurance Framework	Significant assurance with some improvements required
Committee Structures	Significant assurance with some improvements required
Data Security & Protection Toolkit	Significant assurance with some improvements required
Estates Strategy & Capital Planning	Significant assurance with some improvements required
Data Quality	Partial assurance with some improvements required
Contract Management System	Significant assurance with some improvements required
Performance Management arrangements	Partial assurance with some improvements required
General Data Protection Regulations	Partial assurance with some improvements required
Cyber Security follow up	Significant assurance

There were no high risk recommendations arising from the above Internal Audits.

3.3.5 The Head of Internal Audit Opinion:

"Our overall opinion for the period 1 April 2018 to 31 March 2019 is that based on the scope of reviews undertaken and the sample tests completed during the period, that significant assurance with some improvements required can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.".

3.3.6 Conclusion

No significant internal control issues have been identified.

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: JSpencer ..... Date 29/05/19.....

Josie Spencer
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 salaries and other allowances of the senior managers who have held office for all or part of the 2018/19 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	2018/19					
		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)
Roisin Fallon-Williams	Chief Executive (until 31/05/18)	20-25	-	-	-	-	20-25
Josephine Spencer**	Chief Executive (from (16/06/18)*****	125-130	4	-	-	237.5-240	365-370
Paul Cracknell***	Deputy Chief Executive (from 06/11/18)	105-110	48	-	-	27.5-30	135-140
Andrew Hopkins	Director of Finance and Performance	115-120	-	-	-	12.5-15	130-135
Anna Morgan	Director of Nursing and Quality	110-115	-	-	-	20-22.5	130-135
Lorrayne Barrett****	Director of Community Health & Social Care Operations (until 14/1/2019)	80-85	2	-	-	27.5-30	110-115
Laura Clear	Interim Director of Community Health and Social Care Operation (from 12/11/18)	45-50	2	-	-	62.5-65	110-115
Venu Harilal*	Medical Director / Consultant	115-120	-	0-5	-	37.5-40	155-160
Geraldine Broderick	Chair	30-35	-	-	-	-	30-35
Geoffrey Rivers	Non-Executive Director	5-10	-	-	-	-	5-10
Heather Peck	Non-Executive Director	5-10	1	-	-	-	5-10
Iain Brooksby	Non-Executive Director (until 09/07/18)	0-5	-	-	-	-	0-5
John Kennedy	Non-Executive Director	5-10	-	-	-	-	5-10
Andrew Williams	Non-Executive Director	5-10	7	-	-	-	5-10
Lorna Bailey	Non-Executive Director	5-10	-	-	-	-	5-10
Graham Nice	Non-Executive Director (from 15/10/18)	0-5	-	-	-	-	0-5

*Dr Harilal's remuneration includes both a Clinical and Medical Director role, the salary is split £70,000 for the Clinical role and £50,000 for the Medical Director role.
**The increase in pension related benefits for Josephine Spencer is due to a recalculation of her historically accumulated final salary pension benefits following her appointment as Chief Executive.
***Paul Cracknell was Director of Strategy and Transformation up until he took up the position of Deputy Chief Executive. The taxable benefit is in relation to a salary sacrifice car provided by the Trust.
****Lorrayne Barrett was seconded to Norfolk County Council from 15/01/2019.
*****Josephine Spencer was Interim Chief Executive until 01/03/2019.

A '-' indicates nil.

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.

4.1.3 Fair pay disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid Director/Member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director/Member in the organisation in the financial year 2018-19 was £145k-£150k (2017/18, £140k-£145k). This was 6.0 times (2017/18, 5.6) the median remuneration of the workforce, which was £24,915 (£25,551 in 2017/18). In 2017/18, no employees (no employees in 2017/18) received whole time equivalent remuneration in excess of the highest paid director. Remuneration ranged from £6,157 to £149,950 (2017/18 £6,157 to £143,924). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

4.1.4 Pension benefits

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 2018-19 (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 2019 is based on valuation data at 31 March 2018, updated to 31 March 2019 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.

2018/19		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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018 (to nearest £1,000)	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019 (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 (until 31/05/18)	0	(2.5)-0	55-60	175-180	1,167	- 201	-	-
Josie Spencer	Chief Executive (from (16/06/18)	7.5-10	20-22.5	65-70	185-190	1,053	257	1,433	-
Paul Cracknell	Deputy Chief Executive (from 06/11/18)	0-2.5	0-2.5	20-25	40-45	245	47	314	-
Andrew Hopkins	Director of Finance And Performance	0-2.5	(2.5)-0	45-50	115-120	776	98	921	-
Anna Morgan	Director of Nursing and Quality	0-2.5	(2.5)-0	35-40	40-45	472	68	569	-
Lorrayne Barrett	Director of Community Health & Social Care Operations (until 14/01/19)	0-2.5	0	5-10	0	74	17	116	-
Laura Clear	Interim Director of Community Health & Social Care Operation (from 12/11/18)	0-2.5	2.5-5	35-40	105-110	640	48	803	-
Venu Harilal	Medical Director	2.5-5	0-2.5	35-40	35-40	411	77	515	-

**Roisin Fallon-Williams has chosen to take the benefits of her pension and as such there is no current year CETV shown*

A '-' indicates nil.

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	-

4.1.5 Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's 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 8A	68
Band 8B	33
Band 8C	12
Band 8D	5
Band 9	4
VSM	2

At March 31st 2019

This includes one band 8B post held by the STP

Table showing staff numbers

Staff Numbers

	2018-19			2017-18
	Total Number	**Permanent Employed Number**	**Other Number**	**Total Number**
Average Staff Numbers				
Medical and dental	**30**	30	0	**29**
Ambulance staff	**0**	0	0	**0**
Administration and estates	**429**	423	6	**438**
Healthcare assistants and other support staff	**665**	626	39	**691**
Nursing, midwifery and health visiting staff	**625**	597	28	**733**
Nursing, midwifery and health visiting learners	**0**	0	0	**0**
Scientific, therapeutic and technical staff	**292**	287	5	**341**
Healthcare science staff	**4**	4	0	**4**
Social care staff	**1**	1	0	**1**
Agency and contract staff	**0**			**0**
Bank staff	**0**			**0**
Other	**7**	7	0	**7**
Total	**2,053**	**1,975**	**78**	**2,244**
Of the above - staff enaged on capital projects	**4**	4	0	**5**

Table below showing employee benefits

Employee Benefits - Gross Expenditure

2018-19	Total £000	Permanently Employed total £000	Other total £000
Salaries and wages	61,750	59,374	2,376
Social security costs	5,796	5,581	215
Apprenticeship levy	297	297	0
Pension cost - employer contributions to NHS pension scheme	8,313	8,005	308
Pension cost - other	11	11	0
Other post employment benefits	0	0	0
Other employment benefits	167	167	0
Termination benefits	862	862	0
Temporary staff - external bank	0		0
Temporary staff - agency/contract staff	1,214		1,214
TOTAL STAFF COSTS	**78,410**	**74,297**	**4,113**
Included within:			
Employee Costs Capitalised	**243**	**243**	**0**
Operating expenditure analysed as:			
Gross Employee Benefits excluding Capitalised costs	**78,410**	**74,297**	**4,113**

2017-18	Total £000	Permanently Employed total £000	Other total £000
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 post employment benefits	0	0	0
Other employment benefits	210	210	0
Termination benefits	177	177	0
Temporary staff - external bank	0	0	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**

"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 showing staff numbers by gender

Staff Category	Female	Male	Total
Directors (Voting)	6	5	11
Non-voting directors and other VSMs	0	2	2
Other staff	1980	323	2303
Total	1986	330	2316

Comparison to census data

The 2011 Census information (Norfolk) has enabled us to compare the staff profile to the Norfolk population. The tables below detail comparisons by ethnicity, religious belief, and age. Data on sexual orientation and disability is also presented although this was not covered within the Census.

Ethnic Origin	NCHC (%)	2011 Census Norfolk (%)
0 White	0.1%	-
A White - British	85.2%	92.4%
B White - Irish	0.4%	0.4%
C White - Any other White background	2.3%	-
C3 White Unspecified	0.0%	-
CA White English	0.6%	-
CB White Scottish	0.0%	-
CC White Welsh	0.1%	-
CK White Italian	0.0%	-
CM White Traveller	0.0%	-
CN White Gypsy/Romany	0.0%	-
CP White Polish	0.0%	-
CU White Croatian	0.0%	-
CW White Other Ex-Yugoslav	0.0%	-
CY White Other European	0.2%	3.5%
C2 White Northern Irish	0.0%	-
D Mixed - White & Black Caribbean	0.0%	0.1%
E Mixed - White & Black African	0.3%	0.3%
F Mixed - White & Asian	0.0%	0.2%
G Mixed - Any other mixed background	0.1%	0.3%
H Asian or Asian British - Indian	0.8%	0.3%
J Asian or Asian British - Pakistani	0.0%	0.5%
K Asian or Asian British - Bangladeshi	0.0%	0.1%
L Asian or Asian British - Any other Asian background	0.9%	0.1%
LA Asian Mixed	0.0%	0.1%
LD Asian East African	0.0%	0.1%
LE Asian Sri Lankan	0.0%	0.5%
LF Asian Tamil	0.0%	-
LJ Asian Caribbean	0.0%	0.4%
LK Asian Unspecified	0.0%	-
M Black or Black British - Caribbean	0.2%	0.1%
N Black or Black British - African	0.5%	0.4%
P Black or Black British - Any other Black background	0.0%	0.1%
PD Black British	0.0%	0.1%
PE Black Unspecified	0.0%	-
R Chinese	0.1%	0.1%
S Any Other Ethnic Group	0.2%	0.1%
SC Filipino	0.2%	-
SE Other Specified	0.0%	-
Undefined	0.5%	-
Z Not Stated	7.0%	-

Religious belief

This table (right) represents the profile of NCH&C staff for religious beliefs compared to the data published from the 2011 Census (Norfolk) population.

Religious Belief	NCH&C %	2011 Census Norfolk (%)
Athaism	12.9%	29.6%
Buddhism	0.3%	0.3%
Christianity	42.9%	61.0%
Hinduism	0.4%	0.3%
Islam	0.2%	0.8%
Jainism	0.0%	??
Judaism	0.0%	0.1%
Sikhism	0.1%	0.1%
Other	7.5%	0.5%
I do not w ish to disclose my religion/belief	35.1%	7.8%
Undefined	0.6%	-

Age

This table (below) represents the profile of NCH&C staff for age compared to the data published from the 2011 Census (Norfolk) population.

Age Profile	16 - 20	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 - 50	51 - 55	56 - 60	61 - 65	66 - 70	71+
NCH&C Staff Profile	1.2%	5.2%	9.6%	11.0%	10.5%	11.4%	15.2%	17.1%	12.1%	5.6%	0.9%	0.1%
2011 Census Norfolk (%)	7.1%	7.3%	6.9%	6.4%	7.0%	8.2%	8.5%	7.6%	7.4%	8.4%	7.4%	17.6%

Disability

The 2011 census did not request information from the UK population on registered disability status, but instead asked questions around the level of general health. As such we are unable to make a direct comparison of NCH&C staff vs local population.

	No	Not Declared	Yes
Number of Staff w ho have stated they have a disability	84.6%	9.9%	5.5%

Sexual Orientation

The 2011 census did not request information from the UK population on sexual orientation. As such we are unable to make a direct comparison of NCH&C staff vs local population.

Sexual Orientation	NCH&C %
Heterosexual or Straight	67.3%
Gay or Lesbian	1.1%
Bisexual	0.6%
Not stated (person asked but declined to provide a response)	30.3%
Undefined	0.7%

4.2.3 National Staff Survey

The graphics below provide a summary of the main findings from the National Staff Survey

Survey Coordination Centre

2018 NHS Staff Survey Results > Appendices > Significance testing – 2017 v 2018 theme results

NHS England

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2018 score is significantly higher than last year's, whereas ↓ indicates that the 2018 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	1164	**9.5**	1202	↑
Health & wellbeing	**5.8**	1168	**5.9**	1198	Not significant
Immediate managers	**6.9**	1166	**6.9**	1197	Not significant
Morale		0	**6.3**	1182	N/A
Quality of appraisals	**5.1**	1022	**5.5**	1078	↑
Quality of care	**7.2**	1012	**7.2**	1049	Not significant
Safe environment - Bullying & harassment	**8.0**	1160	**8.1**	1194	Not significant
Safe environment - Violence	**9.5**	1162	**9.6**	1191	↑
Safety culture	**6.7**	1165	**6.9**	1201	↑
Staff engagement	**6.9**	1173	**7.2**	1201	↑

4.2.4 Examples of workforce developments

NCHC continues to transform its models of delivery to provide services where and when patients need support and to make adjustments to its workforce to ensure success. The Trust currently has 39 service transition plans at various stages of implementation which are meeting the objectives of the workforce plan. Its Service Development Plans are reviewed with commissioners so that the Trust can align its plans against expectations. The IMAS demand and capacity model is an operational tool that is used to assist in effectively managing capacity. As part of the approval process, and ongoing management of change programmes, the impact on staff is identified and monitored. QIAs identify where there may be both positive and negative impacts on staff and patients with a focus on mitigating and improving negative consequences and emphasising positive ones. Staff engagement, throughout both the scoping and implementation period, is strongly encouraged and is supported by a structure of Focus groups which canvasses the opinions of staff of all bands and disciplines on specific aspects and details of plans, helping us to develop plans in collaboration with staff.

The Trust's workforce plan seeks to identify ways to adjust its workforce model to ensure the skills and competencies required in the future are available. The plan is formed across organisational boundaries by developing the workforce across health and social care. Within community nursing and therapy services, there are defined competencies in place that allow for the full utilisation of unregistered staff to support more than one professional group, for example nursing and occupational therapy. These will continue to be developed for other professional groups.

Working alongside our STP partners, the Trust is re-designing pathways to provide

care closer to home. The Trust is responding to efficiency drivers across the system in order to maximise resources and redeploy staff to support the new models. There have been, and will continue to be, consultations with staff to ensure feedback is taken in to consideration. Recognising the potential impact on staff wellbeing at a time of extreme change, the Trust has a Board approved Health and Wellbeing Strategy for staff. It includes an agreed action plan for improvement following a full assessment of the organisation using the NHS Improvement Workforce Health and wellbeing framework. There is an Executive and Clinical Lead for health and wellbeing, and a working group in place made up of subject matter experts, trade union representatives and staff who have an interest in health and wellbeing to deliver the strategy. The health and wellbeing strategy will also be reviewed and updated during 2019.

The Trust has a clear programme of work in place until 2022, using its apprenticeship levy, to introduce 236 clinical apprentices across five different training programmes to support the workforce plan. We will also increase the number of Advanced Nurse Practitioners in practice and work closely with primary, mental health and social care to continue to develop new roles and training experiences across the Integrated Care System (ICS), to support Primary Care Networks (PCNs). We are actively involved in the development of an OT Apprenticeship pathway locally and also intend to support the Physiotherapy Apprenticeship programme once it is agreed by the relevant national bodies. We continue to act on behalf of the STP in the promotion of work experience and careers opportunities locally, as well as working with local and national initiatives to support social inclusion and return to employment.

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 fulfill 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 staff profile including ethnicity data compared to the Census for Norfolk is presented above.

The priorities for the coming year are reviewing the outcome of the Stonewall Workplace Equality Index in which the Trust was placed 377th across all sectors (an improvement on last year's placing of 405th). There are a number of actions to take forward in partnership with the Trust's LGBT Ambassador and these will be incorporated in the action plans for the next reporting cycle. Furthermore, the reverse mentoring scheme is being developed for staff who perceive themselves to have a barrier at work.

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.

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

- Changes as a result of commissioning decisions, for example, no longer delivering the Out of Hours Urgent Care Services in the West Locality from April 2019.
- Changes to consolidate services, for example, to establish one Single Point of Contact, providing one contact and referral route into NCHC's Norfolk Services.
- Changes in service delivery, for example, in re-ablement services where support workers, have been re-deployed within the Trust.
- Three staff from the Learning Disabilities Service were TUPE'd out of the organisation.
- Weekend Portering Hours consultation.
- Introduction of a standard shift pattern in the Palliative Care at Home Team.
- Aligning Virtual Hubs to a modified working pattern.

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 achieved for the year. There were no significant health and safety incidents reported during the year.

Sickness absence

The 12 month sickness absence rate for the year is 4.7%. These sickness figures are based on NCHC's internal reporting systems and cover the period 1st April 2018 to 31st March 2019. 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 1st January 2018 to 31st December 2018.

Table below showing staff sickness absence rate

Staff sickness absence	2018-19 **Number**	2017-18 **Number**
Total days lost	20,101	25,110
Total staff years	1,949	2,294
Average working days lost (per WTE)	**10.31**	**10.95**

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

4.2.6 Staff recognition

We celebrated the amazing achievements of our staff at the NCHC REACH Awards.

With 17 award categories, individuals and teams who work in both clinical and business services settings were acknowledged for going above and beyond the call of duty.

Emerging Talent
Rebecca Russell, Community Nurse
Since joining the community nursing team in September 2017 Rebecca has regularly gone above and beyond in her role, consistently demonstrating that the patient is at the centre of everything she does.

Excellence Award – Business Services
Steve Worley, Procurement Improvement and Development Manager
Steve is an expert in procurement, helping staff articulate their requirements to run procurement tenders that have better outcomes in terms of the quality of products and services delivered and reduced costs. He continually strives to find new ways to improve legacy processes and his positive contribution to cost reductions is always evidenced.

Apprentice of the Year
Giusy Angelini, Commercial and Business Development Apprentice
Giusy is a true team player, who not only tailors her approach to any given project but also anticipates the needs of any team that she is part of. She gives every task her absolute all, and truly cares about the work being delivered.

Excellence Award – Clinical
Annette Paul, Continence Service Lead
Annette is passionate about providing excellent service, always ensuring patients are empowered in the process. She has raised the profile of continence issues across the Trust, providing inspirational training sessions to staff and patients, as well as developing consistent standards for continence across Norfolk.

Innovation Award – Clinical
Louise Gilbert, Advanced Specialist Physiotherapist ESD for Stroke Norfolk
Louise has innovated and led in developing a cross-trust and cross-team tone and postural management pathway. She creates an environment for new ideas to be piloted, encourages collaboration with other services and embraces change to improve services.

Innovation Award – Business Services
Adam Fisher, Procurement Systems Manager and Luke Moore, Project Manager
Adam and Luke worked together to implement a new electronic Purchase Order system, with an integrated Stock Management module. They have consistently engaged with clinical colleagues to support staff with the change to their processes. By following up with constant post-implementation support, the installation of the system has been a resounding success.

Partnership Working – *sponsored by NCH&C Charitable Fund*

Children's Services – Service & Clinical Leads

The Leadership Team in Children's Services have consistently emphasised that, with collaboration of Partners and staff, solutions are stronger when built together. One example of this is the co-production (with Commissioners, GPs and acute providers) of a new clinical model for children's continence, which led to a rapid reduction in waiting times.

Mentor of the Year

Claire Mallett, Community Nurse

Claire's compassion and care are truly inspirational. The support she has provided to student nurses has been invaluable, and staff feel comfortable to seek her advice and guidance, no matter how small the issue. She demonstrates an exceptional kindness to patients, which encourages others to follow her example.

Inspirational Leader – *sponsored by Vision Logistics*

Fai de Main, Integrated Team Manager (Health)

Fai is committed to making a difference to the lives of people with learning disabilities, and she does this through clear, positive, supportive management of a team of health staff providing support to people in the community. She motivates staff through her clear communication and her contagious enthusiasm, and she works tirelessly to ensure patient outcomes are improved, as well as supporting her staff to do likewise.

Team of the Year – Business Services

Temporary Worker Service

The Temporary Worker Service have around 1,000 Bank workers who are contacted to fill 'on the ground' vacancies as they arise. This team works under immense pressure, knowing that if they cannot fill a shift, patient care could be compromised. This small team is adaptable, dedicated and are always looking for ways to improve the service.

Team of the Year – Clinical

Wheelchair Assessment Team

Since July 2018 the Wheelchair Assessments team have been supporting the delivery of a service to the West CCG following the collapse of the West Wheelchair service. The service was picked up without existing staff, facilities, equipment or overview of existing service users, but they continue to demonstrate that patients are at the centre of everything they do. Despite an ever-increasing caseload they remain focused, engaged and continue to smile.

Volunteer of the Year – *sponsored by NCH&C Charitable Fund*

Dianne Palmer and Carol Brawn, Patient Assessors for PLACE (Patient Led Assessments of the Care Environment)

When PLACE assessments commenced in 2013 the Trust scored below the national average in all domains. The 2018 assessment saw NCH&C achieve scores above the national average across the board - an improvement that would not have happened without Dianne and Carol's contribution. Both are so natural and at ease when talking to patients during an assessment – compassionate, kind, and easily able to engage with patients and staff alike.

Lifetime Achievement – *sponsored by Birketts Law Firm*

Caroline Copping, Housekeeper

Caroline has worked at Priscilla Bacon Lodge for 30 years, going above and beyond every day for her patients, their relatives and her colleagues. Nothing is ever too much trouble for Caroline, even working on Christmas day. She is the resident party organiser, who frequently organises raffle prizes to raise money for the Priscilla Bacon Lodge Support Group which benefits patients and their families in various ways.

Patient Choice Award

Community Neurology Team (West Norfolk)

Receiving a staggering 10 nominations from patients and their relatives, the positive impact this team has made to countless lives is immeasurable and they take great care in helping their patients remain independent and dedicated to their recovery. Their nomination touched the hearts of the judges and embodied what this award represents.

Unsung Hero Award

Donna Todd, Community Assistant Practitioner

After realising that Band 4 staff were not having the chance to meet and discuss opportunities and issues surrounding their role, Donna set up the 'Band 4 Forum'. An initiative that will not just benefit those she works with, but all the Trust. Donna manages these single handily, in addition to her role and while progressing her own career on the nursing apprenticeship.

CEO Award

Liz Gard, Charge Nurse

New for 2019, this award winner was chosen by our CEO, Josie Spencer, from the full pool of nominations. Josie selected Liz to be the winner of the very first CEO award as she embodies the Trust values and has dedicated her career to working with a client group that are one of the most vulnerable in our society, often have no voice and are "invisible" in terms of the care they need.

Special Recognition Award

Anna Morgan, Director of Nursing and Quality

Anna was awarded a Special Recognition Award for her contribution to enabling NCH&C to become the first community NHS trust in the country to achieve an 'Outstanding' CQC rating last year. Anna was the NCH&C figurehead that drove us forward and led us to our landmark result.

Chair's Award

Rosie Miller, Community Rehab

Unlike the other awards, the winner of the Chair's Award is not based on nominations; it is awarded solely by our chair Geraldine Broderick, who selected Rosie Miller to be the winner of this award. Rosie has been with the Trust for over 25 years, working with patients with complex disorders and injuries. It is clear from direct feedback and patient experience sessions at our Board meetings that the people she works with absolutely love her and that she is an outstanding and inspirational colleague.

4.2.7 Expenditure on consultancy

Expenditure on consultancy services is shown in the accounts Note 4.1 Operating Expenses. The expenditure in 2018/19 was £99k (£117k in 2017/18).

4.2.8 Off-payroll engagements

Table showing existing off-payroll payments as of 31 March 2019, for more than £245 per day and that last longer than six months:

Engagements	**Number**
Existing engagements as of 31 March 2019	1
Of which, then number that have existed:	
for less than one year at the time of reporting	Nil
for between one and two years at the time of reporting	1
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 were no new off-payroll engagements during the year, and one existing off-payroll engagement that has existed for between one and two years. 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 staff, and where necessary that assurance is sought, with the process being overseen by the Remuneration Committee.

Table for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, 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 2018 and 31 March 2019	0
Of which...	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
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 showing any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

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

Table showing exit packages agreed in 2018/19

Exit Packages agreed in 2018-19

Exit package cost band (including any special payment element)	Number of compulsory redundancies Accounts 31 Mar 2019 2018/19	Cost of compulsory redundancies Accounts 31 Mar 2019 2018/19	Number of other departures agreed Accounts 31 Mar 2019 2018/19	Cost of other departures agreed Accounts 31 Mar 2019 2018/19	Total number of exit packages Accounts 31 Mar 2019 2018/19	Total cost of exit packages Accounts 31 Mar 2019 2018/19	Number of departures where special payments have been made Accounts 31 Mar 2019 2018/19	Cost of special payment element included in exit packages Accounts 31 Mar 2019 2018/19
	Number	**£**	**Number**	**£**	**Number**	**£**	**No.**	**£000**
<£10,000	2	9,967	0	0	**2**	**9,967**	0	0
£10,000 - £25,000	0	0	0	0	**0**	0	0	0
£25,001 - 50,000	0	0	0	0	**0**	0	0	0
£50,001 - £100,000	0	0	0	0	**0**	0	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	**2**	**9,967**	**0**	**0**	2	9,967	**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: JSpencer Date 29/08/19

Josie Spencer
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.

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 2019 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 2019 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 2018/19.

Basis for opinion

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

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not 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. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

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 a year from the date of approval of the financial statements. In our evaluation of the Director's conclusions we considered the inherent risks to the Trust's operations, including the impact of Brexit, and analysed how these risks might affect the Trust's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

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 2018/19. 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 2018/19.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 47, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to 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 48 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 48, 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.

SBeavis

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

29 May 2019

Norfolk Community Health and Care NHS Trust

Annual accounts for the year ended 31 March 2019

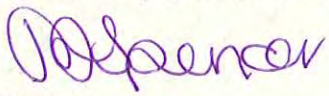
Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	104,739	115,057
Other operating income	4	5,963	4,734
Operating expenses	6	(121,145)	(118,754)
Operating (deficit) / surplus from continuing operations		**(10,444)**	**1,037**
PDC dividends payable		(2,119)	(2,444)
Net finance costs		**(2,119)**	**(2,444)**
Other gains / (losses)		(32)	-
(Deficit) for the year		**(12,595)**	**(1,407)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	13	(10,821)	-
Revaluations	13	5,137	(671)
Total comprehensive (expense) for the period		**(18,279)**	**(2,078)**
Adjusted financial performance (control total basis):	2		
Surplus / (deficit) for the period		(12,595)	(1,407)
Remove net impairments not scoring to the Departmental expenditure limit		5,230	85
Adjustments in respect of donated government grant assets		(36)	47
Adjusted financial performance surplus / (deficit)		**(7,401)**	**(1,275)**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	11	285	43
Property, plant and equipment	12	63,336	75,114
Total non-current assets		**63,621**	**75,157**
Current assets			
Inventories	14	173	180
Receivables	15	12,227	9,967
Non-current assets held for sale / assets in disposal groups	16	897	897
Cash and cash equivalents	17	17,437	18,213
Total current assets		**30,734**	**29,257**
Current liabilities			
Trade and other payables	18	(12,882)	(11,195)
Provisions	19	(7,463)	(257)
Other liabilities		(348)	(164)
Total current liabilities		**(20,693)**	**(11,616)**
Total assets less current liabilities		**73,662**	**92,798**
Non-current liabilities			
Provisions	19	(229)	(1,146)
Total non-current liabilities		**(229)**	**(1,146)**
Total assets employed		**73,433**	**91,652**
Financed by			
Public dividend capital		15,635	15,414
Revaluation reserve		15,390	21,074
Income and expenditure reserve	25.1	42,408	55,164
Total taxpayers' equity		**73,433**	**91,652**

The notes on pages 93 to 128 form part of these accounts.



Name Josie Spencer
Position Chief Executive
Date 29 May 2019

Statement of Changes in Equity for the year ended 31 March 2019

	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
		£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward		**15,414**	**21,074**	**55,164**	**91,652**
Effect of implementing IFRS 9 on 1 April 2018	25.1	-	-	(161)	**(161)**
(Deficit) for the year		-	-	(12,595)	**(12,595)**
Impairments		-	(10,821)	-	**(10,821)**
Revaluation		-	5,137	-	**5,137**
Public dividend capital received		221	-	-	**221**
Taxpayers' equity at 31 March 2019		**15,635**	**15,390**	**42,408**	**73,433**

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

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

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating (deficit) / surplus		(10,444)	1,037
Non-cash income and expense:			
Depreciation and amortisation	6	4,224	4,144
Net impairments	6.2	5,230	85
Income recognised in respect of capital donations	4	(96)	-
(Increase) in receivables and other assets		(2,081)	(938)
Decrease in inventories		7	182
Increase / (decrease) in payables and other liabilities		2,455	(3,130)
Increase in provisions		6,289	309
Other movements in operating cash flows		7	-
Net cash used in operating activities		**5,591**	**1,689**
Cash flows from investing activities			
Purchase of intangible assets		(280)	(64)
Purchase of property, plant, equipment and investment property		(3,945)	(4,036)
Receipt of cash donations to purchase capital assets	4	96	-
Net cash used in investing activities		**(4,129)**	**(4,100)**
Cash flows from financing activities			
Public dividend capital received		221	-
PDC dividend paid		(2,459)	(2,656)
Cash flows from other financing activities		-	21
Net cash used in financing activities		**(2,238)**	**(2,635)**
(Decrease) in cash and cash equivalents		**(776)**	**(5,046)**
Cash and cash equivalents at 1 April - brought forward		**18,213**	**23,259**
Cash and cash equivalents at 31 March	17	**17,437**	**18,213**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 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 2018/19 issued by the Department of Health and Social Care.

The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

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

Note 1.2 Going concern

The Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns 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.

Note 1.3 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. 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.

Note 1.4 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. These are regularly reviewed.

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.

Note 1.4.1 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's 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 1.3 regarding the consolidation of charities, the Trust has determined 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

Notes to the Accounts

Note 1.4.1 Critical judgements in applying accounting policies continued

Revaluation of the Trust's land and buildings
The Trust conducts a revaluation of land and buildings valuations at least every three years. 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 full revaluation was performed at 31 March 2019. 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. Significant judgements are used in determining the fair value of land and buildings. For assets valued at depreciated replacement cost, key judgements include remaining and total useful lives, construction costs and professional fees, unit costs, optimisation, and the Trust's required service potential from assets. For assets valued at existing use value, the key judgement is the market value of the asset given its existing use. For assets valued at market value, the key judgement is the value the property would obtain on an open market.

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

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in the property, plant and equipment note to these financial statements.

Note 1.4.2 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 and intangible assets accounting notes to these financial statements.

Note 1.5 Operating segments

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

Note 1.6 Revenue

Where income is derived from contracts with customers, it is accounted for under IFRS 15 *Revenue from Contracts with Customers*. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

As directed by the GAM, the transition to IFRS 15 *Revenue from Contracts with Customers* (the Standard) has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.

There has been no change to comparative financial information as a result of the transition.

Notes to the Accounts

Note 1.6 Revenue continued

In the adoption of the Standard a number of practical expedients offered in the Standard have been employed. These are as follows;
• As per paragraph 121 of the Standard the Trust will not disclose information regarding performance obligations where part of a contract has an original expected duration of one year or less.
• The Trust is not disclosing information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard, where the right to consideration corresponds directly with value of the performance completed to date.
• The GAM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for healthcare services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patients. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer.

At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. The method adopted to assess progress towards the complete satisfaction of a performance obligation varies by performance obligation and contract.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with commissioners. CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

Other income
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.6.1 Apprenticeship levy

The value of the benefit received when the Trust accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, *Accounting for Government Grants* .

Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Notes to the Accounts

Note 1.7 Employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid.

The cost of leave earned but not taken by employees at the end of the period is immaterial to the Trust as processes are in place to limit the amount of leave earned which is carried forward to future accounting periods. The cost of leave earned but not taken by employees at the end of the period is therefore not accrued in the financial statements.

Retirement benefit costs
NHS Pensions
Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover 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 though they were defined contribution schemes: 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 scheme. 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 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.

National Employment Savings Trust
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 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.

Note 1.8 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.

Note 1.8.1 Value added tax
Most of the activities of the Trust are outside the scope of value added tax (VAT). 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.

Note 1.9 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
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Notes to the accounts

Note 1.9 Property, plant and equipment continued
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 individual useful economic lives.

Measurement
All property, plant and equipment is 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. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment 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. Current values in existing use are determined as follows:
● Land and non-specialised buildings – market value for existing use, or market value for assets planned for disposal.
● Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, *Borrowing Costs* (the Trust currently does not incur borrowing costs). Assets are revalued and depreciation commences when they are brought into use.

IT equipment, and plant and machinery that are held for operational use 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 there is a balance on the reserve for the asset, and thereafter to expenditure. Gains recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

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.

Derecognition
An asset is de-recognised when disposal or demolition occurs.

Note 1.10 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.

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.

Notes to the accounts

Note 1.10 Intangible assets continued

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
Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition 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 valued at depreciated historic cost. Intangible assets are not revalued as any revaluation would be immaterial.

Impairments are treated in the same manner as for property, plant and equipment.

Derecognition
An intangible asset is de-recognised when disposal occurs or when the Trust no longer has access to the intangible asset.

Note 1.11 Depreciation, amortisation and impairments
Freehold land, assets under construction or development and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight-line basis over their estimated useful lives. 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 following asset lives are applied:

	Min life Years	Max life Years
Land	-	-
Buildings	9	75
Plant & machinery	1	15
Information technology	3	6
Software licences	5	10

Leased assets are depreciated over the shorter of the useful life or the lease term.

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Assets not yet available for use are tested for impairment annually at the financial year end.

Notes to the accounts

Note 1.11 Depreciation, amortisation and impairments continued

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

Note 1.12 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at 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 treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

Note 1.13 Government grant funded assets

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Note 1.14 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. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals 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 as an expense on a straight-line basis over the lease term.

Note 1.15 Assets held for sale

Non-current assets are reclassified 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.

Note 1.16 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.

Notes to the accounts

Note 1.17 Cash and cash equivalents

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

Note 1.18 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable 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 using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.1%) in real terms. All general provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A short term rate of positive 0.76% in nominal terms (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years
• A medium term rate of positive 1.14% in nominal terms (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years
• A long term rate of positive 1.99% in nominal terms (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years.

All 2018-19 percentages are in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

Note 1.19 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust.

Note 1.20 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.

Note 1.21 Contingent liabilities and contingent assets

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.

Contingent liabilities are not recognised, but are disclosed in a note to the financial statements, unless the probability of a transfer of economic benefits 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.

Contingent assets are not recognised as assets, but are disclosed in a note to the financial statements where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

Notes to the accounts

Note 1.22 Financial assets

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument 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 when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9 *Financial Instruments* , and is determined at the time of initial recognition.

The Trust currently only holds financial assets classified as financial assets at amortised cost.

Note 1.22.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes the Trust's receivables and cash at bank.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Note 1.22.2 Impairment

For all financial assets measured at amortised cost, lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9 *Financial Instruments* , and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Note 1.22.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Notes to the accounts

Note 1.23 Financial liabilities

Financial liabilities are recognised 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 extinguished – that is, the obligation has been discharged or cancelled or has expired.

After initial recognition, all of the Trust's 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 amortised cost of the financial liability.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.24 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32 *Financial instruments: Presentation* .

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.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5% (prior year: 3.5%)) on the average relevant net assets of the trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- Donated assets (including lottery funded assets)
- Average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short term working capital facility)
- Any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care, 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 the audit of the annual accounts.

Note 1.25 Foreign currencies

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.

Note 1.26 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 normal revenue expenditure).

Details of losses and special payments are given in the 'losses and special payments' note to these financial statements. The losses and special payments note is compiled directly from the losses and compensations register held by the Trust. Bad debts are recorded on the register when the debt is written off, rather than when the debt is provided for.

Notes to the accounts

Note 1.27 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.28 Equity

Note 1.28.1 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.

Note 1.28.2 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.

Note 1.28.3 Retained earnings reserve

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

Note 1.29 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.30 Standards, amendments and interpretations that have been issued but have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2020, but not yet adopted by the FReM: early adoption is not therefore permitted.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but 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 2018-19, were they applied in that year.

Note 2 Adjusted financial performance

In-year control totals are the primary mechanism used by NHS Improvement, one of the Trust's regulators, for assessment of the Trust's financial control. The adjusted financial performance (control total basis) below shows how the Trust's total comprehensive income / (expense) for the period is adjusted to reach the financial performance used by NHS Improvement in determining whether the Trust has achieved its control total.

	2018/19	2017/18
	£000	£000
Adjusted financial performance (control total basis):		
(Deficit) for the period	(12,595)	(1,407)
Plus / (less) adjustments:		
Impairments	5,230	85
Adjustments in respects of donated and granted assets	(36)	47
Adjusted financial performance (deficit)	**(7,401)**	**(1,275)**
Control total	(1,867)	2,033
(Underachievement) against control total	**(5,534)**	**(3,308)**

The Trust has underachieved against its 2018/19 control total due to the £6,091k provision recognised for recovered VAT and associated costs, as set out in the provisions note. This is offset by an additional £401k of unplanned Provider Sustainability Funding (PSF) income, which was provided by NHS Improvement at the end of the financial year.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.6.

Note 3.1 Income from patient care activities (by nature)	**2018/19 £000**	**2017/18 £000**
Community services income from CCGs and NHS England	91,804	92,042
Income from other sources (e.g. local authorities)	11,449	22,745
Private patient income	11	26
Agenda for Change pay award central funding	1,166	-
Other clinical income	309	244
Total income from activities	**104,739**	**115,057**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2018/19 £000**	**2017/18 £000**
NHS England	11,061	11,030
Clinical commissioning groups	80,743	81,012
Department of Health and Social Care	1,182	80
Other NHS providers	4,262	15,591
Local authorities	7,168	7,074
Non-NHS: private patients	11	26
Non NHS: other	312	244
Total income from activities	**104,739**	**115,057**

Note 4 Other operating income

	2018/19 £000	**2017/18 £000**
Other operating income from contracts with customers:		
Research and development (contract)	511	244
Education and training (excluding notional apprenticeship levy income)	687	588
Non-patient care services to other bodies	1,883	1,391
Provider sustainability / sustainability and transformation fund income (PSF / STF)	1,232	687
Other contract income	562	1,034
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	472	106
Receipt of capital grants and donations	96	-
Charitable and other contributions to expenditure	4	14
Rental revenue from operating leases	516	670
Total other operating income	**5,963**	**4,734**

Note 5 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019 £000
within one year	348
after one year, not later than five years	-
after five years	-
Total revenue allocated to remaining performance obligations	**348**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6 Operating expenses

	Note	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies		2,057	2,449
Purchase of healthcare from non-NHS and non-DHSC bodies		1,344	1,174
Staff and executive directors costs		78,167	83,627
Remuneration of non-executive directors		68	69
Supplies and services - clinical (excluding drugs costs)		6,700	7,325
Supplies and services - general		7,638	9,245
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)		607	552
Consultancy costs		99	117
Establishment		857	1,021
Premises		2,347	2,589
Transport (including patient travel)		2,524	2,849
Depreciation on property, plant and equipment		4,186	4,132
Amortisation on intangible assets		38	12
Net impairments	6.2	5,230	85
Movement in credit loss allowance: contract receivables / contract assets		949	
Movement in credit loss allowance: all other receivables and investments		-	528
Increase/(decrease) in other provisions		6,460	-
Change in provisions discount rate(s)		(5)	4
Audit fees payable to the external auditor:			
audit services- statutory audit		52	42
Internal audit costs		86	93
Clinical negligence		299	334
Legal fees		67	(18)
Insurance		13	14
Education and training		832	318
Rentals under operating leases		490	2,136
Car parking & security		32	50
Losses, ex gratia & special payments		7	7
Total		**121,145**	**118,754**

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 6.1 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2018/19 or 2017/18.

Note 6.2 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price and changes in the use of assets	5,230	85
Total net impairments charged to operating surplus / deficit	**5,230**	**85**

Note 7 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	61,750	65,955
Social security costs	5,796	6,201
Apprenticeship levy*	297	319
Employer's contributions to NHS pensions	8,313	8,964
Pension cost - other	11	6
Other post employment benefits	-	-
Other employment benefits	167	210
Termination benefits	862	177
Temporary staff (including agency)	1,214	2,049
Total gross staff costs	**78,410**	**83,880**
Recoveries in respect of seconded staff	-	-
Total staff costs	**78,410**	**83,880**
Of which		
Costs capitalised as part of assets	243	253

* 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 7.1 Retirements due to ill-health

During 2018/19 there were 2 early retirements from the Trust agreed on the grounds of ill-health (2 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £70k (£151k in 2017/18).

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 for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 9 Operating leases

Note 9.1 Norfolk Community Health and Care NHS Trust 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.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	516	670
Total	**516**	**670**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
- not later than one year;	440	427
- later than one year and not later than five years;	230	68
- later than five years.	59	82
Total	**729**	**578**

Note 9.2 Norfolk Community Health and Care NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where the 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.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	490	2,136
Total	**490**	**2,136**

The significant fall in minimum lease payments in 2018/19 is due to the recognition of an onerous lease provision in 2017/18 which was released in 2018/19 as the building was used for service provision. The creation and subsequent release of the provision can be seen in notes 19.1 and 19.2 of these financial statements.

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	909	1,005
- later than one year and not later than five years;	1,138	1,970
- later than five years.	632	3,203
Total	**2,679**	**6,179**
Future minimum sublease payments to be received	-	-

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

There have been no costs incurred over £500 during 2018/19 or 2017/18 in relation to the late payment of commercial debts.

Note 11.1 Intangible assets - 2018/19

	Software licences
	£000
Gross cost at 1 April 2018 - brought forward	**61**
Additions	280
Gross cost at 31 March 2019	**341**
Amortisation at 1 April 2018 - brought forward	**18**
Provided during the year	38
Amortisation at 31 March 2019	**56**
Net book value at 1 April 2018	**43**
Net book value at 31 March 2019	**285**

Note 11.2 Intangible assets - 2017/18

	Software licences
	£000
Gross cost at 1 April 2017- brought forward	**29**
Additions	32
Gross cost at 31 March 2018	**61**
Amortisation at 1 April 2017 - brought forward	**6**
Provided during the year	12
Amortisation at 31 March 2018	**18**
Net book value at 1 April 2017	**23**
Net book value at 31 March 2018	**43**

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

Note 12.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**11,121**	**56,018**	**4,688**	**4,658**	**8,851**	**85,336**
Additions	-	-	3,682	-	-	**3,682**
Impairments	(4,911)	(14,274)	-	-	-	**(19,185)**
Reversals of impairments	-	115	-	-	-	**115**
Revaluations	745	3,389	-	-	-	**4,134**
Reclassifications	-	2,852	(4,242)	(190)	1,300	**(280)**
Disposals / derecognition	-	-	(41)	(351)	(896)	**(1,288)**
Valuation/gross cost at 31 March 2019	**6,955**	**48,100**	**4,087**	**4,117**	**9,255**	**72,514**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**1,912**	**-**	**2,274**	**6,036**	**10,222**
Provided during the year	-	1,937	-	660	1,589	**4,186**
Impairments	-	(3,019)	-	-	-	**(3,019)**
Revaluations	-	(1,003)	-	-	-	**(1,003)**
Reclassifications	-	220	-	(220)	-	**-**
Disposals / derecognition	-	-	-	(321)	(887)	**(1,208)**
Accumulated depreciation at 31 March 2019	**-**	**47**	**-**	**2,393**	**6,738**	**9,178**
Net book value at 31 March 2019	**6,955**	**48,053**	**4,087**	**1,724**	**2,517**	**63,336**
Net book value at 1 April 2018	**11,121**	**54,106**	**4,688**	**2,384**	**2,815**	**75,114**

Additions to assets under construction:	**2018/19**
	£000
Buildings excluding dwellings	1,035
Plant and machinery	1,366
Information technology	1,281
	3,682

Additions to buildings excluding dwellings above includes £96k of assets funded by capital grants, as disclosed as income in note 4 of these financial statements. Capital grants have been provided by Norfolk County Council to fund development of Trust sites, and by the Norfolk Community Health and Care NHS Trust to develop Trust property for the benefit of patients.

Note 12.2 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Total £000
Valuation / gross cost at 1 April 2017	**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	**-**	**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 and machinery	1,016
Information technology	1,184
	4,056

Note 12.3 Property, plant and equipment financing - 2018/19

	Land	Buildings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019						
Owned - purchased	6,888	44,113	4,087	1,724	2,517	**59,329**
Owned - government granted	-	99	-	-	-	**99**
Owned - donated	67	3,841	-	-	-	**3,908**
Net book value total at 31 March 2019	**6,955**	**48,053**	**4,087**	**1,724**	**2,517**	**63,336**

Note 12.4 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 13 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 2019 following a full valuation exercise. The valuation was conducted by Montagu Evans, 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 or market value where the property is expected to be dislosed of, for specialised assets as depreciated replacement cost. These valuation methods are consistent with the methods used in the previous accounting period.

See accounting note 1.4.1 for critical judgements applied by the valuer in determining the fair value of land and buildings.

The valuation methods applied for land and buildings are as follows:

	31 March 2019 £000	31 March 2018 £000
DRC - Modern equivalent asset basis (no alternative site)	47,260	26,754
Market value in existing use	7,572	38,473
Fair value (surplus PPE land and buildings)	176	-
	55,008	**65,227**

Note 14 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	-	1
Consumables	36	59
Other	137	120
Total inventories	**173**	**180**
Of which: held at lower of cost and net realisable value	173	180

Inventories recognised in expenses for the year were £5,034k (2017/18: £4,882k).

Note 15 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables - invoiced*	7,395	
Contract receivables - not yet invoiced / non invoiced*	6,248	
Trade receivables*		7,825
Accrued income*		2,931
Allowance for impaired contract receivables / assets*	(2,338)	
Allowance for other impaired receivables	-	(1,447)
Prepayments (non-PFI)	358	577
PDC dividend receivable	372	32
VAT receivable	192	49
Total current trade and other receivables	**12,227**	**9,967**
Of which receivables due from NHS and DHSC group bodies:	9,273	7,622

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 15.1 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances at 1 Apr 2018 - brought forward	**-**	**1,447**
Impact of implementing IFRS 9 on 1 April 2018	1,608	(1,447)
New allowances arising	1,186	-
Reversals of allowances	(237)	-
Utilisation of allowances (write offs)	(219)	-
Allowances at 31 Mar 2019	**2,338**	**-**

Note 15.2 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances at 1 April 2017	**931**
Increase in provision	776
Amounts utilised	(12)
Unused amounts reversed	(248)
Allowances at 31 Mar 2018	**1,447**

Note 15.3 Exposure to credit risk

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

The following table shows the face value of invoiced contract receivables, the ECL values, and the adjusted value of invoiced contract receivables, by age of invoice:

	Face value of invoiced contract receivables	Expected credit loss	Adjusted value of invoiced contract receivables
	£'000	£'000	£'000
Invoice age at 31 March 2019			
0-30 days	2,150	-	2,150
31-90 days	1,035	-	1,035
90-365 days	985	101	884
Over 365 days	2,808	2,242	566
Total	**6,978**	**2,343**	**4,634**
Invoice age at 31 March 2018			
0-30 days	175	42	133
31-90 days	2,741	12	2,729
90-365 days	2,523	80	2,443
Over 365 days	2,386	1,314	1,072
Total	**7,825**	**1,448**	**6,377**

Note 16 Non-current assets held for sale

	2018/19 £000	2017/18 £000
Net book value of non-current assets for sale at 1 April	**897**	**-**
Assets classified as available for sale in the year	-	897
Net book value of non-current assets for sale at 31 March	**897**	**897**

One site held by the Trust is being actively marketed at 31 March 2018 and 31 March 2019. This has therefore been classified as a non-current asset held for sale. Sale is expected during financial year 2019/20.

Note 17 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.

	2018/19 £000	2017/18 £000
At 1 April	**18,213**	**23,259**
Net change in year	(776)	(5,046)
At 31 March	**17,437**	**18,213**
Broken down into:		
Cash at commercial banks and in hand	12	12
Cash with the Government Banking Service	17,425	18,201
Total cash and cash equivalents as in Statement of Financial Performance	**17,437**	**18,213**
Total cash and cash equivalents as in Statement of Cashflows	**17,437**	**18,213**

Note 17.1 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 2019 £000	31 March 2018 £000
Bank balances	-	2
Total third party assets	**-**	**2**

Note 18 Trade and other payables

Current	31 March 2019 £000	31 March 2018 £000
Trade payables	5,529	3,551
Capital payables	966	1,550
Accruals	4,953	4,241
Receipts in advance (including payments on account)	-	-
Social security costs	1,434	1,853
Total current trade and other payables	**12,882**	**11,195**
Of which payables due to NHS and DHSC group bodies:	2,890	1,945

Note 19.1 Provisions for liabilities and charges analysis at 31 March 2019

	Pensions: injury benefits*	Legal claims	Redundancy	VAT	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2018	**249**	**141**	**320**	**-**	**693**	**1,403**
Change in the discount rate	(5)	-	-	-	-	**(5)**
Arising during the year	7	21	864	6,091	104	**7,087**
Utilised during the year	(11)	-	(13)	-	(180)	**(204)**
Reversed unused	-	(30)	-	-	(559)	**(589)**
At 31 March 2019	**240**	**132**	**1,171**	**6,091**	**58**	**7,692**
Expected timing of cash flows:						
- not later than one year	11	132	1,171	6,091	58	**7,463**
- later than one year and not later than five years;	44	-	-	-	-	**44**
- later than five years.	185	-	-	-	-	**185**
Total	**240**	**132**	**1,171**	**6,091**	**58**	**7,692**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within early departure costs.

The provision for injury benefits 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 0.29% (2017/18: 0.1%). 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 are expected to be been disestablished following service reconfiguration. Costs have been identified based on the affected individuals. All costs are expected to occur in 2019/20.

The VAT provision of £6,091k has been recognised for VAT previously reclaimed by the Trust under NHS VAT rules which HMRC believes should not have been reclaimed. The Trust disagrees with HMRC's view and believes it was fully appropriate to reclaim the VAT. HMRC are still considering the Trust's position on this.

The closing 'other' provision is for dilapidation provisions, being the estimated costs to make good properties the Trust leases at the end of the lease term.

Note 19.2 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 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**

Note 19.2 Clinical negligence liabilities

At 31 March 2019, £726k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Norfolk Community Health and Care NHS Trust (31 March 2018: £1,544k).

Note 20 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	9	8
Value of contingent liabilities	**9**	**8**

There were no contingent assets at 31 March 2019 and 31 March 2018.

Note 21 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	37	436
Total	**37**	**436**

Note 23 Financial instruments

Note 23.1 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 2019 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 23.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total book value
Carrying values of financial assets at 31 March 2019 under IFRS 9	**£000**	**£000**
Trade and other receivables excluding non financial assets	11,113	**11,113**
Cash and cash equivalents at bank and in hand	17,437	**17,437**
Total at 31 March 2019	**28,550**	**28,550**

	Loans and receivables	Total book value
Carrying values of financial assets at 31 March 2018 under IAS 39	**£000**	**£000**
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**

Note 23.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total book value
	£000	**£000**
Carrying values of financial liabilities at 31 March 2019 under IFRS 9		
Trade and other payables excluding non financial liabilities	11,448	11,448
Provisions under contract	1,601	1,601
Total at 31 March 2019	**13,049**	**13,049**

	Other financial liabilities	Total book value
	£000	**£000**
Carrying values of financial liabilities at 31 March 2018 under IAS 39		
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**

Note 23.4 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	**£000**
In one year or less	12,820	8,315
In more than one year but not more than two years	9	904
In more than two years but not more than five years	35	242
In more than five years	185	-
Total	**13,049**	**9,461**

Note 24 Losses and special payments

	2018/19		2017/18	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	2	2	1	1
Bad debts and claims abandoned	250	153	6	7
Total losses	**253**	**155**	**7**	**8**
Special payments				
Ex-gratia payments	1	1	3	1
Extra-statutory and extra-regulatory payments	-	-	1	1
Total special payments	**1**	**1**	**4**	**2**
Total losses and special payments	**254**	**156**	**11**	**10**

Bad debts are recognised in this note at the time the debt is written off. This may be different to the time the debt is provided for, and so the value of losses and special payments in this note is not the same as the value of losses and special payments shown in note 6, operating expenses.

Bad debts and claims abandoned are high in value and number due to a detailed review of older debts being undertaken and irrecoverable debts being written off in the 2018/19 financial year.

Note 25.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to retained earnings on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Reassessment of allowances for credit losses under the expected loss model resulted in a £161k decrease in the carrying value of receivables. This has changed the opening value of retained earnings as follows:

	£000
Retained earnings at 31 March 2018 as disclosed in the 2018/19 financial statements	55,164
Reduction in retained earnings as a result of recognising allowances for credit losses	(161)
Retained earnings at 1 April 2019 after adjustments under IFRS 9	**55,003**

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax.

Note 25.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively. The Trust has performed an assessment of material revenue streams and has determined there is no material effect on the Trust's opening balances at 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

The Trust has performed an assessment of material revenue streams and has determined there is no material effect on the Trust's opening balances at 1 April 2018.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 26 Related parties

The Department of Health and Social Care (the Department) is the Trust's parent department. During the 2018/19 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
Coventry and Warwickshire Partnership NHS Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
NHS Resolution
Department of Health and Social Care
Health Education England
NHS Business Services Authority
NHS Property Services Limited
Community Health Partnerships
Care Quality Commission
NHS Pension Scheme

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:
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.

	2018/19 £000	2017/18 £000	31 March 2019 £000	31 March 2018 £000
Total income received from the Charitable Fund	232	194	-	-
Accounts receivable balance due from the Charitable Fund	-	-	7	12
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 27 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	13,808	47,146	16,320	52,185
Total non-NHS trade invoices paid within target	10,109	33,738	13,196	39,035
Percentage of non-NHS trade invoices paid within target	73.2%	71.6%	80.9%	74.8%
NHS Payables				
Total NHS trade invoices paid in the year	403	4,346	663	6,199
Total NHS trade invoices paid within target	236	1,903	431	4,499
Percentage of NHS trade invoices paid within target	58.6%	43.8%	65.0%	72.6%

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 28 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.

	2018/19 £000	2017/18 £000
Cash flow financing	997	(7,225)
External financing requirement	**997**	**(7,225)**
External financing limit (EFL)	3,001	(7,225)
Under / (over) spend against EFL	**2,004**	**-**

Note 29 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	3,682	4,088
Less: Disposals	(80)	(10)
Less: Donated and granted capital additions	(96)	-
Charge against Capital Resource Limit	**3,506**	**4,078**
Capital Resource Limit	3,742	4,246
Under / (over) spend against CRL	**236**	**168**

Note 30 Breakeven duty rolling assessment

	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Breakeven duty in-year financial performance	552	637	2,683	4,630	2,628	2,129	2,695	(1,275)	(7,401)
Breakeven duty cumulative position	552	1,189	3,872	8,502	11,130	13,259	15,954	14,679	7,278
Operating income	130,709	127,725	124,843	123,266	123,796	129,920	133,126	119,791	110,702
Cumulative breakeven position as a percentage of operating income	0.4%	0.9%	3.1%	6.9%	9.0%	10.2%	12.0%	12.3%	6.6%

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. The table above starts from 2010/11, as this is when the Trust was established.

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 £7.28m 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 2.

Note 31 Comparators

Where required, comparatives have been adjusted to conform to the current year's presentation.