Norfolk Community Health and Care NHS Trust

Annual Report and Accounts 2019/20

FINAL 22.05.20

The Annual Report and Accounts is set out as follows:

A. PERFORMANCE REPORT

1. Overview

    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

2. Performance Analysis, optional to omit due to Covid-19 pandemic

B. ACCOUNTABILITY REPORT

3. Corporate Governance Report:

    3.1 Directors' report

    3.2 Statement of Accountable Officer's responsibilities

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4. Remuneration and Staff Report

    4.1 Remuneration Report

    4.2 Staff Report

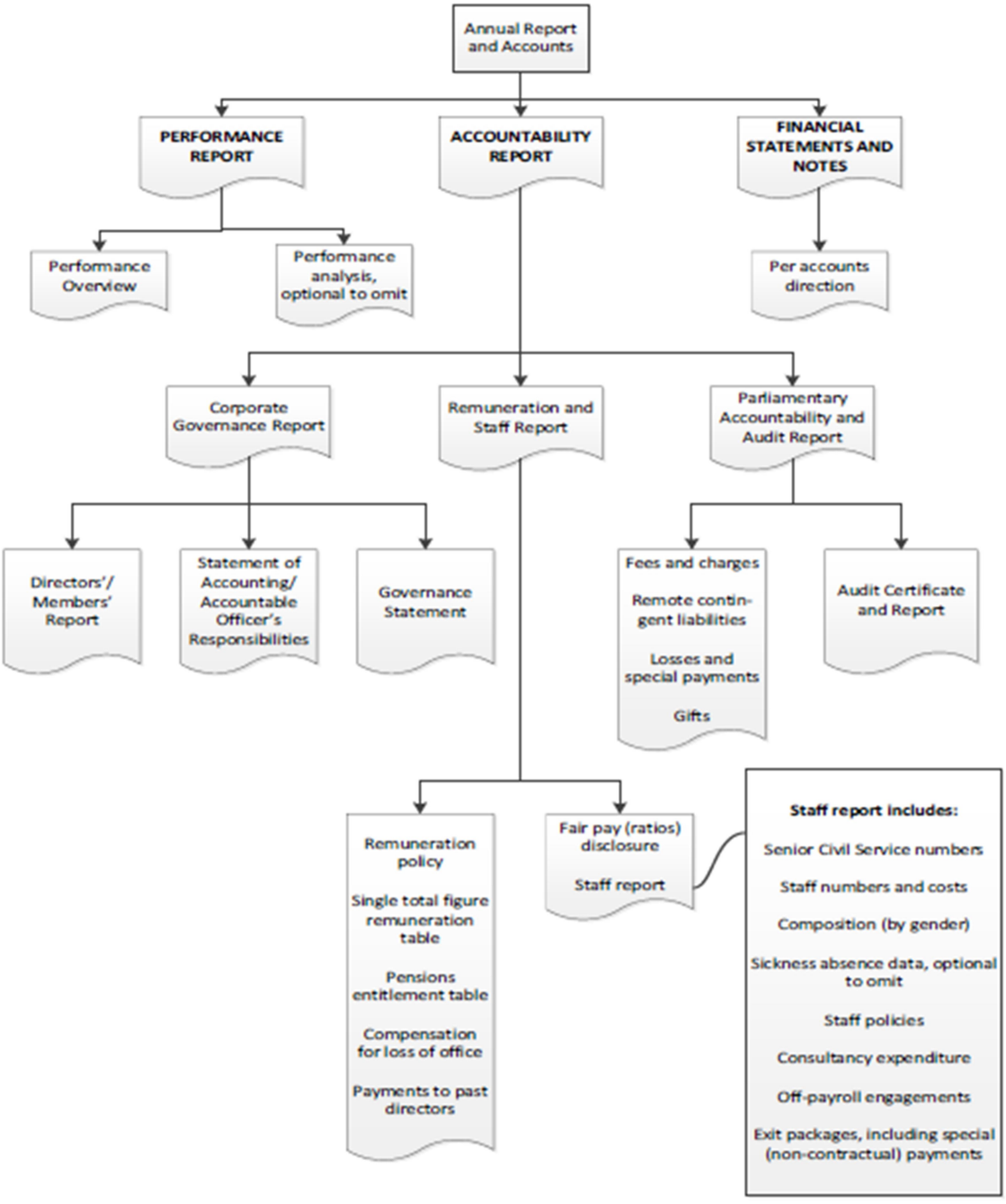
5. Parliamentary Accountability and Audit Report

Independent Auditor's Report to the Directors of NCHC

C. FINANCIAL STATEMENTS

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
Primary Care Networks - PCN

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

The purpose of the performance report of the annual report is to provide information on the Trust, its main objectives and strategies and the principal risks that it faces. The requirements of the performance report are based on the matters required to be dealt with in a Strategic Report as set out in Chapter 4A of Part 15 of the Companies Act 2006, as amended by SI 2013 No.1970, The Companies Act 2006 (Strategic Report and Directors' Report) Regulations 2013. Public entities must comply with the Act as adapted: i.e. they must treat themselves as if they were quoted companies.

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. In response to the Covid-19 pandemic changes to annual reporting requirements have been made for NHS bodies. In particular, the detailed performance analysis section is not included this year.

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's most recently published assessment of NCHC through the NHS Oversight Framework (on 21 October 2016 under the previously known version of the Single Oversight Framework) is that the Trust is 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". However, the Trust's oversight framework rating in finance and use of resources was 1 (defined as maximum autonomy) at the year end. The Oversight Framework is described in more detail below.

The NHS Staff Survey 2019 is one way for staff to share their views about their job, the organisation and the NHS. Responses to the survey are strictly confidential and handled independently on behalf of the NHS. Overall, the 2019 NHS Staff Survey results present no statistically significant changes in any of 11 themes. Therefore these results have led to a focus on looking at how to improve the areas where the Trust has plateaued this year, whilst also embracing new ways of working.

This year has been a busy and challenging time, not only for NCHC, but across the region as a whole. We are very proud of how staff have worked relentlessly to provide safe patient care, despite the extreme demands on services. We should all be very proud of these results and of the way in which teams are pulling together, often across organisational boundaries, to effectively manage these pressures together and in the very best interests of patient care.

For the second consecutive year NCHC is the best performing Community Trust in acting fairly with regards to career progression/promotion regardless of any protected characteristics, as well as for how staff rate their level of pay and in regards to staff reporting errors. The staff engagement theme, has three sub-themes, one of these is motivation. For three years running now, NCHC has been at or above average in all three of the questions that makes up this sub-theme. NCHC is the best NHS provider Trust in Norfolk across all 11 themes and therefore will continue to share and support others in the region. Nationally we are in the top five community trusts for staff recommending our Trust as a place to receive care, with 80% recommending.

NCHC has continued to play an active and leading role in the Norfolk and Waveney STP 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. For example, NCHC has aligned its services with the PCNs, consulted on a new operational management structure for implementation in 20/21, and is working with PCNs on projects to enhance care.

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. NCHC is currently awaiting investment decisions from commissioners to expand the service. 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 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.

Primary Care Networks (PCN) are now in place and to meet demand, complex needs and expectations of patients, are changing the way they deliver care in order to ensure safety, effectiveness and positive experience for patients. Annual Priorities committed the Trust to reviewing the operating model and strategy to support more consistent delivery, implement the workforce plan and embed place-based care. We want to see locally responsive services working as part of the PCNs. Reviewing the operating model comes out of the commitment to continuous improvement and an expectation that all colleagues have a role in its development and delivery and providing high quality care. Business unit and locality structures were reviewed for how services are allocated across the Trust and this consultation considered a revised operational and clinical management structure to support increased delegated responsibility, earned autonomy and collaborative working with partners. The changes agreed allow the Trust to ensure that the right people are in place to co-create the most effective ways of providing services to the people of Norfolk. NCHC is creating empowered and autonomous leaders who can make the right decisions at the right time, supported by a structure that provides them with immediate, accurate and timely information. The planned implementation from 1 April 2020 of the new clinical and operational management structure to align with PCNs was put on hold due to the Covid-19 pandemic.

On 20 March 2020 NCHC declared a major incident in response to the Covid-19 pandemic and all of the Trust's efforts have been mobilised to focus on responding to this by ensuring patient safety and staff wellbeing.

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 Values.
1.2.2 Services provided by NCHC.

Longer term plans:

1.2.3 Health and Care Strategy
1.2.4 Sustainability and Transformation Partnership and Integrated Care System
1.2.5 Transformation Programme
1.2.6 Annual Priorities

Graphic below showing NCHC's values and strategic objectives

1.2.1 Vision and values

NHS
Norfolk Community Health and Care
NHS Trust

Vision & Values

Our vision

"To improve the quality of people's lives, in their homes and community through the best in integrated health and social care."

Our values

Community

As one trust, we enhance the lives of our patients through our commitment, support and working together

We are proud to serve our local community by providing integrated quality services with our partner organisations

We respect and value the trust we are given to enter our patients' homes and lives

Compassion

We provide compassionate, co-ordinated and personalised quality care that is safe and effective

We empower and educate our patients and their carers in the effective delivery and management of their own independence, health and wellbeing

We are dedicated to holistic, compassionate care and demonstrate this through our commitment to our personal and professional development

Creativity

Our expertise, commitment and creativity are key to the successful delivery of our services

We are always open to new ideas that support us in delivering effective compassionate care to our patients

We continuously innovate and implement efficient delivery of care

LOOKING AFTER YOU LOCALLY

1.2.2 Services provided by NCHC

The graphic below shows the type and location of services provided by NCHC.

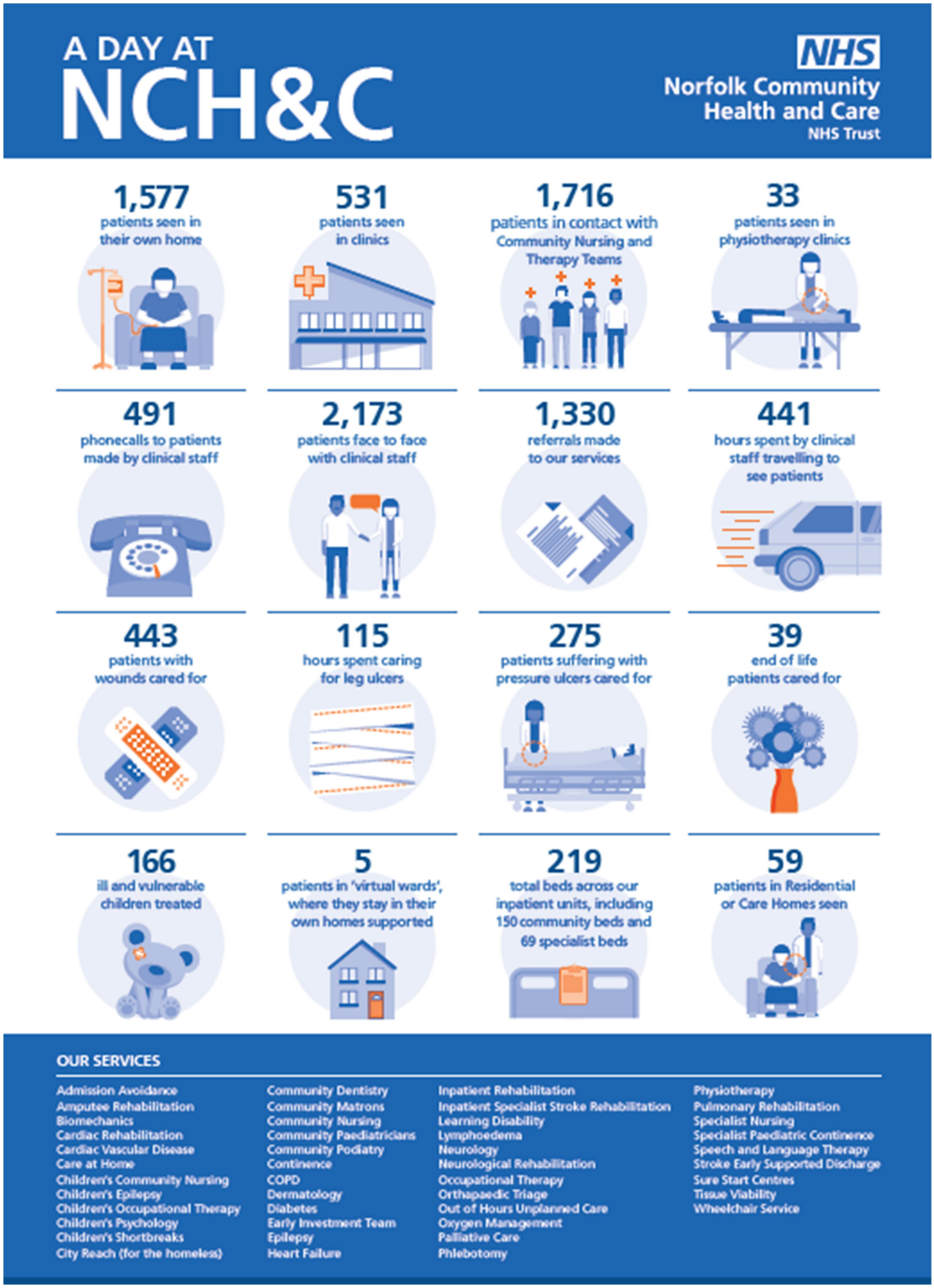
NHS
Norfolk Community Health and Care
NHS Trust

Our services include…

Amputee Rehabilitation | Cardiac Rehabilitation | Children's Nursing | Children's Short Breaks | Community hospitals | Continence | Coordination Centres (NEAT) | Early Intervention Vehicles | Falls Prevention | Heart Failure | Infection Control | Learning Disabilities | Musculoskeletal Physiotherapy | Neurodevelopmental Neurology | Occupational Therapy | Palliative Care | Phlebotomy | Podiatry | Prosthetics and Reablement | Pulmonary Rehabilitation | Safeguarding Services for vulnerable groups | Specialist Nursing | Specialist Respiratory | Speech and Language Therapy | Starfish LD CAMHS and Starfish Plus | Stroke | Virtual wards

LOOKING AFTER YOU LOCALLY

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



Longer term plans

This section includes:

1.2.3 Health and Care Strategy
1.2.4 Norfolk and Waveney Sustainability and Transformation Partnership and Integrated Care System
1.2.5 NCHC Transformation Programme
1.2.6 Annual Priorities

1.2.3 The Health and Care Strategy

Launched in 2015 and updated annually, 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.

1.2.4 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 sets 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.

1.2.5 NCHC Transformation Programme

The health and social care system in Norfolk and Waveney is changing to ensure its long term sustainability. Commissioning health services is the responsibility of the CCG, which in turn works 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 sets 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 have been divided into specific workstreams which 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.

Section 75 arrangement with Norfolk County Council

A Section 75 arrangement between NCHC and Norfolk County Council has been in place since October 2014 for all of Norfolk other than the Great Yarmouth locality. It covers senior management posts for community health and social care: A Director and Deputy Director, plus an Assistant Director and a Head of Service of different professional disciplines for each of the four CCG localities – North, South, West and Norwich. The staff they manage remain employed by their existing organisations. Few of them have been integrated, exceptions being Integrated Care Coordinators, staff forming the Norwich OT service, plus a few posts based at acute hospitals. The agreement initially for a five-year term, has been extended for a further year until October 2020. The principal purpose for this was to provide an opportunity to understand how resources need to be flexed to respond to unfolding changes driven by the NHSE 10 Year Long Term Plan (LTP) both for strategic commissioning and for

Primary Care Network development. The extension has allowed time for completion for a fundamental review of the S75 arrangements and to consider future proposals.
The review included a staff survey, and in-depth interviews with the senior managers referred to above, other senior managers in both organisations and with a small number of service users. The responses from these four groups were consistent. Having an integrated management structure helped provide a more seamless service for patient/ service users. Staff were more aware of the availability of resources outside their service area, particularly where they are collocated.

The table below shows the strategic programmes of work that make up the Trust's strategic objectives.

Improving our quality	**Enabling our people**	**Securing the future**
• Providing consistently compassionate, safe and effective care • Improving the quality of our services through continuous learning and research, applying innovation and increased digitalisation • Empowering people and communities in the care that they receive, co-designing changes and providing an excellent patient experience	• Working together to make NCH&C and our wider health and care system a safe, inclusive, and well-led place to work • Empowering staff to develop professionally and ensuring their health and wellbeing is seen as a priority so that they can deliver outstanding care and support • Enable our staff to work as one for the benefit of our population, whether this is in clinical or support services, or with wider partners in Primary Care Networks	• Improving the clinical and financial sustainability of our services through eliminating waste and delivering our workforce plan. • As a committed partner, leading within Primary Care Networks and our Integrated Care System. Making the most of opportunities for collaboration and best use of shared resources • Increasing awareness and effectiveness of prevention, self-management of conditions, and proactive care

1.2.6 Annual Priorities

The graphic below describes the Trust's Annual Priorities for 2020/21

Each year we review where we are as an organisation; in particular the issues that we are facing, and the needs and priorities of staff and the public. This is what our annual priorities are based on. In light of the Covid-19 pandemic we have refined our annual priorities to reflect the need to focus operational attention on responding to the crisis. The wider annual priorities will be revisited once the incident is stood down.

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 a continuous quality improvement approach.
- 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.
- New risks emerging in-year have been the response to the Covid-19 pandemic, and also the increased cyber security risks during this period.

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:

- Improving out-of-hospital care (primary and community services).
- Reducing pressure on emergency hospital services.
- Delivering person-centred care.
- Digitally enabled primary and outpatient care.
- 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. Norfolk and Waveney have been selected as one of seven NHS and local government teams to develop services based around community response teams, to deliver to the new access standards. A two-hour target will require health systems to deliver community health crisis services to older patients and those with complex health needs within two hours of referral. A separate two-day target requires health systems to deliver reablement care to patients in need within two days of referral. This is a key component of the long-term plan and the new NHS community services strategy, Ageing Well. The new pilot sites "will be the first to deliver the new standards for care", enabling NHSE to standardise the measurement and delivery of urgent community services across the country.
- 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 started 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.

- Care home staff will have access to NHS mail. This gives staff in care homes the ability to securely share residents' data and queries with doctors, nurses and GPs in the NHS, and get timely responses. It also connects them securely to pharmacists, dentists and anyone else in health and care with a secure email, such as an NHS mail account
- 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 NHS Oversight Framework segmentation
1.4.3 Financial performance
1.4.4 Operational performance
1.4.5 Workforce
1.4.6 Covid-19 pandemic response
1.4.7 Brexit planning

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

The CQC's rating of the Trust was published on 22 June 2018, and is summarised in the table below.

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

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.

The Trust was due to be inspected again in 2019/20 and completed the CQC's routine provider information return as requested in preparation for the inspection. However, the Trust was notified that due to the Covid-19 pandemic the inspection would be delayed until later in 2020.

1.4.2 NHS Oversight Framework segmentation

The NHS Oversight Framework 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. In close collaboration with the CQC.
Finance and use of resources	To balance finances and improve the productivity of the provider sector.
Operational performance	To maintain and improve performance against NHS constitutional standards.
Strategic change	To ensure providers are contributing through ICSs and/or STPs to the development and delivery of clinically, operationally and financially sustainable patterns of care.
Leadership and improvement capability (well-led)	To build provider leadership and improvement capability to deliver sustainable services. In 19/20 this also includes culture and organisational health.

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.

There are four levels of segmentation or categorisation described below.

Providers		
Segment/ category	**Description of support needs**	**Level of support offered**
1 (Maximum autonomy)	No actual support needs identified across the five themes described in the provider annex. Maximum autonomy and lowest level of oversight appropriate. Expectation that provider supports providers in other segments.	**Universal (voluntary)**
2 (Targeted support)	Support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action is not considered needed.	**Universal + targeted** (not mandatory) support as agreed with the provider to address issues identified and help move the provider to segment 1.
3 (Mandated support)	The provider has significant support needs and is in actual or suspected breach of the licence (or equivalent for NHS trusts) but is not in special measures.	**Universal targeted + mandated** support as determined by the regional team to address specific issues and help move the provider to segment 2 or 1.
4 (Special measures for providers; legal directions for CCGs)	The provider is in actual or suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean it is in special measures.	**Universal targeted + mandated** support as determined to minimise the time the provider is in special measures.

NHS Improvement's latest published (21 October 2016 under the previous version known as the Single Oversight Framework) assessment of NCHC through the NHS Oversight Framework is that the Trust is 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". However, the Trust's oversight framework rating in finance and use of resources was 1 (defined as maximum autonomy) at the year end.

Information about the NHS Oversight Framework and the Trust's segmentation can be found on NHSI's website here:

https://improvement.nhs.uk/resources/nhs-oversight-framework-trust-segmentation/

1.4.3 Financial performance

NCHC's financial plan for 2019/20 was to improve on the underlying financial performance of 2018/19 and deliver a surplus of £0.4m supported by an efficiency programme of £4.5m. The actual surplus delivered was £0.6m, which was an improvement from plan of £0.2m. This compares favourably with the prior year result of a deficit of £12.6m, which included one-off costs in relation to asset impairments (£5.2m) and provision for repayment of VAT (£6.1m). The VAT case has yet to be resolved satisfactorily and Trust is continuing to seek recovery of the £2.8m paid to HMRC, the costs associated with the case have been fully recognised in the accounts.

The Trust's financial performance is monitored using a number of measures both internally and externally (by NHS England and NHS Improvement). The main measure is a control total based on an adjusted surplus/deficit delivery. In 2019/20 the Trust was initially set a control total of break-even, a stretch target of £0.3m was requested to support the wider NHS financial performance. The Trust met this stretch target.

The Trust met its capital resourcing limit (CRL) of £3.8m which relates to the amount of capital expenditure the Trust can incur in the year. Against the Trust's agency ceiling of £2.5m expenditure was £1.1m (44% of the ceiling). This reflects the work the Trust has done to reduce high cost agency and increase the use of bank and substantive staffing.

This performance has seen the Trust achieve a NHS Oversight Framework Financial Use of Resources rating of 1, which is the highest score achievable and reflects the Trust's strong financial management.

The Trust's efficiency programme of £4.5m consisted of £1.2m of recurrent savings and £3.3m of non-recurrent savings. The programme achieved savings of £4.4m during the year, £0.1m (2.5%) under-achievement. Of these savings £1.1m was recurrent and the remainder 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 the community services and will continue to be a major component of the Trust's long-term financial strategy.

Financial performance and Covid-19

In 2019/20 the COVID-19 pandemic resulted in additional expenditure in relation to revenue (£0.1m) and capital (£0.2m). These costs were reimbursed in full by NHS England and NHS Improvement to ensure the Trust continued to meet its financial plan.

1.4.4 Operational performance

The Trust met the 92% waiting time target overall and for consultant led services (four services) at 93.9% and 99.0% respectively. There were no breaches of the 52 weeks waiting time standard. At the year end the number of over 40-week waiters was as follows:

- 33 patients waiting over 40 weeks for treatment, longest waiting time is 46.6 weeks.
- Five patients are waiting in the wheelchair service and 28 in neurodevelopmental services.

At the end of February 2020, performance against key metrics is summarised in the table below:

Category	Metrics	Achieving	Below	No Data
Waiting Times	5	5	0	0
Safe Care	10	9	0	1
Productivity, efficiency and value for money	8	8	0	0
Workforce	9	7	2	0
Patient experience	4	4	0	0
Local KPIs (adults)	77	69	8	0
Local KPIs (children)	10	8	2	0
Local KPIs (new)	6	2	4	0

Operational performance and Covid-19

The redeployment of staff during the Covid-19 pandemic is likely to impact adversely on waiting lists. To help mitigate this services are using remote technologies to consult and treat patients where possible as attendance in face-to-face appointments had been declining.

Every service is working to manage patients on the waiting list based on clinical need and risk.

1.4.5 Workforce

The Trust uses various metrics to measure workforce performance and these are set out in the bi-monthly workforce report available in public Board papers. The NHS Oversight Framework assesses performance taking into account: (1) staff sickness, (2) staff turnover, (3) NHS Staff Survey, (4) proportion of temporary staff, (5) workforce race equality standards. The Trust has performed well against all of these metrics. Further information is provided in the staff report section.

National Staff Survey

NHS Staff Survey was completed by staff between September and November 2019, with results being received by the Trust in February 2020. This year a new theme has been introduced, Team Working, so there are now 11 Key Themes, and in 2019 there have been no statistically significant changes (positive or negative) to any theme. For two areas “My level of pay” and “staff reporting errors,” NCHC was identified as the best performing community trust within the cohort. Following a focus in the Trust Annual Priorities on Safety, to identify safety improvement actions and demonstrate how they help the Trust to deliver harm free care, the results of this year’s survey highlight the continuing improvement being experienced by staff in this area. “Staff Recommending the Trust” has also seen demonstrable improvement since 2015 with staff continuing to recommend the Trust as a place to work and receive care.

There are now two priorities, firstly working closely with business units to analyse their local results, particularly with 5 business units (Learning Disabilities, North, Systems Operations & Resilience, Specialist Services and West) who will be provided with intensive support to

address their results. Secondly, to progress the proposed four central priority action areas of Equality & Diversity, Staff Engagement, Immediate Manager and Health and Wellbeing.

Workforce and Covid-19

Temporarily closing clinics and reducing the number of community visits has allowed for the redeployment of staff to inpatient units, which has enabled the Trust to be sufficiently staffed, despite the fact that there were a total of 25 whole time equivalent registered nurse vacancies at the beginning of March. In response to the Covid-19 pandemic the ratio of registered nurses to patients was decreased from 1:8 to 1:12 as a minimum. This is in line with other Trusts and an approach adopted to consider other staffing resources. This supports the Trust's response to the system's requirement for extra beds. This is made possible by increasing the number of health care assistants, reviewing the role of therapists in contributing to safer staffing and the tasks undertaken by registered nurses.

To ensure physical distancing most corporate and support staff have been enabled to work from home during the pandemic.

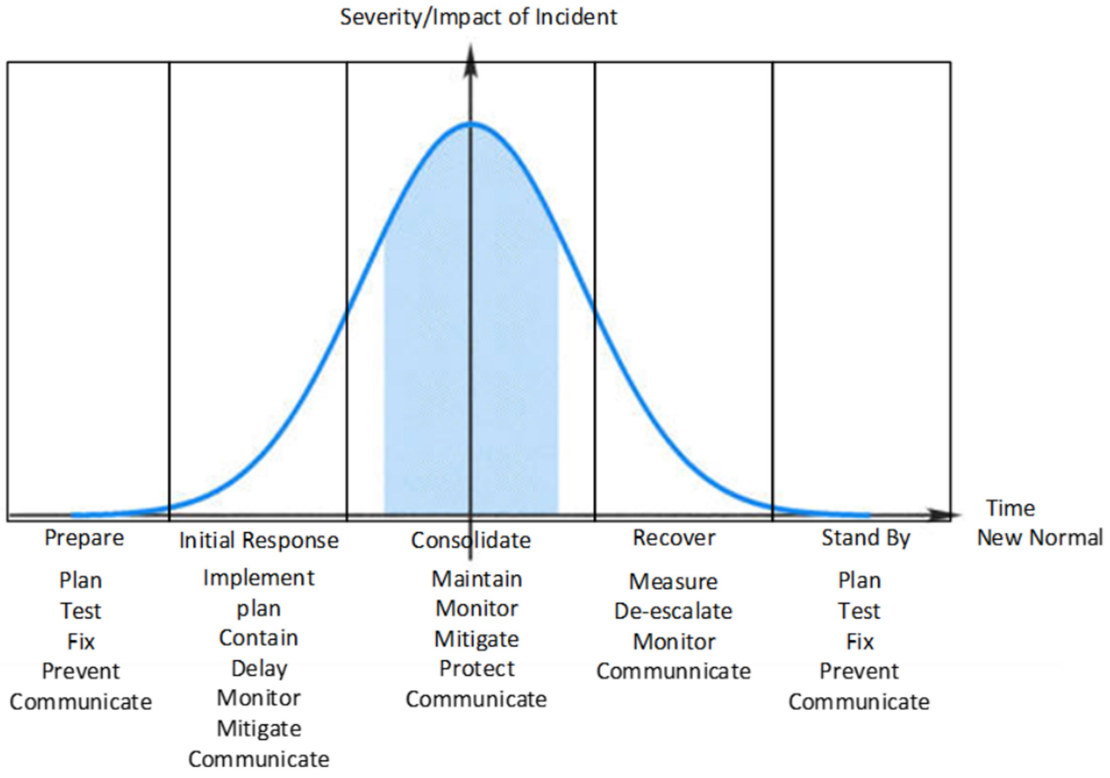
1.4.6 Covid-19 pandemic response

On 17 March 2020 NCHC enacted the operational plan in response to the Covid-19 pandemic. On 20 March a major incident was declared. The plan was based on the following assumptions:

- Loss of corporate and clinical capacity: prepare for the loss of up to 20% of staff as a result of isolation due to potential or confirmed infection, or performing carer duties.
- Increase in demand due to widespread community illness (COVID-19 disproportionally affects older people); loss of service provision on which people rely such as social care, volunteers, etc. Assume 12% of all Covid-19 cases are likely to require hospitalisation; therefore, acute providers will require community services to support discharge.
- Variation in supply chain, caused by reduced productivity and potential restrictions on travel.

NCHC's main effort has been to mitigate the impact of the Covid-19 on service provision in order to maximise the organisation's capacity to treat those in most need, reduce morbidity and mortality. A Command and Control arrangement was established, which is a set of organisational and technical attributes that employs human, physical and information resources to solve problems and accomplish missions to achieve the goal of an organisation. It provides a structure with clearly defined roles, responsibilities, behaviours, accountabilities and decision making authority.

The pandemic is a 'rising tide' incident meaning that its peak is foreseeable and its impact builds overtime, as shown in the graphic below.



1.4.7 UK Withdrawal from the European Union (Brexit)

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; (3) data protection; (4) merger review and anti-competitive activity; (5) exhaustion of intellectual property rights; and, (6) recognition of professional qualifications, and other workforce issues. The Deputy Chief Executive is the nominated lead executive for Brexit planning and has reported to the Audit Committee and Board throughout the year. Assurance to the Board on Brexit preparations was provided in the following areas:

Operational communications: The lead executive has ensured that the Board has been sighted on Brexit arrangements, a number of preparatory messages have been sent to staff with our communications team fully engaged, and the Trust has been involved in Local Health Resilience Partnership preparations and discussion at the A&E Delivery Board.

Operational readiness: A Brexit working group has been established, including local leads for all subject areas and regular meetings have been in place chaired by the lead executive, out of hours processes have been increased, including management capacity and preparedness for different delivery patterns for supplies, services have been involved in identifying risks and testing scenarios and plans, there is process in place for submission of sitreps from services that will be reviewed centrally within the Trust ready for wider escalation and reporting, resilience is in place to manage external reporting.

Supply: risk assessments have been undertaken for all suppliers, with no significant issues identified, the procurement team has followed all published guidance in relation to supplies and preparedness, additional assurance has been provided including moving non contract suppliers to contract basis, communication to the organisation on potential delays has been shared, out of hours plans are in place for deliveries.

Workforce: NCHC has a low-number of EU national members of staff and there has been no indication of staff leaving due to Brexit and this is being monitored by the HR department. NCHC is more at risk of the indirect impact over time on domiciliary care and partner organisations, and this will be monitored over time and managed through continued participation in system wide forums.

Clinical trials: NCHC does not sponsor clinical trials and has limited involvement in them.

Data: Positive assurance has been received from providers and relevant national returns completed. Guidance from the information commissioner has been reviewed and confirmation of compliance received.

Finance: There were no extra costs to report in terms of direct cash expenditure. Additional pharmacy assurance has been provided through a system via national funding. However there has been significant staff time incurred. Processes are in place to monitor additional expenditure. No further support has been identified.

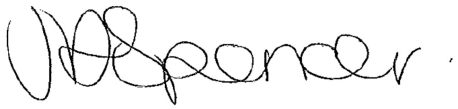
Health demand: No significant increase anticipated or access issues identified. NCHC have participated in a multi-agency scenario testing.

2. Performance Analysis

This section is optional due to streamlining the annual reporting requirements as a result of the Covid-19 pandemic. The Trust has therefore opted not to include this section.

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:…… ……..…….

Josephine Spencer
Chief Executive
Norfolk Community Health and Care NHS Trust

Date:……02 June 2020……

B. ACCOUNTABILITY REPORT

Scope of the Accountability Report

The purpose of the accountability section of the annual report is to meet key accountability requirements to Parliament. The requirements of the Accountability Report are based on the matters required to be dealt with in a Directors' Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006 and Schedule 7 of SI 2008 No.410, The Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2013 No 1981, The Large and Medium-sized Companies and Groups (Accounts and Reports) (Amendment) Regulations 2013. The requirements of the Companies Act 2006 have been adapted for the public sector context and are followed by the Trust (which is not a company) to the extent that they are incorporated into the Group Accounting Manual.

The Accountability Report includes:

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

3. Corporate Governance Report

This section of the report includes:

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

3.1 Directors' Report

This section includes:

3.1.1 Board composition and declaration of interests
3.1.2 Audit Committee
3.1.3 Disclosure of personal data related incidents
3.1.4 Directors' statement
3.1.5 Modern Slavery Act 2015 – Transparency in Supply Chains

3.1.1 Board composition and declaration of interests

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 from 1 April 2019 to 31 March 2020 except where indicated.

Board member	Designation	Declared Interest
Lorna Bailey (Deputy Trust Chair from 01.01.20)	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
Deborah Beresford Deputised for the Director of Nursing and Quality from 01.08.20 to 31.08.20	Executive	None
Geraldine Broderick Trust Chair	Non Executive	None
Laura Clear Director of Community Health and Social care Operations Interim from 12.11.18 Substantive from 01.04.20	Executive	None
Paul Cracknell Deputy Chief Executive and Director of Strategy and Transformation	Executive Non-voting	None
Steve Crowe Associate from 01.10.19 NED from 01.01.20	Non Executive	Director, Angling Direct PLC
Carolyn Fowler Director of Nursing and Quality from 02.09.20	Executive	None
Venu Harilal Medical Director	Executive	Clinical input to Oak Court, 321 Fakenham Road, Taverham, Norwich NR8 6L, and Environmental Control Service, Suffolk Community Healthcare
Andrew Hopkins Director of Finance and Performance (absent from 01.09.19 to 30.11.19)	Executive	None
John Kennedy (left 30.09.19)	Non Executive	None
Emma Lunny Deputy Director of Finance and Performance (deputised for the director to cover the director's absence 01.09.19 to 30.11.19)	Executive	Company director of a holiday let business (Norfolk Properties Ltd) - no conflict of interest
Anna Morgan Director of Nursing and Quality Seconded to Norfolk and Waveney STP from 31.07.19	Executive	Peer Reviewer for RCN Publications, Clinical and Professional Advisor for CQC inspections, Clinical Senate member for East of England
Heather Peck Deputy Trust Chair (left 31.12.19)	Non Executive	Chair, Dog Welfare Trust, Adviser, Citizens Advice, Chair, LANTRA, Former Chair, Cambridgeshire Community Services, Trustee, Norfolk Citizens' Advice
Graham Nice	Non Executive	Specialist Advisor to the CQC, Managing Director, Graham Nice Associates Ltd

Geoff Rivers Leaves 30.04.20	Non Executive	Director, Geoff Rivers Associates – local government work, Governor, Arch Bishop Sancroft High School, Harleston , Norfolk, Vice Cahir 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
Josephine Spencer Chief Executive	Executive	None
Andrew Williams Associate from 01.09.17 NED from 01.10.19	Non Executive Non-voting	Volunteer at Headway
Njoki Yaxley Associate from 26.02.19 NED from 01.05.20		None

The Board is supported by Mike Jones, chartered governance professional (ACG) and Chartered Secretary (ACIS).

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 Committee
- Finance and Performance Committee
- Charitable Funds Committee
- Remuneration and Nominations Committee
- Audit Committee

The Board also established a temporary Business Continuity Assurance Committee during the Covid-19 pandemic response.

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

3.1.2 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	Committee Member, Non Executive Director
Heather Peck (until 31.12.19)	Committee member, Non Executive Director
Steve Crowe (from 01.01.20)	Committee member, Non Executive Director

3.1.3 Disclosure of personal data related incidents

Information on personal data related incidents where these have been formally reported to the Information Commissioners Office are detailed in the Annual Governance Statement below.

3.1.4 Directors' statement

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.

3.1.5 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.

Statement of Directors' responsibilities in respect of the accounts

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

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

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

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

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board

.Date.....02 June 2020....Chief Executive

Date.....02 June 2020.....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, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....  ...Chief Executive

Date....2nd June 2020

3.3 Governance Statement

This section includes:

3.3.1 Scope of Accountable Officer's responsibility

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

3.3.2 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 2020 and up to the date of approval of the annual report and accounts.

3.3.3 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.

3.3.4 The risk and control framework

The Trust has a Risk Management Strategy and Policy that describes how NCHC identifies, evaluates, controls and prioritises risk using a risk management matrix, which calculates the possible impact of the risk occurring by the likelihood of it happening, before and after mitigation. The Trust's appetite for risk is established through the agreement of target risk ratings for each risk. Strategic risks are maintained using the Board Assurance Framework. Operational and other corporate risks are maintained through the corporate risk register and local service risk registers. The Trust's governance framework for quality provides assurance to the chief executive, the chairman, the board of directors, senior managers and clinicians that the essential standards of quality and safety are being delivered by the organisation. It also provides assurance that the processes for the governance of quality are embedded throughout the organisation. Assurance is obtained routinely on compliance with CQC registration requirements through self assessment, peer review and independent scrutiny and audit. Risks to data security are being managed and controlled as part of this process through: (1) better cyber monitoring, threat intelligence, and incident responses, (2) better support and guidance for services, (3) better cyber training and greater awareness and engagement with cyber security national best practice among NHS staff and organisations.

The Board Assurance Framework identifies the Trust's six major risks as follows:

- Risk to the strategic objective of improving quality: risk to providing outstanding care. Assessed at the start of the year as 4x4=16, mitigated down to the target rating of 4x3=12 at the year end. This was achieved through the introduction and embedding of a continuous quality improvement process and new quality and risk management processes.
- Risk to the strategic objective of enabling our people: risk to enabling staff to provide outstanding care. Assessed to already be at the target level at the start of the year at 4x2=8 and maintained at that level to the year end. This was evidenced through the results of the national staff survey.
- Risk to the strategic objective of securing the future: risk to partner relations. Assessed to be already at the target level of 3x3=9 at the start of the year and maintained at that level to the year end. This was evidenced through close collaboration with primary care networks, clinical commissioning groups, regulators, Norfolk County Council, partner NHS trusts and the voluntary sector.
- Risk to the strategic objective of securing the future: risk to delivering the financial plan. Assessed at the start of the year as 3x5=15, mitigated down to better than the target level at 3x2=6. This was evidenced through achieving all of the key metrics within the financial plan.
- Risk to the strategic objective of securing the future: risk to the long term sustainability of services. Assessed at the start of the year as 4x4=16, despite mitigation the risk increased to 4x5=20 at the year end. The target date was extended beyond the year to reflect the timeline of the STP financial plan. The risk increased due to uncertainties over delivery of the financial trajectories across the remaining years of the five year plan (to 2023/24) and the pace of the transformation work required across the STP to deliver the plan.
- A new in-year clinical and operational risk which emerged in March 2020 was the response to the Covid-19 pandemic. This is reflected in the BAF as 4x4=16.
- A new risk that emerged during 2019/20 but was escalated to the BAF after 1 April 2020 was on Cyber Security. Covid-19 has increased the risk of cyber threats targeting the NHS, and the IM&T department had limited opportunities to deploy

security patches to staff working from home or mobile working. This was assessed as 4x4=16.

The Board undertook a self assessment against the Well Led Framework and identified four priority areas for further action and development. This is summarised as:

- Quality Improvement (QI): Board approved NCHC's approach to innovation and improvement that codifies the QI approach, and assesses our effectiveness against it.
- Governance and Accountability: Internal Audit reviewed the Board Assurance Framework, the operation of the Board's committees, and the Governance Framework. All of the audits received significant assurance with some low risk or advisory recommendations. A new approach to performance management was also established.
- Stakeholder appraisal of the Trust: an external review was commissioned but put on hold due the Covid-19 pandemic.
- Range of internal actions have been incorporated into a number of quality improvement action plans.

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 assessed the risks to non-compliance and concluded that NCHC is compliant with the NHS Provider Licence.

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

- Staff training and development in risk
- Risk Group monthly meeting of all risks leads from across the Trust.
- Local risk registers kept at service level and a Trust-wide corporate risk register.
- Risks are regularly reviewed in Board committees and by the Executive.
- Equality impact assessments (EIA) are integrated into core Trust business through them being required for every policy and strategy.

- Incident reporting is openly encouraged. For example, all serious incidents, including actions and learning, are reported to Board monthly. All serious incidents are investigated using root cause analysis methodology. Initial investigation reports to commissioners are submitted within three days of reporting and full investigation reports are submitted together with any resulting action plan to commissioners within 40 days of it being reported. Lessons learned are disseminated to staff through the Quality and Safety Newsletter.

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

- Audit Committee.
- Quality 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.

Quality Committee

Quality Committee provides the leadership, supervision and monitoring of all serious incidents, complaints, claims and Coroner's inquests. It provides the overview, enquiry and challenge to ensure consistency; appropriate levels of investigation; root cause analysis and that key learning is implemented; clear responsibilities and roles within the risk management process ensure that all actions and recommendations identified as part of the process are completed; and that there are effective interfaces between the Trust's directorates, to monitor ongoing compliance. The lessons learnt from these processes are communicated Trust-wide through clear lines of communication. Quality Committee reviews the content of the Quality Account before it is presented to Board. The Committee receives minutes and exception reports from sub-groups that monitor specific areas of clinical quality and risk, for example: Learning from Deaths; Safeguarding; Infection Control; Patient Experience; Clinical

Audit and Effectiveness. The Committee has oversight of the Trust's entire risk profile, both clinical and non-clinical and routinely escalates non-clinical risks to other committees. The Committee also monitors other areas of quality and risk, such as: Information Governance; Records Management; Health and Safety; and Equality and Diversity.

Finance and Performance Committee

The Finance and Performance Committee usually meets monthly to review the financial and performance strategies, policies and reports and efficiency plans of the Trust.

Business Continuity Assurance Committee (Covid-19)

For the duration of the Covid-19 pandemic response the Board approved changes to the Governance Manual to temporarily stand down the Quality Committee and the Finance and Performance Committee and instead establish a Business Continuity Assurance Committee (BCAC) to take over their key functions. The BCAC is chaired by the Chair of the Quality Committee and also comprises the Chair of the Finance and Performance Committee (as deputy chair) and one other NED member. The Medical Director, the Director of Nursing and Quality and the Director of Finance and Performance are also members of the BCAC. Governance support is provided by the Trust Secretary.

Remuneration Committee

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

Charitable Funds Committee

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

Executive Team

The Executive Team usually meets three times per month and comprises the Chief Executive, the Executive Directors and the Trust Secretary. It operates under the principle of collective leadership. Most decisions fall within the remit of individual executives, as defined within the Trust's Governance Manual, but they may choose to exercise their discretion in bringing items to the Executive Team for the purposes of: (1) Making decisions or recommendations together, including expenditure and savings decisions, especially where these impact across more than one directorate or have Trust-wide implications. (2) Sharing information including system intelligence, communicating and educating each other. (3) Large scale or high risk staff consultations. (4) Service changes requiring a public consultation. (5) Creating solutions, sharing inspiration and collective problem-solving. (6) Building effective team relationships, including sharing in a safe environment what might be troubling us and how others can help. The Chief Executive reports directly into Board through a monthly written report.

Other leadership forums in the Trust include the Trust Management Team comprising Executives and the next tier below. This meeting alternates monthly with the Trust Leadership Team which is an open forum for all team leaders and clinical leads.

Assessment of Board effectiveness

The Board undertakes an annual self-assessment of its effectiveness using the good practice questions from the NHS Providers “Compendium of Best Practice”, and then agrees an action plan to drive through continuous improvements.

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.
- NCHC is fully compliant with the registration requirements of the Care Quality Commission.
- NCHC has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the ‘Managing Conflicts of Interest in the NHS’ guidance.

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

NCHC has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). NCHC ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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 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.

Freedom to Speak Up has:

- Achieved national recognition through being featured as a good practice case study in a previous year's 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 Freedom to Speak Up 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.

Counter Fraud

Grant Thornton UK LLP have been 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.

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.

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

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

The Board has exercised effective financial stewardship by assuring itself that the Trust is operating effectively, efficiently, economically and with probity in the use of resources. It has also ensured that financial reporting and internal control principles are applied, and appropriate relationships with the Trust's internal and external auditors are maintained. The Board sees financial stewardship as underpinning and facilitating the delivery of quality care. This includes a careful assessment and understanding of the quality and patient care consequences of financial decisions. The challenge of balancing effective financial stewardship and effective quality governance is a significant one for the Board operating in a

financially constrained health and care system. The Board works with staff, patients and stakeholders to identify opportunities for reshaping services and improving quality of care which also delivers value for money.

Audit Committee

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

Audit

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

The following audits were planned for 2019/20 to be undertaken by Internal Audit:

Review area	**Description**	**Assurance rating**
Medicines Management	A review of the Trust's policies, procedures and reporting in relation to the storing, administering and monitoring medicines, including visits to a range of clinical areas to assess compliance with the required standards and legal requirements.	Significant Assurance with Some Improvement Required
Governance	A review of the Trust's governance manual against good practice from other NHS organisations.	Significant Assurance with Some Improvement Required
Financial sustainability and CIP development	A review of the Trust's arrangements, policies and procedures for the identification, implementation and reporting on CIPs to achieve financial sustainability.	Significant Assurance with Some Improvement Required
Recruitment and retention of	Review of the Trust's	Significant Assurance with

staff	policies and procedures to recruit and retain appropriately qualified and experienced staff.	Some Improvement Required
Programme and project management	A Review of the Trust's arrangement for the monitoring and management of programmes and projects to deliver improvements in service quality and/or performance.	Significant Assurance
Healthcare and non healthcare contract management	A post implementation review of the Trust's new Contract Management System	Postponed until 2020/21 to allow the Trust to focus on the response to the Covid-19 pandemic
Core financial systems	A review of the Trust's controls around the transfer of the general ledger to Oracle; payment of employee expenses and adequacy of management information reporting.	Significant Assurance with Some Improvement Required
Risk management	A review of the Trust's Risk Management policies and procedures as well as the reporting of risks to the Trust Board	Significant Assurance with Some Improvement Required
Freedom to speak up arrangements	A Review of the Trust's Freedom to Speak up arrangements.	Postponed until 2020/21 to allow the Trust to focus on the response to the Covid-19 pandemic
Waiting list management	A review of the Trust's arrangements for : • Reporting progress of the Trust against improvement plans for the 18-week RTT target; • The processes and controls the Trust has in place to improve performance against the RTT target; • Relative performance of different service areas against RTT target and the root causes of inconsistency; • RTT pathways across the service areas reviewed; The quality of data associated with waiting times; and • The integrity of data	Significant Assurance with Some Improvement Required

	used to produce patient tracking lists.	
IT related audit/Data protection and security toolkit	A review of a sample of the Trust's planned responses for the 2019/20 toolkit submission.	Partial assurance with Improvement Required
Partnership working	A review of the Trust's arrangement for working with STP partners.	Postponed until 2020/21 to allow the Trust to focus on the response to the Covid-19 pandemic.

The Head of Internal Audit concluded that:

"Our overall opinion for the period 1 April 2019 to 31 March 2020 is that based on the scope of reviews undertaken and the sample tests completed during the period, that significant assurance with minor 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 Information governance

NCHC identified two serious incidents relating to information governance (defined as data loss or confidentiality breach) and reported these to the Information Commissioners Office (ICO), summarised as:

- Inpatient overview containing 24 patient names, NHS number, diagnosis and clinical details found by a member of the public in a public park. The root cause was identified as human error. Actions to prevent recurrence included review of the confidential waste bin sites, placing ICO posters to remind staff not to take confidential information off the ward, in the process of implementing electronic patient records, learning from incident shared throughout the Trust. No further action was required by the ICO
- Patient booked in for General Anaesthetic for dental treatment but the service was unable to locate the patient's record. However, the record was later found. No further action was required by the ICO.

Data quality and governance

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.

3.3.7 Review of effectiveness

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

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

- The Board reviewed the Board Assurance Framework 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.
- The Accountable Officer has taken into account the views of the Caldicott Guardian and Senior Information Risk Owner.

- The Accountable Officer has taken into account the findings from the Internal Audit programme and the Head of Internal Audit Opinion.
- Performance assessed by NHS regulators. As described in the Performance Summary section above, the CQC has rated the Trust as “Outstanding” following an inspection in June 2018 and NHSI has placed the Trust into segment two of the NHS Oversight Framework in October 2016.

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

Covid-19 pandemic response

On 20 March 2020 NCHC declared a major incident. In drafting the Governance Statement the Accountable Officer has been mindful throughout of the impact of Covid-19. Described below are the actions taken in response to the pandemic which demonstrate that the Trust’s structure of governance was designed to allow a prompt response to a significant change in circumstances. The Command and Control arrangements allowed the Trust to maintain control over its decision making during the Covid-19 response. The Trust’s control environment was also adapted as follows:

- Emergency addendum to the Governance Manual agreed by the Board.
- Board adopted amended terms of reference to allow remote decision making and committee meetings through video conferencing by Board and committees.
- Business Continuity Assurance Committee established under NED chairmanship to temporarily replace the key functions of the Quality Committee and Finance and Performance Committee.

The pandemic is a ‘rising tide’ incident meaning that its peak is foreseeable and its impact builds overtime. Prior to declaring a major incident, the Trust had mobilised its business continuity plans and processes. These remain in place. This included designating a Director as overall commander for the incident, establishing an Incident Control Centre (operational 7 days a week), reviewing and developing plans, establishing incident control mechanisms such as formally logged daily briefings, Risk/Actions/Issues/Decision logs and monitoring and responding to the ongoing impact on service delivery whether in clinical or support services.

The Trust did not experience any notable business continuity issues. The business continuity plan will be reviewed again as part of the Trust’s assessment of its response to the pandemic. The Trust has opened additional bed capacity to respond to increased demand. In line with National Guidance services have been risk assessed and prioritised leading to some reduced service offers and some services ceased due to the vulnerable nature of the client group and Government advice on ‘shielding’. The Trust has monitored the use of Personal Protective Equipment and at the time of writing has not had any material issues that have impacted its use within the Trust. Additional support has been implemented in the form of daily briefings, Health and Wellbeing Newsletters, Resources to support managers, wellbeing hubs at keys sites and Directors’ visibility through blogs/vlogs and video FAQ sessions. Weekly briefings with union representatives have also been established.

3.3.8 Conclusion

No significant internal control issues have been identified.

Governance Statement signature

Signed… 

Chief Executive Date: 02nd June 2020

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 and Social Care determines the remuneration of the Chair and Non-Executive Directors nationally.

Remuneration for Executive Board members is determined by the Remuneration Committee. In the case of the Chief Executive, a spot salary applies which is calculated on the basis of the weighted population of the county through the Very Senior Managers national framework. For the other Executive Directors' remuneration, the Trust applies the mandatory guidance given by NHS Employers through the Agenda for Change framework for directors holding employment contracts.

4.1.2 Salaries and allowances

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

The salaries and other allowances of the senior managers who have held office for all or part of the 2019/20 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	2019/20					
		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)
Lorna Bailey	Non-Executive Director	5-10	-	-	-	-	5-10
Geraldine Broderick	Chair	30-35	3	-	-	-	30-35
Laura Clear****	Director of Community Health and Social Care Operations	110-115	1	-	-	100-102.5	210-215
Paul Cracknell	Deputy Chief Executive	110-115	57	-	-	32.5-35	150-155
Steven Crowe	Non-Executive Director	0-5	-	-	-	-	0-5
Carolyn Fowler***	Director of Nursing and Quality (from 02/09/2019)	60-65	-	-	-	157.5-160	220-225
Venu Harilal*	Medical Director / Consultant	125-130	-	0-5**	-	30-32.5	155-160
Andrew Hopkins	Director of Finance and Performance	120-125	-	-	-	15-17.5	135-140
John Kennedy	Non-Executive Director	0-5	-	-	-	-	0-5
Anna Morgan	Director of Nursing and Quality (until 31/07/2019)	35-40	-	-	-	30-32.5	65-70
Graham Nice	Non-Executive Director	5-10	1	-	-	-	5-10
Heather Peck	Non-Executive Director	5-10	1	-	-	-	5-10
Geoffrey Rivers	Non-Executive Director	5-10	-	-	-	-	5-10
Josephine Spencer	Chief Executive	150-155	3	-	-	27.5-30	180-185
Andrew Williams	Non-Executive Director	5-10	1	-	-	-	5-10
Njoki Yaxley	Non-Executive Director	0-5	-	-	-	-	0-5

*Dr Harilal's remuneration includes both a Clinical and Medical Director role; the salary is split 39% for the Clinical role and 61% for the Medical Director role.
**Dr Harilal's performance and pay bonuses relate to a Clinical Excellence Award as part of his clinical role.
*** The increase in pension related benefits for Carolyn Fowler is due to a recalculation of her historically accumulated final salary pension benefits following her appointment as Director of Nursing and Quality.
**** The increase in pension related benefits for Laura Clear is due to a recalculation of her historically accumulated final salary pension benefits following her appointment as Director of Community Health and Social Care Operations.
A '-' indicates nil.

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

*Dr Harilal's remuneration includes both a Clinical and Medical Director role; the salary is split 39% for the Clinical role and 61% 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.

4.1.3 Fair pay disclosure

The narrative below has been independently audited by KPMG.

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 in the organisation in the financial year 2019/20 was £150k-£155k (2018/19, £145k-£150k). This was 5.6 times (2018/19, 6.0) the median remuneration of the workforce, which was £27,260 (£24,915 in 2018/19).

In 2019/20, no employees (no employees in 2018/19) received whole time equivalent remuneration in excess of the highest paid director. Remuneration ranged from £7,625.91 to £151,929 (2018/19 £6,157 to £149,950).

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

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

Past and present employees are covered by the provisions of the two NHS Pension Schemes, the 1995/2008 Scheme and the 2015 Scheme. 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 2019/20 (the FReM) requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

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 2020 is based on valuation data at 31 March 2019, updated to 31 March 2020 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.

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 and Social Care, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

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

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

Tables showing pension benefits of executive members of the Board

2019/20		Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2019 (to nearest £1,000)	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020 (to nearest £1,000)	Employer's contribution to stakeholder pension**
Name	**Title**	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Laura Clear	**Director of Community Health & Social Care Operations**	5-7.5	15-17.5	40-45	125-130	803	117	963	-
Paul Cracknell	**Deputy Chief Executive**	0-2.5	0-2.5	20-25	40-45	314	20	356	-
Carolyn Fowler*	**Director of Nursing and Quality (from 02/09/2019)**	2.5-5	12.5-15	35-40	115-120	707	94	902	-
Venu Harilal	**Medical Director**	0-2.5	0-2.5	35-40	35-40	515	25	571	-
Andrew Hopkins	**Director of Finance and Performance**	0-2.5	0-2.5	45-50	115-120	921	16	982	-
Anna Morgan**	**Director of Nursing and Quality (until 31/07/2019)**	0-2.5	0-2.5	35-40	40-45	569	7	620	-
Josie Spencer	**Chief Executive**	0-2.5	0-2.5	70-75	185-190	1,433	47	1,524	-

* The increase in pension related benefits for Carolyn Fowler is due to a recalculation of her historically accumulated final salary pension benefits following her appointment as Director of Nursing and Quality.
**The period between Anna Morgan's departure and Carolyn Fowler's arrival was covered by the Deputy Director of Quality.

A '-' indicates nil.

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
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	-
Paul Cracknell	Deputy Chief Executive (from 06/11/18)	0-2.5	0-2.5	20-25	40-45	245	47	314	-
Roisin Fallon-Williams*	Chief Executive (until 31/05/18)	0	(2.5)-0	55-60	175-180	1,167	- 201	-	-
Venu Harilal	Medical Director	2.5-5	0-2.5	35-40	35-40	411	77	515	-
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	-
Josie Spencer	Chief Executive (from (16/06/18)	7.5-10	20-22.5	65-70	185-190	1,053	257	1,433	-

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

4.1.5 Cash Equivalent Transfer Values

The following narrative has been independently audited by KPMG.

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

Real Increase in CETV

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

4.2 Staff Report

4.2.1 An analysis of staff numbers and costs
4.2.2 Staff composition
4.2.3 Expenditure on consultancy
4.2.4 Off-payroll engagements
4.2.5 Exit packages
4.2.6 Staff engagement
4.2.7 Quality improvement
4.2.8 Trade Union reporting requirements
4.2.9 Equal opportunities
4.2.10 Social, community and human rights
4.2.11 Employee consultation
4.2.12 Health and Safety
4.2.13 Sickness absence

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 pay band within the Trust is set out below:

Table showing number of senior management by pay band at 31 March 2020

Band	Headcount
Band 8A	74
Band 8B	33
Band 8C	12
Band 8D	6
Band 9	4
VSM	2

This includes one band 8A post hosted by NCHC for the STP

Table showing staff (whole time equivalent) numbers

Staff Numbers

	2019-20			2018-19		
	Total Number	**Permanent Employed Number**	**Other Number**	**Total Number**	**Permanent Employed Number**	**Other Number**
Average Staff Numbers						
Medical and dental	**24**	24		**30**	30	
Ambulance staff	**0**			**0**		
Administration and estates	**437**	426	11	**429**	423	6
Healthcare assistants and other support staff	**688**	639	49	**665**	626	39
Nursing, midwifery and health visiting staff	**618**	586	32	**625**	597	28
Nursing, midwifery and health visiting learners	**0**			**0**		
Scientific, therapeutic and technical staff	**316**	310	6	**292**	287	5
Healthcare science staff	**4**	4		**4**	4	
Social care staff	**1**	1		**1**	1	
Agency and contract staff	**0**			**0**		
Bank staff	**0**			**0**		
Other	**0**			**7**	7	
Total	**2,087**	**1,990**	**98**	**2,053**	**1,975**	**78**
Of the above - staff enaged on capital projects	**5**	5		**4**	4	

Table showing employee benefits

Employee Benefits - Gross Expenditure

2019-20	Total £000	Permanently Employed total £000	Other total £000
Salaries and wages	64,002	61,497	2,505
Social security costs	6,043	5,809	234
Apprenticeship levy	313	313	0
Pension cost - employer contributions to NHS pension scheme	8,704	8,367	337
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	3,812	3,597	215
Pension cost - other	26	26	0
Other post employment benefits	0	0	0
Other employment benefits	127	127	0
Termination benefits	(496)	(496)	0
Temporary staff - external bank	0	0	0
Temporary staff - agency/contract staff	1,091	0	1,091
TOTAL STAFF COSTS	**83,621**	**79,239**	**4,382**
Included within:			
Employee Costs Capitalised	**383**	**383**	**0**
Operating expenditure analysed as:			
Gross Employee Benefits excluding Capitalised costs	**83,239**	**78,857**	**4,382**

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	**78,167**	**74,054**	**4,113**

“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 as at 31 March 2020

Staff Category	Female	Male	Total
Directors (Voting)	6	6	12
Non-voting directors and other VSMs	1	1	2
Other staff	1,901	335	2,236
Total	1,908	342	2,250

4.2.3 Expenditure on consultancy

Expenditure on consultancy services is shown in the accounts Note 4.1 Operating Expenses. The expenditure in 2019/20 was £110k (£99k in 2018/19).

4.2.4 Off-payroll engagements

Table showing existing off-payroll payments as of 31 March 2020, for more than £245 per day and that last longer than six months:

Engagements	Number
Existing engagements as of 31 March 2020	1
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	-
for between two and three years at the time of reporting	-
for between three and four years at the time of reporting	-
for four years or more at the time of reporting	-

The existing arrangement at 31st March 2019 was ceased during the year. There was one new off-payroll engagement during the year. Any new off-payroll engagements are subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of 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 2019 and 31 March 2020, 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 2019 and 31 March 2020	1
Of which...	
No. assessed as caught by IR35	-
No. assessed as not caught by IR35	1
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	-
No. of engagements reassessed for consistency / assurance purposes during the year	-
No. of engagements that saw a change to IR35 status following the consistency review	-

Table showing any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year. (1)	-
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)	-

4.2.5 Exit packages

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

Table showing exit packages agreed in 2019/20

Exit Packages agreed in 2019-20

Exit package cost band (including any special payment element)	Number of compulsory redundancies Accounts 31 Mar 2020 2020/20	Cost of compulsory redundancies Accounts 31 Mar 2020 2019/20	Number of other departures agreed Accounts 31 Mar 2020 2019/20	Cost of other departures agreed Accounts 31 Mar 2020 2019/20	Total number of exit packages Accounts 31 Mar 2020 2019/20	Total cost of exit packages Accounts 31 Mar 2020 2019/20	Number of departures where special payments have been made Accounts 31 Mar 2020 2019/20	Cost of special payment element included in exit packages Accounts 31 Mar 2020 2019/20
	Number	£	Number	£	Number	£	Number	£000
<£10,000	6	35,600	-	-	6	35,600	-	-
£10,000 - £25,000	11	193,197	-	-	11	193,197	-	-
£25,001 - 50,000	2	55,023	-	-	2	55,023	-	-
£50,001 - £100,000	-	-	-	-	-	-	-	-
£100,001 - £150,000	-	-	-	-	-	-	-	-
£150,001 - £200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
Total	**19**	**283,820**	**-**	**-**	**19**	**283,820**	**-**	**-**

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 redundancy 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.

4.2.6 Staff Engagement

During the year the Staff Engagement steering group have engaged across the Trust to understand 'what's next for staff engagement' at NCHC. With the move to PCNs the view was to have both a central and a localised offering.

In May 2019 the OD strategy for 2019/22 was ratified at Board. As a result there were 5 key destinations (work streams): Direction, Digitalisation, Development, Diversity and Delegation. This had been developed using the Your Voice Our Future staff engagement campaign. During the year 2019/20 the majority of 1st year actions were completed with few to be completed by May 2020. These included the description of a positive and healthy culture, the promotion and improved use of technology, review and refresh of the first line leader programme, resources for leaders managing large scale change, WRES Diversity actions and planning for earned autonomy as part of the new PCN structures and processes. Evidence of many of these actions have come to fruition during Covid-19, such as leadership styles, culture and the improved use of technology.

4.2.7 Quality Improvement

The Board agreed the Trust's approach to continuous quality improvement, learning and innovation. A Quality Improvement post is being recruited to that will lead on this piece of work, including supporting the Quality Champions programme.

Quality Champions Programme

The Quality Champions programme has continued and is now more closely linked to the First Line Leader programme as many of the skills are critical to our leaders. As part of the revamp and promotion of the First Line Leader programme the Quality Champions Programme will be promoted and developed to continue to meet the needs of the organisation. In addition a paper as to how as a Trust we learn and continuously improve to Board stated the Quality Champions programme as integral to this agenda and there are many examples through projects to prove this process already.

Talent Management

Talent management is now on its 4th round and at the beginning of this round had a re-launch to ensure more recent and relevant strategic drivers. It related particularly to the NHS Long term plan and NHS interim people plan. In addition continuous improvements to the process have been made, such as more appropriate managers groups, more comprehensive notes taken to help with the feedback, continuing to look at succession planning and a high potential talent pool. Certain areas such as learning disability services and the West locality started with lower banded staff by having managers trained as facilitators. A presentation to the East of England Talent Community of Practice depicted the journey and development of the talent process in NCHC over the last 4 years.

Reverse Mentoring pilot

We implemented a pilot for reverse mentoring with 8 pairs to date. A mid term review was set for March yet currently delayed due the Covid-19 pandemic response. The purpose was to have individuals who have experienced issues relating to being a minority under the 9 personal characteristics who have acted as mentors to senior mentees (all Directors or Deputy Directors) for the pilot. This is due to be evaluated by the University of Nottingham.

Leadership/Coaching process

A coaching process has been created to support Strategic leaders and 11 coaches have been externally procured. In addition 7 internal coaches are supporting Operational leaders. This is a process to support the development of strategic leaders resulting from a development centre/process to give strategic operational leaders personal development plans working towards new roles in the PCNs. 50 Operational leaders have now attended the Operational Leader programme and internal coaching will continue to support this. During COVID 19 they have been having team virtual coaching sessions from the leadership development consultants too.

Other initiatives include:

- REAL programme for developing leaders. REAL stands for Releasing potential, Empowering And Leading.
- Re-validation for nurses and re-registration for Allied Health Professionals, doctors, dentists and others.
- Preceptorship.
- Apprenticeships.
- Flexible Nursing.
- Care Certificate.
- Staff Health and Wellbeing.
- Local staff surveys.

4.2.8 Trade Union Reporting Requirements

As part of the requirements of the Trade Union (Facility Time Publication Requirements Regulations 2017), the Trust monitors the following trade union activity:

- Employee Relations Hearings
- Union Health & Safety Training
- Union Learning Representation Activity
- Staff Management Council
- Policy Working Group
- Job Evaluation
- Local Liaison Group
- Health & Well Being Committee
- Workforce Committee
- Staff Engagement

The data is captured using an interactive database managed through the HR Operations function. At the end of the financial year HR Operations collate the final position and upload the information into the government portal each July. The information is then also published on the Trust's internet page.

Table below showing activities recorded in hours by Trade Union representatives

	2019-2020	2018-2019	Difference
Employee Relations Hearings	291.65	321.11	-29.46
Health & Wellbeing Committee	18.5	42.5	-24
Job Evaluation	128.5	79.25	49.25
Local Liaison Group	86	79.5	6.5
Local Negotiating Committee	54	45.5	8.5
Other Union Training	223.5	244.5	-21
Other Working Groups	133.5	190.8	-57.3
Policy Working Group	53	59	-6
Staff Engagement Committee	5	15.5	-10.5
Staff Management Council	1020.5	1143.1	-122.6
Union H&S Training	11.75	79.5	-67.75
Union Learning Representation Activity	16	14.25	1.75
Workforce Committee	2	15	-13
Grand Total	**2043.9**	**2329.51**	-285.61

4.2.9 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, Diversity and Inclusion, and approved a revised statement during the year. This action plan is available on NCHC's website and is summarised below. The Trust also met its obligations to report on the gender pay gap, and compliance with the workforce disability equality standard and the workforce race equality standard.

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

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

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

The 2011 Census information (Norfolk) has been published and as a result, the Trust is able to compare its ethnicity profile to the Norfolk population. The table shows a summary level comparison of the Black Minority Ethnic (BME) versus non-BME numbers. 9.3% of staff ethnicity is recorded as not stated/undefined.

Category	NCHC (%)	2011 Census Norfolk (%)
non-BME	86.3%	96.3%
BME	4.2%	4.0%
Not Stated / Undefined	9.3%	0.0%

The table below provides data on the declared religious belief of staff

Religious Belief	NCH&C %	2011 Census Norfolk (%)
Atheism	16.0%	29.6%
Buddhism	0.4%	0.3%
Christianity	41.1%	61.0%
Hinduism	0.3%	0.3%
Islam	0.2%	0.6%
Jainism	0.0%	??
Judaism	0.0%	0.1%
Sikhism	0.1%	0.1%
Other	8.4%	0.5%
I do not wish to disclose my religion/belief	33.0%	7.6%
Undefined	0.5%	-

The table below provide data on the age profile of staff

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	2.1%	6.3%	10.1%	10.9%	10.7%	10.6%	14.1%	16.3%	12.2%	5.7%	1.0%	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%

The table below shows the proportion of staff who have declared a disability

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	2.1%	6.3%	10.1%	10.9%	10.7%	10.6%	14.1%	16.3%	12.2%	5.7%	1.0%	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%

The table below shows data on the declared sexual orientation of staff

Sexual Orientation	NCH&C %
Heterosexual or Straight	68.7%
Gay or Lesbian	1.4%
Bisexual	1.0%
Undecided	0.0%
Not stated (person asked but declined to provide a response)	28.0%
Undefined	0.7%
Other sexual orientation not listed	0.1%

4.2.10 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 advocate 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. 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 continued to be a Diversity Champion with Stonewall, a lobbying organisation for Lesbian, Gay, Bi-sexual and Transgendered 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.

4.2.11 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 national staff survey. NCHC issues a monthly newsletter to all staff, to keep staff updated and informed. A presentation on staff engagement and consultation forms part of the mandatory staff induction programme. The senior team has an open door policy allowing them to be available to staff at any time.

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

- The Future of Clinical Staff Based at the Norwich Locality Hub
- Consultation Document for staff transferred under TUPE into Palliative Care Hospice at Home Team from Marie Curie
- Decommissioning of Cranmer House Intermediate Care Beds
- Children's Centres Consultation of Staff Transfer
- Special Care Dentistry Service Consultation of Staff Transfer
- Consultation to Change Working Practices in the Dental Access Services
- Review of Alder Ward Staff Working Patterns
- Primary Care Networks Operational and Clinical Management Structure
- Children's Nursing Review
- Change of Base from St. James, King's Lynn to Swaffham Community Hospital

4.2.12 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.

4.2.13 Sickness absence

The 12 month sickness absence rate for the year is 4.82%, compared to 4.7% for the previous year. These sickness figures are based on NCHC's internal reporting systems and cover the period 1st April 2019 to 31st March 2020. 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 2019 to 31st December 2019.

Staff sickness absence	2019-20 **Number**	2018-19 **Number**
Total days lost	25,073	20,101
Total staff years	1,990	1,949
Average working days lost (per WTE)	**12.60**	**10.31**
Source: NHS Digital - Sickness Absense and Publication - based on data from the ESR Data Warehouse		

Sickness absence data is available from the NHS Digital website by following the link below:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

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.

Accountability Report signature

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

Accountable Officer's signature

Signed:  Date…02 June 2020……

Josephine Spencer
Chief Executive
Norfolk Community Health and Care NHS Trust

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 2020 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 2020 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 and Social Care Group Accounting Manual 2019/20.

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 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 and Social Care Group Accounting Manual 2019/20. 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 and Social Care Group Accounting Manual 2019/20.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 32, 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 33 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 33, 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 December 2019 and updated in April 2020 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 for the year ended 31 March 2020 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

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

2 June 2020

C FINANCIAL STATEMENTS

Norfolk Community Health and Care NHS Trust

Annual accounts for the year ended 31 March 2020

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	2	110,452	104,739
Other operating income	3	7,230	5,963
Operating expenses	5, 6	(115,285)	(121,145)
Operating surplus/(deficit)		**2,397**	**(10,444)**
PDC dividends payable		(1,832)	(2,119)
Net finance costs		**(1,832)**	**(2,119)**
Other gains / (losses)	10	61	(32)
Surplus / (deficit) for the year		**626**	**(12,595)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	5.3	(528)	(10,821)
Revaluations	13	4,679	5,137
Other reserve movements		(23)	-
Total comprehensive income / (expense) for the period		**4,754**	**(18,279)**

The Trust's financial performance is assessed by NHS England / Improvement using an adjusted financial result. The table below shows this adjusted financial result measure:

	2019/20	2018/19
Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	626	(12,595)
Remove net impairments which are not included in the adjusted result	(399)	5,230
Remove Statement of Comprehensive Income effect of capital grants and donations	282	(36)
Adjusted financial performance surplus / (deficit)	**509**	**(7,401)**

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	11	240	285
Property, plant and equipment	12	65,989	63,336
Total non-current assets		**66,229**	**63,621**
Current assets			
Inventories	18	195	173
Receivables	15	6,254	12,227
Non-current assets for sale and assets in disposal groups	16	116	897
Cash and cash equivalents	17	25,973	17,437
Total current assets		**32,538**	**30,734**
Current liabilities			
Trade and other payables	18	(17,151)	(12,882)
Provisions	19	(2,761)	(7,463)
Other liabilities		(277)	(348)
Total current liabilities		**(20,189)**	**(20,693)**
Total assets less current liabilities		**78,578**	**73,662**
Non-current liabilities			
Provisions	19	(256)	(229)
Total non-current liabilities		**(256)**	**(229)**
Total assets employed		**78,322**	**73,433**
Financed by			
Public dividend capital		15,770	15,635
Revaluation reserve		19,518	15,390
Income and expenditure reserve		43,034	42,408
Total taxpayers' equity		**78,322**	**73,433**

The notes on pages 103 to 142 form part of these accounts.

Name	Josie Spencer
Position	Chief Executive
Date	02 June 2020

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2019 - brought forward	**15,635**	**15,390**	**42,408**	**73,433**
Surplus/(deficit) for the year	-	-	626	**626**
Impairments	-	(528)	-	**(528)**
Revaluations	-	4,679	-	**4,679**
Other recognised gains and losses	-	-	-	**-**
Public dividend capital received	135	-	-	**135**
Other reserve movements	-	(23)	-	**(23)**
Taxpayers' equity at 31 March 2020	**15,770**	**19,518**	**43,034**	**78,322**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018	**15,414**	**21,074**	**55,164**	**91,652**
Effect of implementing IFRS 9 on 1 April 2018	-	-	(161)	**(161)**
Surplus/(deficit) for the year	-	-	(12,595)	**(12,595)**
Impairments	-	(10,821)	-	**(10,821)**
Revaluations	-	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 Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		2,397	(10,444)
Non-cash income and expense:			
Depreciation and amortisation	5	4,525	4,224
Net impairments	5.3	1,374	5,230
Income recognised in respect of capital donations	3	(65)	(96)
(Increase) / decrease in receivables and other assets		5,658	(2,081)
(Increase) / decrease in inventories		(22)	7
Increase / (decrease) in payables and other liabilities		4,417	2,455
Increase / (decrease) in provisions		(4,675)	6,289
Other movements in operating cash flows		(23)	7
Net cash flows from operating activities		**13,586**	**5,591**
Cash flows from investing activities			
Purchase of intangible assets		-	(280)
Purchase of PPE and investment property		(4,963)	(3,945)
Sales of PPE		1,230	-
Receipt of cash donations to purchase assets		65	96
Net cash flows (used in) investing activities		**(3,668)**	**(4,129)**
Cash flows from financing activities			
Public dividend capital received		135	221
PDC dividend (paid) / refunded		(1,517)	(2,459)
Cash flows from (used in) other financing activities		-	-
Net cash flows from / (used in) financing activities		**(1,382)**	**(2,238)**
Increase / (decrease) in cash and cash equivalents		**8,536**	**(776)**
Cash and cash equivalents at 1 April - brought forward		**17,437**	**18,213**
Cash and cash equivalents at 31 March	17	**25,973**	**17,437**

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 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 2019/20 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 the common control of NHS bodies are consolidated within the entity's financial statements. The Trust has determined that consolidation of its related Charitable Fund falls within this provision, however as the Charitable Fund is not considered material in the context of the Trust's accounts its results will not be consolidated. 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 various judgements, estimates and assumptions. 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.

Note 1.4.1 Critical accounting judgements and key sources of estimation uncertainty

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.

Note 1.4.1 Critical accounting judgements and key sources of estimation uncertainty continued

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

A full revaluation was performed at 31 December 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 - Global Standards 2020 and the RICS Valuation – Global Standards 2017 – UK National Supplement, 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 has been determined there has not been a material change in the fair value of land and buildings between 31 December 2019, when the revaluation of land and buildings was performed, and the balance date of 31 March 2020.

Note 1.4.2 Key sources of estimation uncertainty

The following are sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

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.

Value of expected credit losses
The Trust estimates the expected credit loss of accounts receivable balances and reduces the value of its accounts receivable balances by this estimate in the financial statements.

The value of the Trust's aged accounts receivable and the estimated credit losses of these debts are shown in the accounts receivable note to these financial statements. Accounting policy note 1.19.1 below explains how the expected credit loss is calculated.

The Trust has a significant amount of aged accounts receivable balances. The estimation of expected credit losses is therefore considered a material source of estimation uncertainty.

Note 1.5 Operating segments

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

Notes to the Accounts

Note 1.6 Revenue from contracts with customers

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

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

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for health care services. 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 patient. 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, and where material, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

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 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.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)
The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Sale of non-current assets
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 Revenue from contracts with customers continued

Expedients applied
In the application of IFRS 15 (the standard) a number of practical expedients offered in the standard have been employed. These are as follows:

• The Trust does not disclose information regarding performance obligations of part of a contract that has an original expected duration of one year or less,

• The Trust does not disclose information where revenue is recognised in line with the practical expedient offered in the standard, where the right to consideration corresponds directly with value of the performance completed to date.

• The Government Financial Reporting Manual (the FReM) has mandated the exercise of the practical expedient offered in the standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application of the standard on 1 April 2018.

Note 1.6.1 Apprenticeship levy

The cost of the apprenticeship levy paid to the Government is recognised as part of payroll expense.

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

When Trust staff utilise courses provided by 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.

Note 1.7 Expenditure on 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 has been accrued at 31 March 2020. This is because accrued leave has increased significantly as a result of the Trust's response to the covid19 pandemic. The cost of leave earned but not taken by employees at 1 April 2018 and 1 April 2019 was not accrued as it was immaterial.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Notes to the accounts

Note 1.7 Expenditure on employee benefits continued

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 Expenditure on other goods and services

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

Note 1.9 Clinical negligence costs

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

Note 1.10 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.

The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in the provisions note to the accounts, but is not recognised in the Trust's accounts.
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.

The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in the provisions note to the accounts, but is not recognised in the Trust's accounts.

Note 1.11 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
● it is held for use in delivering services or for administrative purposes;
● it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
● it is expected to be used for more than one financial year;
● the cost of the item can be measured reliably; and either
● the item 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.

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.

Notes to the accounts

Note 1.11 Property, plant and equipment continued

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.

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

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

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised.

Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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

Notes to the accounts

Note 1.12 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.

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

Measurement
Intangible assets acquired separately are initially recognised at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

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 1.13 Depreciation, amortisation, revaluation, and impairments

Depreciation and amortisation
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.

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

	Min life Years	Max life Years
Land	-	-
Buildings	1	73
Plant & machinery	1	23
Information technology	3	6
Furniture & fittings	-	-
Software licences	5	10

Leasehold improvements are depreciated over the shorter of the useful life or the lease term.

Note 1.13 Depreciation, amortisation, revaluation, and impairments continued

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
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.

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.14 Donated and granted assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.15 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 1.16 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 1.17 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 material effect on the financial statements.

Note 1.18 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. The sale must be highly probable and the asset available for immediate sale in its present condition. They are measured at the lower of their carrying amount and fair value less costs to sell.

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

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

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

Notes to the accounts

Note 1.19 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 1.19.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held 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.

Impairment
For all financial assets measured at amortised cost including lease receivables and contract assets the Trust recognises an allowance for expected credit losses.

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.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

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

Notes to the accounts

Note 1.20 Financial liabilities

Financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs.

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.

Note 1.21 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount for which it is probable that there will be a future outflow of cash or other resources and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

Note 1.22 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.

Note 1.22 Contingent liabilities and contingent assets continued

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.

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.

Note 1.23 Public dividend capital

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 and grant funded assets
• Average daily cash balances held with the Government Banking Service (GBS) (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 is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.24 Value added tax

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

Note 1.25 Currency

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

Notes to the accounts

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.

Note 1.27 Equity

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 and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend. This charge is reflected in the Statement of Comprehensive Income.

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.

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

Note 1.28 Early adoption of standards, amendments, and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Notes to the accounts

Note 1.29 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases
IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021 the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard.

The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does expect this standard to have a material effect on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations
The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2019-20. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020-21, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 14 Regulatory deferral accounts – not endorsed by the EU and not applicable to DHSC group bodies, including the Trust.
- 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 believe adopting this standard will not have a material effect on the financial statements.

Note 2 Operating income from patient care activities

Note 2.1 Income from patient care activities (by nature)

	2019/20	2018/19
	£000	£000
Community services income from CCGs and NHS England	96,730	91,804
Income from other sources (e.g. local authorities)	9,568	11,449
Private patient income	15	11
Agenda for Change pay award central funding*	-	1,166
Additional pension contribution central funding**	3,812	-
Other clinical income	327	309
Total income from activities	**110,452**	**104,739**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into contract income for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 2.2 Income from patient care activities (by source)

	2019/20	2018/19
Income from patient care activities received from:	£000	£000
NHS England	13,224	11,061
Clinical commissioning groups	87,449	80,743
Department of Health and Social Care	23	1,182
Other NHS providers	4,419	4,262
Local authorities	5,126	7,168
Non-NHS: private patients	15	11
Non NHS: other	196	312
Total income from activities	**110,452**	**104,739**

Note 3 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	511	-	**511**	511	-	**511**
Education and training	643	738	**1,381**	687	472	**1,159**
Non-patient care services to other bodies	1,424	-	**1,424**	1,883	-	**1,883**
Provider sustainability fund (PSF)	856	-	**856**	1,232	-	**1,232**
Financial recovery fund (FRF)	1,919	-	**1,919**	-	-	**-**
Receipt of capital grants and donations	-	65	**65**	-	96	**96**
Charitable and other contributions to expenditure	-	8	**8**	-	4	**4**
Rental revenue from operating leases	-	571	**571**	-	516	**516**
Other income	496	-	**496**	562	-	**562**
Total other operating income	**5,848**	**1,382**	**7,230**	**4,875**	**1,088**	**5,963**

Note 4.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	348	164
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0	0

Note 4.2 Transaction price allocated to remaining performance obligations

All revenue from existing contracts allocated to remaining performance obligations is expected to be recognised within one year.

Note 5 Operating expenses

	2019/20	2018/19
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,271	2,057
Purchase of healthcare from non-NHS and non-DHSC bodies	1,074	1,344
Staff and executive directors costs (see note 5.1)	83,239	78,167
Remuneration of non-executive directors (see note 5.1)	80	68
Supplies and services - clinical (excluding drugs costs)	5,868	6,700
Supplies and services - general	8,178	7,638
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	582	607
Consultancy costs	110	99
Establishment	938	857
Premises	3,019	2,347
Transport (including patient travel)	2,492	2,524
Depreciation on property, plant and equipment	4,488	4,186
Amortisation on intangible assets	37	38
Net impairments (see note 5.3)	1,374	5,230
Movement in credit loss allowance: contract receivables / contract assets	1,047	949
Increase/(decrease) in other provisions	(1,750)	6,460
Change in provisions discount rate(s)	24	(5)
Audit fees payable to the external auditor		
audit services- statutory audit	50	52
Internal audit costs	84	86
Clinical negligence	299	299
Legal fees	171	67
Insurance	5	13
Education and training	1,114	832
Rentals under operating leases	462	490
Car parking & security	29	32
Losses, ex gratia & special payments	1	7
Total	**115,285**	**121,145**

Note 5.1 Staff, executive director, and non-executive director costs

See the remuneration report within this annual report for further information on staff and director costs.

Note 5.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2019/20 and 2018/19.

Note 5.3 Impairment of assets

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Abandonment of assets in course of construction	1,773	-
Changes in market price	(399)	5,230
Total net impairments charged to operating surplus / deficit	**1,374**	**5,230**
Impairments charged to the revaluation reserve	528	10,821
Total net impairments	**1,902**	**16,051**

Note 6 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	64,002	61,750
Social security costs	6,043	5,796
Apprenticeship levy*	313	297
Employer's contributions to NHS pensions	12,516	8,313
Pension cost - other	26	11
Other employment benefits	127	167
Termination benefits**	(496)	862
Temporary staff (including agency)	1,091	1,214
Total staff costs	**83,621**	**78,410**
Of which		
Costs capitalised as part of assets	383	243
Costs recognised as an expense in the statement of comprehensive income	83,239	78,167

* The figure shown above represents the Trust's gross apprenticeship levy. The Trust utilises this by contributing towards the cost of staff apprenticeship training.

** Termination benefits are negative as a provision held at 1 April 2019 was not utilised as fewer staff were made redundant as a result of service closure than expected in 2019/20. The provision was therefore reversed unused.

Note 6.1 Retirements due to ill-health

During 2019/20 there was 1 early retirement from the Trust agreed on the grounds of ill-health (2 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £58k (£70k in 2018/19).

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

Note 7 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) 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 2020 is based on valuation data at 31 March 2019, updated to 31 March 2020 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 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 at 20.6%, and the Scheme Regulations were amended accordingly.

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.

c) Other defined contribution workplace pension scheme

The Trust also offers an additional defined contribution workplace pension scheme, the the National Employment Savings Scheme (NEST)). A minority of staff employed by the Trust are enrolled in this scheme. Additional information on accounting for the scheme is given in accounting policy note 1.7.

Note 8 Operating leases

Note 8.1 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. See note 29 for an amendment to the 31 March 2019 future minimum lease receipts due disclosed below.

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

	2019/20	2018/19
	£000	£000
Operating lease revenue		
Minimum lease receipts	571	516
Total	**571**	**516**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	180	183
- later than one year and not later than five years;	223	230
- later than five years.	19	59
Total	**422**	**472**

Note 8.2 Norfolk Community Health and Care NHS Trust as a lessee

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

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

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	462	490
Total	**462**	**490**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	808	909
- later than one year and not later than five years;	659	1,138
- later than five years.	552	632
Total	**2,019**	**2,679**

Note 9 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

There have been no costs incurred over £500 during 2019/20 or 2018/19 in relation to the late payment of commercial debts.

Note 10 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	61	-
Losses on disposal of assets	-	(32)
Total other gains / (losses)	**61**	**(32)**

Note 11.1 Intangible assets - 2019/20

	Software licences
	£000
Gross cost at 1 April 2019	**341**
Reclassifications from work in progress	-
Disposals / derecognition	(12)
Gross cost at 31 March 2020	**329**
Amortisation at 1 April 2019	**56**
Provided during the year	37
Disposals / derecognition	(4)
Amortisation at 31 March 2020	**89**
Net book value at 31 March 2020	**240**
Net book value at 1 April 2019	**285**

Note 11.2 Intangible assets - 2018/19

	Software licences
	£000
Gross cost at 1 April 2018	**61**
Reclassifications from work in progress (shown in the PPE note)	280
Disposals / derecognition	-
Gross cost at 31 March 2019	**341**
Amortisation at 1 April 2018	**18**
Provided during the year	38
Disposals / derecognition	-
Amortisation at 31 March 2019	**56**
Net book value at 31 March 2019	**285**
Net book value at 1 April 2018	**43**

Note 12.1 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**6,955**	**48,100**	**4,087**	**4,117**	**9,255**	**72,514**
Additions	1,713	-	2,987	44	-	**4,744**
Impairments	(18)	(1,811)	(1,772)	-	-	**(3,601)**
Reversals of impairments	-	1,310	-	-	-	**1,310**
Revaluations	97	3,042	-	-	-	**3,139**
Reclassifications	-	629	(2,148)	228	1,291	**-**
Transfers to / from assets held for sale	(53)	(123)	-	-	-	**(176)**
Disposals / derecognition	-	(68)	-	(750)	-	**(818)**
Valuation/gross cost at 31 March 2020	**8,694**	**51,079**	**3,154**	**3,639**	**10,546**	**77,112**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**47**	**-**	**2,393**	**6,738**	**9,178**
Provided during the year	-	2,658	-	561	1,269	**4,488**
Impairments	-	(447)	-	-	-	**(447)**
Reversals of impairments	-	-	-	-	-	**-**
Revaluations	-	(1,540)	-	-	-	**(1,540)**
Reclassifications	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	(2)	-	-	-	**(2)**
Disposals / derecognition	-	(6)	-	(548)	-	**(554)**
Accumulated depreciation at 31 March 2020	**-**	**710**	**-**	**2,406**	**8,007**	**11,123**
Net book value at 31 March 2020	**8,694**	**50,369**	**3,154**	**1,233**	**2,539**	**65,989**
Net book value at 1 April 2019	**6,955**	**48,053**	**4,087**	**1,724**	**2,517**	**63,336**

Additions to buildings and plant and machinery above includes £65 (2018/29: £96k) of assets funded by capital grants, as disclosed as income in note 3 of these financial statements. Capital grants have been provided by the Norfolk Community Health and Care NHS Trust Charitable Funds to develop Trust property for the benefit of patients and to provide equipment which would not otherwise be available, and by Health Education England to develop facilities for junior doctors.

The impairments lines in the above note are made up of amounts going through the revaluation reserve of £528k, and through the SOCI of £854k.

Note 12.2 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	**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)**
Transfers to / from assets held for sale	-	-	-	-	-	**-**
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	**-**	**1,912**	**-**	**2,274**	**6,036**	**10,222**
Provided during the year	-	1,937	-	660	1,589	**4,186**
Impairments	-	(3,019)	-	-	-	**(3,019)**
Reversals of impairments	-	-	-	-	-	**-**
Revaluations	-	(1,003)	-	-	-	**(1,003)**
Reclassifications	-	220	-	(220)	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	**-**
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**

Note 12.3 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020						
Owned - purchased	8,099	46,393	3,089	1,233	2,539	**61,353**
Owned - government granted	-	97	-	-	-	**97**
Owned - donated	595	3,879	65	-	-	**4,539**
NBV total at 31 March 2020	**8,694**	**50,369**	**3,154**	**1,233**	**2,539**	**65,989**

Note 12.4 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	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**
NBV total at 31 March 2019	**6,955**	**48,053**	**4,087**	**1,724**	**2,517**	**63,336**

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 December 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 - Global Standards 2020 and the RICS Valuation – Global Standards 2017 – UK National Supplement, and the accounting framework.

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, and 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 2020	31 March 2019
	£000	£000
DRC - Modern equivalent asset basis (no alternative site	49,898	47,260
Market value in existing use	7,465	7,572
Fair value (surplus PPE land and buildings)	1,700	176
	59,063	**55,008**

Note 14 Inventories

	31 March 2020 £000	31 March 2019 £000
Drugs	10	-
Consumables	42	36
Other	143	137
Total inventories	**195**	**173**

Inventories recognised in expenses for the year were £6,806k (2018/19: £5,034k). Write-down of inventories recognised as expenses for the year were nil (2018/19: nil).

Note 15 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	8,889	13,643
Allowance for impaired contract receivables / assets	(3,317)	(2,338)
Prepayments	425	358
PDC dividend receivable	57	372
VAT receivable	200	192
Other receivables	-	-
Total current receivables	**6,254**	**12,227**
Of which receivable from NHS and DHSC group bodies:	4,537	9,273

Note 15.1 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances at 1 April	**2,338**	**-**	**-**	**1,447**
Effect of implementing IFRS 9 (and IFRS 15) on 1 April 2018*			1,608	(1,447)
New allowances arising	2,317	-	1,186	-
Reversals of allowances	(1,270)	-	(237)	-
Utilisation of allowances (write offs)	(68)	-	(219)	-
Allowances at 31 March	**3,317**	**-**	**2,338**	**-**

*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 15.2 Exposure to credit risk

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

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 2020			
0-30 days	1,935	-	1,935
31-90 days	425	41	384
91-365 days	1,657	391	1,266
Over 365 days	2,885	2,885	-
Total	**6,902**	**3,317**	**3,585**
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	2,237	566
Total	**6,978**	**2,338**	**4,634**

Note 16 Non-current assets held for sale

	31 March 2020	31 March 2019
	£000	£000
Net book value of non-current assets for sale at 1 April	**897**	**897**
Assets classified as available for sale in the year	174	-
Assets sold in year	(897)	-
Impairment of assets held for sale	(58)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**116**	**897**

One site held by the Trust and located in Norwich, Norfolk, was being actively marketed at 31 March 2019. This site was disposed of during 2019/20.

A further asset located in Aylsham, Norfolk, was being actively marketed at 31 March 2020. This site is expected to be disposed of during 2020/21.

Both sites were identified as surplus to operational requirements for the Norfolk and Waveney NHS region.

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.

	31 March 2020	31 March 2019
	£000	£000
Cash balance at 31 March	**25,973**	**17,437**
Broken down into:		
Cash at commercial banks and in hand	10	12
Cash with the Government Banking Service	25,963	17,425
Total cash and cash equivalents	**25,973**	**17,437**

Note 18 Trade and other payables

	31 March 2020	31 March 2019
	£000	£000
Current		
Trade payables	6,512	5,529
Capital payables	747	966
Accruals	8,027	4,953
Social security costs	1,864	1,434
Other payables	-	-
Total current trade and other payables	**17,151**	**12,882**
Of which payables from NHS and DHSC group bodies:	6,838	2,890

Note 19.1 Provisions for liabilities and charges analysis at 31 March 2020

	Pensions: injury benefits	Legal claims	Redundancy	VAT	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2019	**240**	**132**	**1,171**	**6,091**	**58**	**7,692**
Change in the discount rate	24	-	-	-	-	**24**
Arising during the year	8	475	311	75	1,479	**2,348**
Utilised during the year	(5)	(2)	(40)	(2,406)	-	**(2,453)**
Reversed unused	-	(10)	(815)	(3,760)	(9)	**(4,594)**
Unwinding of discount	-	-	-	-	-	**-**
At 31 March 2020	**267**	**595**	**627**	**-**	**1,528**	**3,017**
Expected timing of cash flows:						
- not later than one year;	11	595	627	-	1,528	**2,761**
- later than one year and not later than five years;	45	-	-	-	-	**45**
- later than five years.	211	-	-	-	-	**211**
Total	**267**	**595**	**627**	**-**	**1,528**	**3,017**

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 -0.51% (2018/19: 0.29%). 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, legal costs associated with disputing the VAT case noted above, 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 2020/21.

The VAT provision related to a challenge made by HMRC in 2018/29 on the Trust's reclaiming of VAT on two large contracts. HMRC have confirmed the Trust had correctly recovered VAT on one of these contracts, and the provision relating to this contract has been reversed unused during 2019/20. HMRC believes the Trust incorrectly reclaimed VAT on the second of these contracts, and this was paid to HMRC during 2019/20. The Trust continues to dispute this, and has indicated it wishes to progress to Tax Tribunal in respect of this.

The closing 'other' provision is for a challenge by a supplier on services they believe they have not been paid for dating back some years, a provision for the potential costs relating to holiday pay on overtime, and dilapidation provisions for leased properties. The timing of potential outflows for all these provisions is

Note 19.2 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**

Note 19.3 Clinical negligence liabilities

At 31 March 2020, £832k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Norfolk Community Health and Care NHS Trust (31 March 2019: £726k).

Note 20 Contingent assets and liabilities

	31 March 2020	31 March 2019
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(9)	(9)
Employment tribunal and other employee related litigation	-	-
Total value of contingent liabilities	**(9)**	**(9)**

There were no contingent assets at 31 March 2020 and 31 March 2019.

Note 21 Contractual capital commitments

	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	782	37
Total	**782**	**37**

Note 22 Financial instruments

Note 22.1 Financial risk management

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

Currency risk

The Trust is principally a domestic organisation with the 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 exposure as at 31 March 2020 are in receivables from customers, as disclosed in the trade and other receivables note.

The Trust is exposed to some risk from debt due for rent from certain GP surgeries. Surgeries can reclaim this expense back from NHS England/Improvement, but have yet to sign lease agreements to enable this to occur. Where uncertainty over recovery of this debt exists, debt has been provided for within the expected credit loss provision disclosed in note 20.3 of these financial statements.

Liquidity risk

The Trust's operating costs are mainly 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 risk.

Note 22.2 Carrying values of financial assets

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

Carrying values of financial assets at 31 March

	31 March 2020	31 March 2019
	£000	£000
Trade and other receivables excluding non financial assets	5,572	11,113
Cash and cash equivalents	25,973	17,437
Total of financial assets held at amortised cost	**31,545**	**28,550**

Note 22.3 Carrying values of financial liabilities

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

Carrying values of financial liabilities at 31 March

	31 March 2020	31 March 2019
	£000	£000
Trade and other payables excluding non financial liabilities	15,286	11,448
Provisions under contract	3,017	1,601
Total of financial liabilities held at amortised cost	**18,303**	**13,049**

Note 22.4 Maturity of financial liabilities

	31 March 2020	31 March 2019
	£000	£000
In one year or less	18,047	12,820
In more than one year but not more than two years	34	9
In more than two years but not more than five years	11	35
In more than five years	211	185
Total	**18,303**	**13,049**

Note 23 Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	2	2
Bad debts and claims abandoned	2	1	250	153
Stores losses and damage to property	-	-	1	-
Total losses	**2**	**1**	**253**	**155**
Special payments				
Ex-gratia payments	5	1	1	1
Total special payments	**5**	**1**	**1**	**1**
Total losses and special payments	**7**	**2**	**254**	**156**

Note 24 Events after the reporting date

Since the year end HMRC has changed its decision on the recoverability of VAT on a large historic contract. As a result, the Trust will receive approximately £2.3m from HMRC during 2020/21 for VAT paid on this contract.

Note 24 Related parties

The Department of Health and Social Care (the Department) is the Trust's parent department. During the 2019/20 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.

Those the Trust had transactions over £100,000 in the year were:

Norwich Clinical Commissioning Group (CCG)
Great Yarmouth and Waveney CCG
Ipswich and East Suffolk CCG
North Norfolk CCG
South Norfolk CCG
West Norfolk CCG
West Suffolk CCG
Cambridge and Peterborough CCG
Coventry and Warwickshire Partnership NHS Trust
Norfolk and Suffolk NHS Foundation Trust (FT)
Norfolk and Norwich University Hospitals NHS FT
Queen Elizabeth Hospital Kings Lynn NHS FT
Hertfordshire Partnership NHS FT

NHS England / Improvement
NHS Resolution
Department of Health and Social Care
Health Education England
NHS Business Services Authority
NHS Property Services Limited
Community Health Partnerships
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.

	2019/20	2018/19	31 March 2020	31 March 2019
	£000	£000	£000	£000
Total income received from the Charitable Fund	190	232		
Accounts receivable balance due from the Charitable Fund			69	7
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 25 Better Payment Practice code

Non-NHS Payables	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Total non-NHS trade invoices paid in the year	14,661	52,889	13,808	47,146
Total non-NHS trade invoices paid within target	10,305	31,363	10,109	33,738
Percentage of non-NHS trade invoices paid within target	70.3%	59.3%	73.2%	71.6%
NHS Payables				
Total NHS trade invoices paid in the year	860	7,839	403	4,346
Total NHS trade invoices paid within target	351	3,222	236	1,903
Percentage of NHS trade invoices paid within target	40.8%	41.1%	58.6%	43.8%

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

The Trust changed finance systems during 2019/20, which has affected the timeliness of invoice payment. The Trust is working with suppliers to improve this.

Note 25.1 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust had no costs for the late payment of commercial debts (interest) Act 1998.

Note 26 External financing limit

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.

	2019/20 £000	2018/19 £000
Cash flow financing	(8,401)	997
Other capital receipts	-	-
External financing requirement	**(8,401)**	**997**
External financing limit (EFL)	3,299	3,001
Under / (over) spend against EFL	**11,700**	**2,004**

Note 27 Capital Resource Limit

	2019/20 £000	2018/19 £000
Gross capital expenditure	4,744	3,682
Less: Disposals	(1,169)	(80)
Less: Donated and granted capital additions	(65)	(96)
Charge against Capital Resource Limit	**3,510**	**3,506**
Capital Resource Limit	4,587	3,742
Under / (over) spend against CRL	**1,077**	**236**

Note 28.1 Breakeven duty financial performance

	2019/20 £000	2018/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	509	(7,401)
Remove net impairments which are not included in the breakeven duty assessment	1,773	-
Breakeven duty financial performance surplus / (deficit)	**2,282**	**(7,401)**

Note 28.2 Breakeven duty rolling assessment

	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000
Breakeven duty in-year financial performance	552	637	2,683	4,630	2,628
Breakeven duty cumulative position	552	1,189	3,872	8,502	11,130
Operating income	130,709	127,725	124,843	123,266	123,796
Cumulative breakeven position as a percentage of operating income	0.4%	0.9%	3.1%	6.9%	9.0%

	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000
Breakeven duty in-year financial performance	2,129	2,695	- 1,275	- 7,401	509
Breakeven duty cumulative position	13,259	15,954	14,679	7,278	7,787
Operating income	129,920	133,126	119,791	110,702	117,682
Cumulative breakeven position as a percentage of operating income	10.2%	12.0%	12.3%	6.6%	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.

At 31 March 2020 the Trust had a cumulative breakeven position of £9.6m 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.

Note 29 Comparators

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

Note 8 discloses future minimum lease receipts due. In previous years, this note has assumed the Trust would receive one further year of rental income for properties where there was an established tenant but no lease agreement in place. This year, the note has been calculated on the basis of existing leases at 31 March only. This is assessed as providing a truer figure for minimum lease receipts due. Comparative results have been amended as follows:

	31 March 2019 original	Amendments made	31 March 2019 restated
	£000	£000	£000
Future minimum lease receipts due:			
- not later than one year;	440	(257)	183
- later than one year and not later than five years;	230	-	230
- later than five years.	59	-	59
Total	**729**	(257)	**472**

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 2020 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 2020 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 and Social Care Group Accounting Manual 2019/20.

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 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 and Social Care Group Accounting Manual 2019/20. 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 and Social Care Group Accounting Manual 2019/20.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 32, 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 33 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 33, 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 December 2019 and updated in April 2020 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 for the year ended 31 March 2020 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

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

2 June 2020

Norfolk Community Health and Care NHS Trust

Annual accounts for the year ended 31 March 2020

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	2	110,452	104,739
Other operating income	3	7,230	5,963
Operating expenses	5, 6	(115,285)	(121,145)
Operating surplus/(deficit)		**2,397**	**(10,444)**
PDC dividends payable		(1,832)	(2,119)
Net finance costs		**(1,832)**	**(2,119)**
Other gains / (losses)	10	61	(32)
Surplus / (deficit) for the year		**626**	**(12,595)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	5.3	(528)	(10,821)
Revaluations	13	4,679	5,137
Other reserve movements		(23)	-
Total comprehensive income / (expense) for the period		**4,754**	**(18,279)**

The Trust's financial performance is assessed by NHS England / Improvement using an adjusted financial result. The table below shows this adjusted financial result measure:

	2019/20	2018/19
Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	626	(12,595)
Remove net impairments which are not included in the adjusted result	(399)	5,230
Remove Statement of Comprehensive Income effect of capital grants and donations	282	(36)
Adjusted financial performance surplus / (deficit)	**509**	**(7,401)**

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	11	240	285
Property, plant and equipment	12	65,989	63,336
Total non-current assets		**66,229**	**63,621**
Current assets			
Inventories	18	195	173
Receivables	15	6,254	12,227
Non-current assets for sale and assets in disposal groups	16	116	897
Cash and cash equivalents	17	25,973	17,437
Total current assets		**32,538**	**30,734**
Current liabilities			
Trade and other payables	18	(17,151)	(12,882)
Provisions	19	(2,761)	(7,463)
Other liabilities		(277)	(348)
Total current liabilities		**(20,189)**	**(20,693)**
Total assets less current liabilities		**78,578**	**73,662**
Non-current liabilities			
Provisions	19	(256)	(229)
Total non-current liabilities		**(256)**	**(229)**
Total assets employed		**78,322**	**73,433**
Financed by			
Public dividend capital		15,770	15,635
Revaluation reserve		19,518	15,390
Income and expenditure reserve		43,034	42,408
Total taxpayers' equity		**78,322**	**73,433**

The notes on pages 103 to 142 form part of these accounts.

Name	Josie Spencer
Position	Chief Executive
Date	02 June 2020

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2019 - brought forward	**15,635**	**15,390**	**42,408**	**73,433**
Surplus/(deficit) for the year	-	-	626	**626**
Impairments	-	(528)	-	**(528)**
Revaluations	-	4,679	-	**4,679**
Other recognised gains and losses	-	-	-	**-**
Public dividend capital received	135	-	-	**135**
Other reserve movements	-	(23)	-	**(23)**
Taxpayers' equity at 31 March 2020	**15,770**	**19,518**	**43,034**	**78,322**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018	**15,414**	**21,074**	**55,164**	**91,652**
Effect of implementing IFRS 9 on 1 April 2018	-	-	(161)	**(161)**
Surplus/(deficit) for the year	-	-	(12,595)	**(12,595)**
Impairments	-	(10,821)	-	**(10,821)**
Revaluations	-	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 Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		2,397	(10,444)
Non-cash income and expense:			
Depreciation and amortisation	5	4,525	4,224
Net impairments	5.3	1,374	5,230
Income recognised in respect of capital donations	3	(65)	(96)
(Increase) / decrease in receivables and other assets		5,658	(2,081)
(Increase) / decrease in inventories		(22)	7
Increase / (decrease) in payables and other liabilities		4,417	2,455
Increase / (decrease) in provisions		(4,675)	6,289
Other movements in operating cash flows		(23)	7
Net cash flows from operating activities		**13,586**	**5,591**
Cash flows from investing activities			
Purchase of intangible assets		-	(280)
Purchase of PPE and investment property		(4,963)	(3,945)
Sales of PPE		1,230	-
Receipt of cash donations to purchase assets		65	96
Net cash flows (used in) investing activities		**(3,668)**	**(4,129)**
Cash flows from financing activities			
Public dividend capital received		135	221
PDC dividend (paid) / refunded		(1,517)	(2,459)
Cash flows from (used in) other financing activities		-	-
Net cash flows from / (used in) financing activities		**(1,382)**	**(2,238)**
Increase / (decrease) in cash and cash equivalents		**8,536**	**(776)**
Cash and cash equivalents at 1 April - brought forward		**17,437**	**18,213**
Cash and cash equivalents at 31 March	17	**25,973**	**17,437**

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 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 2019/20 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 the common control of NHS bodies are consolidated within the entity's financial statements. The Trust has determined that consolidation of its related Charitable Fund falls within this provision, however as the Charitable Fund is not considered material in the context of the Trust's accounts its results will not be consolidated. 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 various judgements, estimates and assumptions. 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.

Note 1.4.1 Critical accounting judgements and key sources of estimation uncertainty

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.

Note 1.4.1 Critical accounting judgements and key sources of estimation uncertainty continued

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

A full revaluation was performed at 31 December 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 - Global Standards 2020 and the RICS Valuation – Global Standards 2017 – UK National Supplement, 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 has been determined there has not been a material change in the fair value of land and buildings between 31 December 2019, when the revaluation of land and buildings was performed, and the balance date of 31 March 2020.

Note 1.4.2 Key sources of estimation uncertainty

The following are sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

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.

Value of expected credit losses
The Trust estimates the expected credit loss of accounts receivable balances and reduces the value of its accounts receivable balances by this estimate in the financial statements.

The value of the Trust's aged accounts receivable and the estimated credit losses of these debts are shown in the accounts receivable note to these financial statements. Accounting policy note 1.19.1 below explains how the expected credit loss is calculated.

The Trust has a significant amount of aged accounts receivable balances. The estimation of expected credit losses is therefore considered a material source of estimation uncertainty.

Note 1.5 Operating segments

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

Notes to the Accounts

Note 1.6 Revenue from contracts with customers

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

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

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for health care services. 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 patient. 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, and where material, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

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 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.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)
The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Sale of non-current assets
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 Revenue from contracts with customers continued

Expedients applied
In the application of IFRS 15 (the standard) a number of practical expedients offered in the standard have been employed. These are as follows:

• The Trust does not disclose information regarding performance obligations of part of a contract that has an original expected duration of one year or less,

• The Trust does not disclose information where revenue is recognised in line with the practical expedient offered in the standard, where the right to consideration corresponds directly with value of the performance completed to date.

• The Government Financial Reporting Manual (the FReM) has mandated the exercise of the practical expedient offered in the standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application of the standard on 1 April 2018.

Note 1.6.1 Apprenticeship levy

The cost of the apprenticeship levy paid to the Government is recognised as part of payroll expense.

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

When Trust staff utilise courses provided by 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.

Note 1.7 Expenditure on 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 has been accrued at 31 March 2020. This is because accrued leave has increased significantly as a result of the Trust's response to the covid19 pandemic. The cost of leave earned but not taken by employees at 1 April 2018 and 1 April 2019 was not accrued as it was immaterial.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Notes to the accounts

Note 1.7 Expenditure on employee benefits continued

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 Expenditure on other goods and services

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

Note 1.9 Clinical negligence costs

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

Note 1.10 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.

The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in the provisions note to the accounts, but is not recognised in the Trust's accounts.
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.

The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in the provisions note to the accounts, but is not recognised in the Trust's accounts.

Note 1.11 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
● it is held for use in delivering services or for administrative purposes;
● it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
● it is expected to be used for more than one financial year;
● the cost of the item can be measured reliably; and either
● the item 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.

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.

Notes to the accounts

Note 1.11 Property, plant and equipment continued

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.

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

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

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised.

Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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

Notes to the accounts

Note 1.12 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.

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

Measurement
Intangible assets acquired separately are initially recognised at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

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 1.13 Depreciation, amortisation, revaluation, and impairments

Depreciation and amortisation
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.

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

	Min life Years	Max life Years
Land	-	-
Buildings	1	73
Plant & machinery	1	23
Information technology	3	6
Furniture & fittings	-	-
Software licences	5	10

Leasehold improvements are depreciated over the shorter of the useful life or the lease term.

Note 1.13 Depreciation, amortisation, revaluation, and impairments continued

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
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.

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.14 Donated and granted assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.15 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 1.16 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 1.17 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 material effect on the financial statements.

Note 1.18 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. The sale must be highly probable and the asset available for immediate sale in its present condition. They are measured at the lower of their carrying amount and fair value less costs to sell.

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

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

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

Notes to the accounts

Note 1.19 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 1.19.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held 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.

Impairment
For all financial assets measured at amortised cost including lease receivables and contract assets the Trust recognises an allowance for expected credit losses.

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.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

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

Notes to the accounts

Note 1.20 Financial liabilities

Financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs.

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.

Note 1.21 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount for which it is probable that there will be a future outflow of cash or other resources and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

Note 1.22 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.

Note 1.22 Contingent liabilities and contingent assets continued

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.

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.

Note 1.23 Public dividend capital

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 and grant funded assets
• Average daily cash balances held with the Government Banking Service (GBS) (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 is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.24 Value added tax

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

Note 1.25 Currency

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

Notes to the accounts

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.

Note 1.27 Equity

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 and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend. This charge is reflected in the Statement of Comprehensive Income.

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.

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

Note 1.28 Early adoption of standards, amendments, and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Notes to the accounts

Note 1.29 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases
IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021 the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard.

The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does expect this standard to have a material effect on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations
The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2019-20. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020-21, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 14 Regulatory deferral accounts – not endorsed by the EU and not applicable to DHSC group bodies, including the Trust.
- 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 believe adopting this standard will not have a material effect on the financial statements.

Note 2 Operating income from patient care activities

Note 2.1 Income from patient care activities (by nature)

	2019/20	2018/19
	£000	£000
Community services income from CCGs and NHS England	96,730	91,804
Income from other sources (e.g. local authorities)	9,568	11,449
Private patient income	15	11
Agenda for Change pay award central funding*	-	1,166
Additional pension contribution central funding**	3,812	-
Other clinical income	327	309
Total income from activities	**110,452**	**104,739**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into contract income for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 2.2 Income from patient care activities (by source)

	2019/20	2018/19
Income from patient care activities received from:	£000	£000
NHS England	13,224	11,061
Clinical commissioning groups	87,449	80,743
Department of Health and Social Care	23	1,182
Other NHS providers	4,419	4,262
Local authorities	5,126	7,168
Non-NHS: private patients	15	11
Non NHS: other	196	312
Total income from activities	**110,452**	**104,739**

Note 3 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	511	-	**511**	511	-	**511**
Education and training	643	738	**1,381**	687	472	**1,159**
Non-patient care services to other bodies	1,424	-	**1,424**	1,883	-	**1,883**
Provider sustainability fund (PSF)	856	-	**856**	1,232	-	**1,232**
Financial recovery fund (FRF)	1,919	-	**1,919**	-	-	**-**
Receipt of capital grants and donations	-	65	**65**	-	96	**96**
Charitable and other contributions to expenditure	-	8	**8**	-	4	**4**
Rental revenue from operating leases	-	571	**571**	-	516	**516**
Other income	496	-	**496**	562	-	**562**
Total other operating income	**5,848**	**1,382**	**7,230**	**4,875**	**1,088**	**5,963**

Note 4.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	348	164
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0	0

Note 4.2 Transaction price allocated to remaining performance obligations

All revenue from existing contracts allocated to remaining performance obligations is expected to be recognised within one year.

Note 5 Operating expenses

	2019/20	2018/19
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,271	2,057
Purchase of healthcare from non-NHS and non-DHSC bodies	1,074	1,344
Staff and executive directors costs (see note 5.1)	83,239	78,167
Remuneration of non-executive directors (see note 5.1)	80	68
Supplies and services - clinical (excluding drugs costs)	5,868	6,700
Supplies and services - general	8,178	7,638
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	582	607
Consultancy costs	110	99
Establishment	938	857
Premises	3,019	2,347
Transport (including patient travel)	2,492	2,524
Depreciation on property, plant and equipment	4,488	4,186
Amortisation on intangible assets	37	38
Net impairments (see note 5.3)	1,374	5,230
Movement in credit loss allowance: contract receivables / contract assets	1,047	949
Increase/(decrease) in other provisions	(1,750)	6,460
Change in provisions discount rate(s)	24	(5)
Audit fees payable to the external auditor		
audit services- statutory audit	50	52
Internal audit costs	84	86
Clinical negligence	299	299
Legal fees	171	67
Insurance	5	13
Education and training	1,114	832
Rentals under operating leases	462	490
Car parking & security	29	32
Losses, ex gratia & special payments	1	7
Total	**115,285**	**121,145**

Note 5.1 Staff, executive director, and non-executive director costs

See the remuneration report within this annual report for further information on staff and director costs.

Note 5.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2019/20 and 2018/19.

Note 5.3 Impairment of assets

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Abandonment of assets in course of construction	1,773	-
Changes in market price	(399)	5,230
Total net impairments charged to operating surplus / deficit	**1,374**	**5,230**
Impairments charged to the revaluation reserve	528	10,821
Total net impairments	**1,902**	**16,051**

Note 6 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	64,002	61,750
Social security costs	6,043	5,796
Apprenticeship levy*	313	297
Employer's contributions to NHS pensions	12,516	8,313
Pension cost - other	26	11
Other employment benefits	127	167
Termination benefits**	(496)	862
Temporary staff (including agency)	1,091	1,214
Total staff costs	**83,621**	**78,410**
Of which		
Costs capitalised as part of assets	383	243
Costs recognised as an expense in the statement of comprehensive income	83,239	78,167

* The figure shown above represents the Trust's gross apprenticeship levy. The Trust utilises this by contributing towards the cost of staff apprenticeship training.

** Termination benefits are negative as a provision held at 1 April 2019 was not utilised as fewer staff were made redundant as a result of service closure than expected in 2019/20. The provision was therefore reversed unused.

Note 6.1 Retirements due to ill-health

During 2019/20 there was 1 early retirement from the Trust agreed on the grounds of ill-health (2 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £58k (£70k in 2018/19).

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

Note 7 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) 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 2020 is based on valuation data at 31 March 2019, updated to 31 March 2020 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 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 at 20.6%, and the Scheme Regulations were amended accordingly.

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.

c) Other defined contribution workplace pension scheme

The Trust also offers an additional defined contribution workplace pension scheme, the the National Employment Savings Scheme (NEST)). A minority of staff employed by the Trust are enrolled in this scheme. Additional information on accounting for the scheme is given in accounting policy note 1.7.

Note 8 Operating leases

Note 8.1 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. See note 29 for an amendment to the 31 March 2019 future minimum lease receipts due disclosed below.

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

	2019/20	2018/19
	£000	£000
Operating lease revenue		
Minimum lease receipts	571	516
Total	**571**	**516**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	180	183
- later than one year and not later than five years;	223	230
- later than five years.	19	59
Total	**422**	**472**

Note 8.2 Norfolk Community Health and Care NHS Trust as a lessee

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

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

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	462	490
Total	**462**	**490**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	808	909
- later than one year and not later than five years;	659	1,138
- later than five years.	552	632
Total	**2,019**	**2,679**

Note 9 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

There have been no costs incurred over £500 during 2019/20 or 2018/19 in relation to the late payment of commercial debts.

Note 10 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	61	-
Losses on disposal of assets	-	(32)
Total other gains / (losses)	**61**	**(32)**

Note 11.1 Intangible assets - 2019/20

	Software licences
	£000
Gross cost at 1 April 2019	**341**
Reclassifications from work in progress	-
Disposals / derecognition	(12)
Gross cost at 31 March 2020	**329**
Amortisation at 1 April 2019	**56**
Provided during the year	37
Disposals / derecognition	(4)
Amortisation at 31 March 2020	**89**
Net book value at 31 March 2020	**240**
Net book value at 1 April 2019	**285**

Note 11.2 Intangible assets - 2018/19

	Software licences
	£000
Gross cost at 1 April 2018	**61**
Reclassifications from work in progress (shown in the PPE note)	280
Disposals / derecognition	-
Gross cost at 31 March 2019	**341**
Amortisation at 1 April 2018	**18**
Provided during the year	38
Disposals / derecognition	-
Amortisation at 31 March 2019	**56**
Net book value at 31 March 2019	**285**
Net book value at 1 April 2018	**43**

Note 12.1 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**6,955**	**48,100**	**4,087**	**4,117**	**9,255**	**72,514**
Additions	1,713	-	2,987	44	-	**4,744**
Impairments	(18)	(1,811)	(1,772)	-	-	**(3,601)**
Reversals of impairments	-	1,310	-	-	-	**1,310**
Revaluations	97	3,042	-	-	-	**3,139**
Reclassifications	-	629	(2,148)	228	1,291	**-**
Transfers to / from assets held for sale	(53)	(123)	-	-	-	**(176)**
Disposals / derecognition	-	(68)	-	(750)	-	**(818)**
Valuation/gross cost at 31 March 2020	**8,694**	**51,079**	**3,154**	**3,639**	**10,546**	**77,112**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**47**	**-**	**2,393**	**6,738**	**9,178**
Provided during the year	-	2,658	-	561	1,269	**4,488**
Impairments	-	(447)	-	-	-	**(447)**
Reversals of impairments	-	-	-	-	-	**-**
Revaluations	-	(1,540)	-	-	-	**(1,540)**
Reclassifications	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	(2)	-	-	-	**(2)**
Disposals / derecognition	-	(6)	-	(548)	-	**(554)**
Accumulated depreciation at 31 March 2020	**-**	**710**	**-**	**2,406**	**8,007**	**11,123**
Net book value at 31 March 2020	**8,694**	**50,369**	**3,154**	**1,233**	**2,539**	**65,989**
Net book value at 1 April 2019	**6,955**	**48,053**	**4,087**	**1,724**	**2,517**	**63,336**

Additions to buildings and plant and machinery above includes £65 (2018/29: £96k) of assets funded by capital grants, as disclosed as income in note 3 of these financial statements. Capital grants have been provided by the Norfolk Community Health and Care NHS Trust Charitable Funds to develop Trust property for the benefit of patients and to provide equipment which would not otherwise be available, and by Health Education England to develop facilities for junior doctors.

The impairments lines in the above note are made up of amounts going through the revaluation reserve of £528k, and through the SOCI of £854k.

Note 12.2 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	**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)**
Transfers to / from assets held for sale	-	-	-	-	-	**-**
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	**-**	**1,912**	**-**	**2,274**	**6,036**	**10,222**
Provided during the year	-	1,937	-	660	1,589	**4,186**
Impairments	-	(3,019)	-	-	-	**(3,019)**
Reversals of impairments	-	-	-	-	-	**-**
Revaluations	-	(1,003)	-	-	-	**(1,003)**
Reclassifications	-	220	-	(220)	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	**-**
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**

Note 12.3 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020						
Owned - purchased	8,099	46,393	3,089	1,233	2,539	**61,353**
Owned - government granted	-	97	-	-	-	**97**
Owned - donated	595	3,879	65	-	-	**4,539**
NBV total at 31 March 2020	**8,694**	**50,369**	**3,154**	**1,233**	**2,539**	**65,989**

Note 12.4 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	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**
NBV total at 31 March 2019	**6,955**	**48,053**	**4,087**	**1,724**	**2,517**	**63,336**

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 December 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 - Global Standards 2020 and the RICS Valuation – Global Standards 2017 – UK National Supplement, and the accounting framework.

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, and 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 2020	31 March 2019
	£000	£000
DRC - Modern equivalent asset basis (no alternative site	49,898	47,260
Market value in existing use	7,465	7,572
Fair value (surplus PPE land and buildings)	1,700	176
	59,063	**55,008**

Note 14 Inventories

	31 March 2020 £000	31 March 2019 £000
Drugs	10	-
Consumables	42	36
Other	143	137
Total inventories	**195**	**173**

Inventories recognised in expenses for the year were £6,806k (2018/19: £5,034k). Write-down of inventories recognised as expenses for the year were nil (2018/19: nil).

Note 15 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	8,889	13,643
Allowance for impaired contract receivables / assets	(3,317)	(2,338)
Prepayments	425	358
PDC dividend receivable	57	372
VAT receivable	200	192
Other receivables	-	-
Total current receivables	**6,254**	**12,227**
Of which receivable from NHS and DHSC group bodies:	4,537	9,273

Note 15.1 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances at 1 April	**2,338**	**-**	**-**	**1,447**
Effect of implementing IFRS 9 (and IFRS 15) on 1 April 2018*			1,608	(1,447)
New allowances arising	2,317	-	1,186	-
Reversals of allowances	(1,270)	-	(237)	-
Utilisation of allowances (write offs)	(68)	-	(219)	-
Allowances at 31 March	**3,317**	**-**	**2,338**	**-**

*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 15.2 Exposure to credit risk

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

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 2020			
0-30 days	1,935	-	1,935
31-90 days	425	41	384
91-365 days	1,657	391	1,266
Over 365 days	2,885	2,885	-
Total	**6,902**	**3,317**	**3,585**
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	2,237	566
Total	**6,978**	**2,338**	**4,634**

Note 16 Non-current assets held for sale

	31 March 2020	31 March 2019
	£000	£000
Net book value of non-current assets for sale at 1 April	**897**	**897**
Assets classified as available for sale in the year	174	-
Assets sold in year	(897)	-
Impairment of assets held for sale	(58)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**116**	**897**

One site held by the Trust and located in Norwich, Norfolk, was being actively marketed at 31 March 2019. This site was disposed of during 2019/20.

A further asset located in Aylsham, Norfolk, was being actively marketed at 31 March 2020. This site is expected to be disposed of during 2020/21.

Both sites were identified as surplus to operational requirements for the Norfolk and Waveney NHS region.

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.

	31 March 2020	31 March 2019
	£000	£000
Cash balance at 31 March	**25,973**	**17,437**
Broken down into:		
Cash at commercial banks and in hand	10	12
Cash with the Government Banking Service	25,963	17,425
Total cash and cash equivalents	**25,973**	**17,437**

Note 18 Trade and other payables

	31 March 2020	31 March 2019
	£000	£000
Current		
Trade payables	6,512	5,529
Capital payables	747	966
Accruals	8,027	4,953
Social security costs	1,864	1,434
Other payables	-	-
Total current trade and other payables	**17,151**	**12,882**
Of which payables from NHS and DHSC group bodies:	6,838	2,890

Note 19.1 Provisions for liabilities and charges analysis at 31 March 2020

	Pensions: injury benefits	Legal claims	Redundancy	VAT	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2019	**240**	**132**	**1,171**	**6,091**	**58**	**7,692**
Change in the discount rate	24	-	-	-	-	**24**
Arising during the year	8	475	311	75	1,479	**2,348**
Utilised during the year	(5)	(2)	(40)	(2,406)	-	**(2,453)**
Reversed unused	-	(10)	(815)	(3,760)	(9)	**(4,594)**
Unwinding of discount	-	-	-	-	-	**-**
At 31 March 2020	**267**	**595**	**627**	**-**	**1,528**	**3,017**
Expected timing of cash flows:						
- not later than one year;	11	595	627	-	1,528	**2,761**
- later than one year and not later than five years;	45	-	-	-	-	**45**
- later than five years.	211	-	-	-	-	**211**
Total	**267**	**595**	**627**	**-**	**1,528**	**3,017**

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 -0.51% (2018/19: 0.29%). 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, legal costs associated with disputing the VAT case noted above, 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 2020/21.

The VAT provision related to a challenge made by HMRC in 2018/29 on the Trust's reclaiming of VAT on two large contracts. HMRC have confirmed the Trust had correctly recovered VAT on one of these contracts, and the provision relating to this contract has been reversed unused during 2019/20. HMRC believes the Trust incorrectly reclaimed VAT on the second of these contracts, and this was paid to HMRC during 2019/20. The Trust continues to dispute this, and has indicated it wishes to progress to Tax Tribunal in respect of this.

The closing 'other' provision is for a challenge by a supplier on services they believe they have not been paid for dating back some years, a provision for the potential costs relating to holiday pay on overtime, and dilapidation provisions for leased properties. The timing of potential outflows for all these provisions is

Note 19.2 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**

Note 19.3 Clinical negligence liabilities

At 31 March 2020, £832k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Norfolk Community Health and Care NHS Trust (31 March 2019: £726k).

Note 20 Contingent assets and liabilities

	31 March 2020	31 March 2019
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(9)	(9)
Employment tribunal and other employee related litigation	-	-
Total value of contingent liabilities	**(9)**	**(9)**

There were no contingent assets at 31 March 2020 and 31 March 2019.

Note 21 Contractual capital commitments

	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	782	37
Total	**782**	**37**

Note 22 Financial instruments

Note 22.1 Financial risk management

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

Currency risk

The Trust is principally a domestic organisation with the 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 exposure as at 31 March 2020 are in receivables from customers, as disclosed in the trade and other receivables note.

The Trust is exposed to some risk from debt due for rent from certain GP surgeries. Surgeries can reclaim this expense back from NHS England/Improvement, but have yet to sign lease agreements to enable this to occur. Where uncertainty over recovery of this debt exists, debt has been provided for within the expected credit loss provision disclosed in note 20.3 of these financial statements.

Liquidity risk

The Trust's operating costs are mainly 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 risk.

Note 22.2 Carrying values of financial assets

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

Carrying values of financial assets at 31 March

	31 March 2020	31 March 2019
	£000	£000
Trade and other receivables excluding non financial assets	5,572	11,113
Cash and cash equivalents	25,973	17,437
Total of financial assets held at amortised cost	**31,545**	**28,550**

Note 22.3 Carrying values of financial liabilities

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

Carrying values of financial liabilities at 31 March

	31 March 2020	31 March 2019
	£000	£000
Trade and other payables excluding non financial liabilities	15,286	11,448
Provisions under contract	3,017	1,601
Total of financial liabilities held at amortised cost	**18,303**	**13,049**

Note 22.4 Maturity of financial liabilities

	31 March 2020	31 March 2019
	£000	£000
In one year or less	18,047	12,820
In more than one year but not more than two years	34	9
In more than two years but not more than five years	11	35
In more than five years	211	185
Total	**18,303**	**13,049**

Note 23 Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	2	2
Bad debts and claims abandoned	2	1	250	153
Stores losses and damage to property	-	-	1	-
Total losses	**2**	**1**	**253**	**155**
Special payments				
Ex-gratia payments	5	1	1	1
Total special payments	**5**	**1**	**1**	**1**
Total losses and special payments	**7**	**2**	**254**	**156**

Note 24 Events after the reporting date

Since the year end HMRC has changed its decision on the recoverability of VAT on a large historic contract. As a result, the Trust will receive approximately £2.3m from HMRC during 2020/21 for VAT paid on this contract.

Note 24 Related parties

The Department of Health and Social Care (the Department) is the Trust's parent department. During the 2019/20 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.

Those the Trust had transactions over £100,000 in the year were:

Norwich Clinical Commissioning Group (CCG)
Great Yarmouth and Waveney CCG
Ipswich and East Suffolk CCG
North Norfolk CCG
South Norfolk CCG
West Norfolk CCG
West Suffolk CCG
Cambridge and Peterborough CCG
Coventry and Warwickshire Partnership NHS Trust
Norfolk and Suffolk NHS Foundation Trust (FT)
Norfolk and Norwich University Hospitals NHS FT
Queen Elizabeth Hospital Kings Lynn NHS FT
Hertfordshire Partnership NHS FT

NHS England / Improvement
NHS Resolution
Department of Health and Social Care
Health Education England
NHS Business Services Authority
NHS Property Services Limited
Community Health Partnerships
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.

	2019/20	2018/19	31 March 2020	31 March 2019
	£000	£000	£000	£000
Total income received from the Charitable Fund	190	232		
Accounts receivable balance due from the Charitable Fund			69	7
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 25 Better Payment Practice code

Non-NHS Payables	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Total non-NHS trade invoices paid in the year	14,661	52,889	13,808	47,146
Total non-NHS trade invoices paid within target	10,305	31,363	10,109	33,738
Percentage of non-NHS trade invoices paid within target	70.3%	59.3%	73.2%	71.6%
NHS Payables				
Total NHS trade invoices paid in the year	860	7,839	403	4,346
Total NHS trade invoices paid within target	351	3,222	236	1,903
Percentage of NHS trade invoices paid within target	40.8%	41.1%	58.6%	43.8%

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

The Trust changed finance systems during 2019/20, which has affected the timeliness of invoice payment. The Trust is working with suppliers to improve this.

Note 25.1 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust had no costs for the late payment of commercial debts (interest) Act 1998.

Note 26 External financing limit

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.

	2019/20 £000	2018/19 £000
Cash flow financing	(8,401)	997
Other capital receipts	-	-
External financing requirement	**(8,401)**	**997**
External financing limit (EFL)	3,299	3,001
Under / (over) spend against EFL	**11,700**	**2,004**

Note 27 Capital Resource Limit

	2019/20 £000	2018/19 £000
Gross capital expenditure	4,744	3,682
Less: Disposals	(1,169)	(80)
Less: Donated and granted capital additions	(65)	(96)
Charge against Capital Resource Limit	**3,510**	**3,506**
Capital Resource Limit	4,587	3,742
Under / (over) spend against CRL	**1,077**	**236**

Note 28.1 Breakeven duty financial performance

	2019/20 £000	2018/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	509	(7,401)
Remove net impairments which are not included in the breakeven duty assessment	1,773	-
Breakeven duty financial performance surplus / (deficit)	**2,282**	**(7,401)**

Note 28.2 Breakeven duty rolling assessment

	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000
Breakeven duty in-year financial performance	552	637	2,683	4,630	2,628
Breakeven duty cumulative position	552	1,189	3,872	8,502	11,130
Operating income	130,709	127,725	124,843	123,266	123,796
Cumulative breakeven position as a percentage of operating income	0.4%	0.9%	3.1%	6.9%	9.0%

	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000
Breakeven duty in-year financial performance	2,129	2,695	- 1,275	- 7,401	509
Breakeven duty cumulative position	13,259	15,954	14,679	7,278	7,787
Operating income	129,920	133,126	119,791	110,702	117,682
Cumulative breakeven position as a percentage of operating income	10.2%	12.0%	12.3%	6.6%	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.

At 31 March 2020 the Trust had a cumulative breakeven position of £9.6m 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.

Note 29 Comparators

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

Note 8 discloses future minimum lease receipts due. In previous years, this note has assumed the Trust would receive one further year of rental income for properties where there was an established tenant but no lease agreement in place. This year, the note has been calculated on the basis of existing leases at 31 March only. This is assessed as providing a truer figure for minimum lease receipts due. Comparative results have been amended as follows:

	31 March 2019 original	Amendments made	31 March 2019 restated
	£000	£000	£000
Future minimum lease receipts due:			
- not later than one year;	440	(257)	183
- later than one year and not later than five years;	230	-	230
- later than five years.	59	-	59
Total	**729**	(257)	**472**