Norfolk Community Health and Care NHS Trust

Annual Report and Accounts 2016/17

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Note: Norfolk Community Health and Care NHS Trust is abbreviated to NCHC throughout this report. Other frequently used abbreviations include:

NHS England NHSE
NHS Improvement NHS I
Clinical Commissioning Groups CCGs
Norfolk County Council NCC
Care Quality Commission CQC
Non Executive Director NED

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A. PERFORMANCE REPORT

1. Overview

This section of the Annual Report includes:

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

The purpose of the overview section is to give the reader a short summary that provides sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year. The overview will be enough for the lay reader to have no need to look further into the rest of the Annual Report and Accounts unless they are interested in further detail or have specific accountability or decision-making needs to be met.

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

1.1 Chief Executive's statement

Our new Chair, Geraldine Broderick, joined the Trust in June 2016 and we said goodbye and thanks to Ken Applegate and wished him well in his retirement. Again this year we have delivered cost improvements without seeing a negative impact on the quality of services, and we have embedded a robust quality impact assessment process to ensure we review the effects of our transformational change programme. We have commenced our Quality Champions Programme, aiming to create a social movement within our organisation by cultivating and supporting a culture for quality improvement in our teams. The aim is for 10% of all staff to have gone through this programme over the next few years.

We have further developed our integrated care services for adults and our work with Norfolk County Council (NCC) is achieving a more effective health and social care service that supports people in a way that works for them and maximises their independence. The Integrated Care Service includes all community health and social care services for adults provided in Norwich, North, South and West Norfolk. Our Specialist Community Learning Disabilities teams are also integrated teams and based in five areas across Norfolk – our specialist teams offer person centred service to individuals with Learning Disabilities, their families and carers. We have also continued to provide community services in East and West Suffolk, developing our integrated community provision.

Along with our partners at NCC we have talent mapped our future leaders to ensure we support career progression in a way that will equip us for the future.

Since we were awarded our ‘Good’ rating by the Care Quality Commission in 2014, we have undertaken further work to ensure we retain our ‘Good’ rating and move forwards through continual quality improvement in our aspirations for an ‘Outstanding’ rating in the future. We have been learning from other high performing trusts and frequently use national benchmarking data to improve the services that we provide. We have launched our Health and Care Strategy with an ambitious work plan being developed that will drive our future workforce requirements.

We have launched “Your Voice Our Future”, which is our crowd-sourcing engagement platform for staff. We have held four online conversations which have helped us shape our plans for change around the priorities staff have expressed to us. These have included improving the consistency of leadership, refreshing the Behaviour Framework (this describes how we work with each other and relate to our patients, service users, carers, and partner organisations) and making practical changes to our environment and information technology.

Our Friends and Family Test results consistently show that 98% of patients recommend our services. NCHC is in the top five Community Trusts in the country with the highest percentage recommendation via this measure.

Our staff survey has shown us that for every 10 staff responses, nine of our staff believe we are making a difference to patients, eight believe team members communicate closely to achieve the team’s objectives and seven of our staff would be happy for their family to be treated here. The staff survey also showed areas where we have further work to do and where we have not progressed as quickly as we would have liked.

Continuing to deliver our vision and strategic priorities, within our values of community, compassion and creativity remains our focus. You will see not only our progress in this report but also the outstanding contributions our staff make every single day in the examples we have included. The Annual Report and Accounts is usefully read in conjunction with our:

Annual Plan: which describes in more detail our plans and priorities for the next two years.

Quality Account: an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive, and patient feedback about the care provided. Much more detail on the quality of our services is reported in the Quality Account, including our Quality Goals and Quality Improvement Strategy.

These documents are available on the Trust’s website.

1.2. Statement of the purpose and activities of the Trust

NCHC was established on 1 November 2010 to provide community-based health and care services. NHS trusts were established under the National Health Service and Community Care Act 1990, with each NHS Trust individually being established by Statutory Instrument (NCHC reference: 2010 no. 2466). Services are

commissioned by clinical commissioning groups (CCGs), Norfolk County Council (NCC) and NHS England (NHSE).

Following public consultation on becoming a foundation trust (FT) in 2011 the application proceeded to assessment by Monitor (the independent regulator, now part of NHS I) but was later withdrawn in September 2016 following a postponement phase. NCHC operated with a shadow FT governance model including a Council of Governors, and public and staff membership, between November 2013 and September 2016. The Board subsequently stood down the shadow Council of Governors but retained the public membership as a component of its Patient Experience and Engagement Strategy.

This section includes NCHC's:

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

Longer term plans:
1.2.4 Health and Care Strategy
1.2.5 Sustainability and Transformation Plan
1.2.6 Transformation Programme
1.2.7 Integration with Adult Social Care.

Graphic showing our Vision and Values

1.2.1 Vision and strategic priorities

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

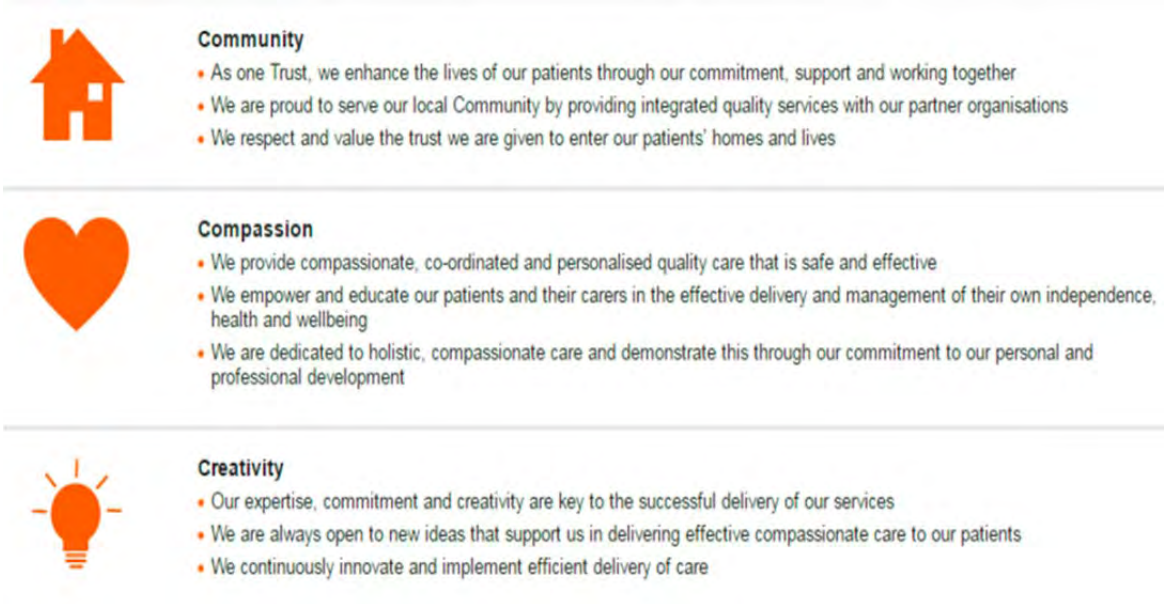
Improving Our Quality: through delivering harm free, clinically effective and compassionate care; involving patients and the public and delivering excellent patient experience; and integrating delivery with social and primary care and having effective partnerships with other organisations.

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

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

1.2.2 Values

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



1.2.3 Services provided by NCHC

NCHC provides the following services

NCHC service areas	
Community nursing	**Admission avoidance**
Rehabilitation, including inpatient beds	**Palliative and end of life care**
Specialist palliative care, including beds	**Long-term conditions management**
Musculoskeletal services	**Case management**
Specialist neuro- rehabilitation	**Stroke rehabilitation**
Amputee and post-surgical rehabilitation	**'Hard to reach' community care**
Diagnostics	**Adult speech and language therapy**
Podiatry and biomechanics	**Wheelchair assessment**
Continence- adults and children	**Dermatology**
Child health information service	**Smoking cessation**
Dental services	**Adult learning disabilities**
Prosthetics	**GP services for the homeless**
SureStart	**Children's community nursing**
Children's therapies	**Community paediatrics**
Children's short Breaks	**Clinical support services**
Norfolk Early Supported Discharge	**Suffolk Early Supported Discharge**
Environmental controls	**Rapid Assessment Team**
Infection Prevention and Control Liaison Nurse	**Looked after children**
Orthopaedic triage	**Prison continence**

Longer term plans

This section includes:

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

1.2.4 The Health and Care Strategy

This Strategy sets out a clear role for NCHC in the provision of services to support adults and children either at home or close to home, particularly those who are vulnerable, with complex needs, or suffering with long term conditions. The success of the strategy will require our commitment to:

- Truly empower our patients and value the contribution of carers, maximising the health and wellbeing of both.
- Build on our ambitions for delivering integrated care.
- Implement a 'grow your own' workforce strategy, introducing new career structures from bands 1-8.

- Do more in terms of innovation and technology.
- Recruit and empower a Health and Care Council to drive forward the implementation of the strategy.
- Develop more formal relationships with the voluntary sector and the use of community assets.
- Acknowledge and meet the challenges set out in NHS England (2014) Five Year Forward View for both cost improvement and effectiveness of care.

1.2.5 Sustainability and Transformation Plan

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

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

1.2.6 Transformation Programme

The table below describes how NCHC’s Transformation Programme aligns with the STP.

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

1.2.7 Integration with Adult Social Care

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

1.3 Key Risks and Issues

This section includes:

1.3.1 Strategic risks
1.3.2 Service changes
1.3.3 Policy drivers

1.3.1 Strategic risks

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

- Risks to improving our quality:
    - delivering harm free care;
    - adequate funding of the Suffolk services contract;
    - implementation of the Health and Care Strategy; and
    - implementation of the Integration Programme.
- Risks to enabling our people:
    - change management;
    - staff engagement; and
    - staff deployment.
- Risks to securing the Future:
    - delivering the cost improvement programme;
    - managing high risk cost pressures; and
    - maintaining good commissioner relations.

1.3.2 Service changes

There are a number of opportunities and challenges that will arise from time to time. These will include both the tendering of NCHC's existing services and services which are outside NCHC's current portfolio. These would therefore align to the 'defend, grow and diversify' strategies within NCHC's Integrated Business Plan (IBP). NCHC undertakes scenario planning based on winning or losing contracts, 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 won the following procurements to provide:

- Integrated Palliative Care Service: this is a five year standalone contract with West Norfolk CCG, partnering with Tapping House and Marie Curie as subcontractors.
- Integrated Therapy Service: this is a three plus two year standalone contract with West Norfolk CCG, partnering with Global Diagnostics and Allied Health Professionals (Suffolk) as subcontractors.

NCHC also supported the transition out of the Trust of musculoskeletal services in North Norfolk. The Trust has also given notice to Commissioners on the provision of the Lymphoedemia service. In 2017/18, the Trust will be losing smoking cessation services and the child health information service from April 2017, and Suffolk community health services from October 2017.

1.3.3 Policy drivers

Local policy drivers derive from the commissioning intentions and actions of Norfolk and Suffolk CCGs, NCC and NHSE. National policy is primarily contained within NHSE and NHS I's joint publication of the Operational and Contracting Planning Guidance. For the first time this covers two financial years to provide greater stability, support transformation, and is underpinned by a two-year NHS Standard

Contract. It provides local NHS organisations with an update on the national priorities as well as updating longer term financial challenges for local systems.

1.4 Performance Summary

This section includes information on:

1.4.1 CQC rating
1.4.2 Single Oversight Framework segmentation

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

1.4.1 CQC rating

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

CQC current rating of services

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

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

1.4.2 Single Oversight Framework segmentation

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams. NHS I has introduced the Single Oversight Framework which is designed to help NHS providers attain and maintain Care Quality Commission ratings of 'Good' or 'Outstanding'. The framework helps identify NHS providers' potential support needs across five themes: (1) quality of care, (2) finance and use of resources, (3) operational performance, (4) strategic change, and (5) leadership and improvement capability. Trusts are placed into one of four segments according to the level of universal, tailored or mandated support each one requires. NCHC was placed into segment two for targeted support to help with specific areas.

2. Performance Analysis

This section includes:

2.1 Key performance measures and analysis

2.1.1 Operational performance against key metrics

NCHC uses the following key metrics to measure performance against the CQC domains and finance metrics:

- Caring: Friends and Family Test, complaints, mixed sex accommodation breaches.
- Well-led: data quality, NHS staff survey, turnover rates, sickness absence, agency spend, annual appraisal rates.
- Effective: unexpected deaths.
- Safe: hospital acquired infection, Never Events, Harm Free Care, serious incidents, central alert system.
- Responsive: referral to treatment waiting times, diagnostic waiting times, appointment cancellations, access to healthcare for people with a learning disability.
- Finance: surplus, efficiency, capital resource limit.

For the last 3 years NCHC has reported performance against the relevant indicators in the TDA's Accountability Framework. However, as the regulator and final arbiter of quality, the CQC model is based on a broader and more comprehensive set of indicators which are used to highlight where a trust is an outlier compared to its peers. These metrics are reported in detail in the Quality Account. In order to be effective in its oversight and performance management of trusts, the TDA's framework used a narrower set of metrics, all of which can be updated frequently so

that changes in performance can be identified and addressed promptly. The TDA (now NHS I) also has a role in ensuring that trusts deliver on commitments made to patients in the NHS Constitution, such as maximum waiting times, and must be able to monitor whether trusts are meeting these standards. The framework has been superseded by the Single Oversight Framework but for comparative purposes the Annual Report presents the information in the same format as in previous years. More detail on financial performance is provided in the Financial Statements section of the Annual Report.

The table below shows current (2016/17) performance against these metrics compared to the previous year (2015/6).

Table showing performance against key performance metrics compared to the previous year

Metric	Period	Standard	Performance
Caring			
Inpatient scores from Friends and Family Test (net promoter score)	2015/16 2016/17	N/A	98% 98%
Complaints	2015/16 2016/17	N/A	236 225
Mixed sex accommodation breaches	2015/16 2016/17	0 0	0 0
Well-led			
Data Quality of trust returns to Health & Social Care Information Centre	2015/16 2016/17	96%	99.9% 100%
NHS Staff Survey: Index measure of staff who would recommend the trust as a place to work or receive treatment (compared to community trusts' average)	2015/16 2016/17	3.66 3.72	3.5 3.58
Trust turnover rate	2015/16 2016/17	7-17%	12.4% 13.9%
Trust level total sickness rate	2015/16 2016/17	4% 4%	5.3% 5.5%
Temporary agency spend as % total pay bill	2015/16 2016/17	Not applicable	4.5% 4.0%
Percentage of staff with annual appraisal	2015/16 2016/17	90% 90%	78.2% 83.43%
Mandatory training: % of staff compliant at the end of each month	2015/16 2016/17	90% 90%	91.1% 92.2%
Effective			
Deaths in low risk conditions. Unexpected deaths [Incidents: Deaths]	2015/16 2016/17	Not applicable	10 5
Safe			
Clostridium difficile – hospital acquired infection	2015/16 2016/17	7 7	7 7
MRSA – hospital acquired infection	2015/16 2016/17	0 0	0 0
Never Event incidence	2015/16 2016/17	0 0	0 0

Medication incidents reported	2015/16 2016/17	Not applicable	469 577
Percentage of Harm Free Care	2015/16 2016/17	97% 92%	Norfolk 90% Norfolk: 91% Suffolk: 94%
Venous thromboembolism assessments on patients admitted to our community hospitals	2015/16 2016/17	95% 95%	95.1% 96.1%
Serious incidents (pressure ulcers (PUs) grade 4 and grade 3 and others) NB Since May 2016 PUs reported as SIRI only if deemed to be preventable by NCHC, hence drop in numbers over last year.	2015/16 2016/17	Not applicable	PUs: 518 Other: 32 PUs: 220 Other 35
Central Alerting System alerts	2015/16 2016/17	Not applicable	100% 100%
Responsive			
18 week performance: % of all patients seen within 18 weeks of referrals (excl. patient choice, clinical reasons and diagnostic delays)	2015/16 2016/17	95% 95%	97.9% 96.7%
18 week performance: % of all patients still waiting at month end within 18 weeks of referrals (excl. patient choice, clinical reasons and diagnostic delays)	2015/16 2016/17	 92%	Not available 96.5%
RTT over 52 week waiters	2015/16 2016/17	0 0	0% 0%
Diagnostic waiting times: percentage patients waiting over 6 weeks for a diagnostic test	2015/16 2016/17	1%	0% 0%
Patients not treated within 28 days of last minute cancellation due to non-clinical reasons	2015/16 2016/17	0% 0%	0% 0%
Compliance regarding access to health care for people with a learning disability	2015/16 2016/17	Yes	Yes Yes
Finance			
NHS financial performance surplus for the year actual compared to plan	2015/16 2016/17	Planned £2,083k Planned £1,770k	Actual £2,121k Actual £2,695k
Actual efficiency recurring – actual compared to plan	2015/16 2016/17	Planned £6,850k Planned £5,400k	Actual £5,683k Actual £2,329k
Forecast year to end charge to capital resource limit	2015/16 2016/17	Planned £4,400k Planned £4,172k	Actual £4,396k Actual £4,137k
Is the Trust forecasting permanent Public Dividend Capital for liquidity purposes?	2015/16 2016/17	No No	No No

2.1.2 Patients' experience

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

This section includes

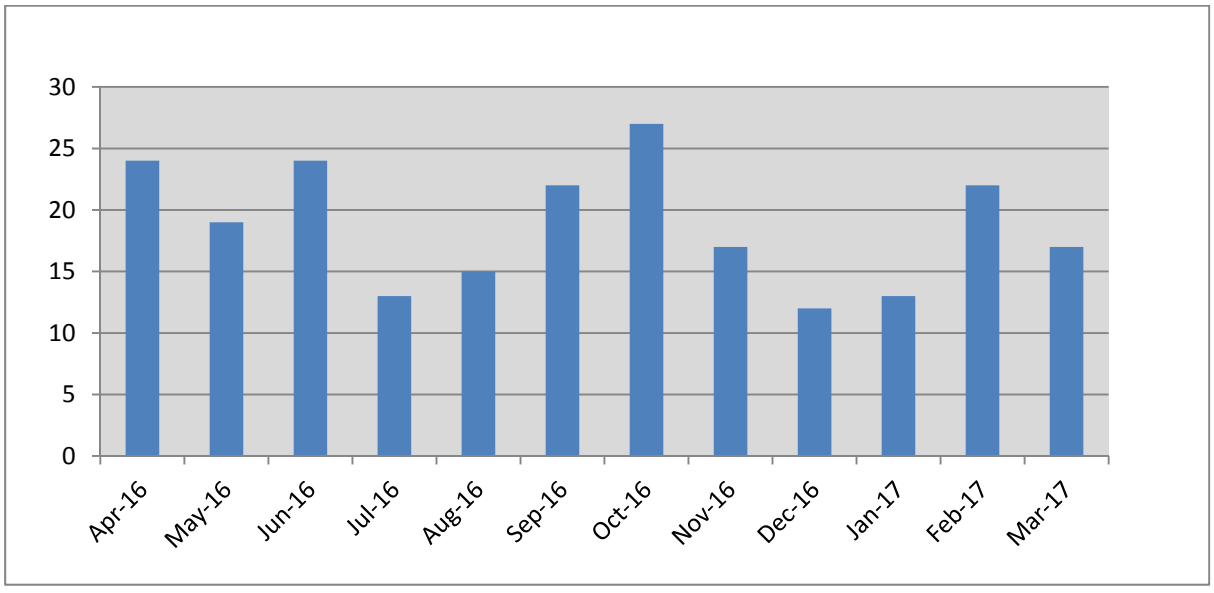
- Complaints
- Compliments
- Friends and Family Test

Complaints

During the year NCHC received 225 complaints, in comparison to 236 during the year 2015/2016. Themes and learning from complaints have been regularly discussed at committees and Board, noted as:

- A theme from the previous year has continued into this year around community paediatrics, and the waiting times for patients to be seen, in particular on the Autistic Spectrum Disorder pathway. This is the subject of on-going discussions with commissioners to resolve;
- Foot health complaints, due to changes in the service specification criteria around which patients are eligible for treatment;
- Changes to the car parking machines, and signage, at Norwich Community Hospital which has led to a number of unjustified parking fines.

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



The continual process of learning from complaints continues, with themes being published in the monthly Safety and Quality Newsletter. Emerging themes are reviewed on a monthly basis with more detailed mid-year reviews.

During the year two external complaint reviews took place which looked at the quality and standard of care for two separate patients, due to the complexity of the concerns

raised. The outcome from these investigations has been shared with a wide group of staff for learning purposes.

Non-Executive Directors also routinely undertake deep-dive exercises into individual complaints for wider organisational learning. Three have taken place during the year, all of which have confirmed that the complaints were handled well, sometimes in difficult circumstances, and there is good evidence that learning has been taken on board and shared.

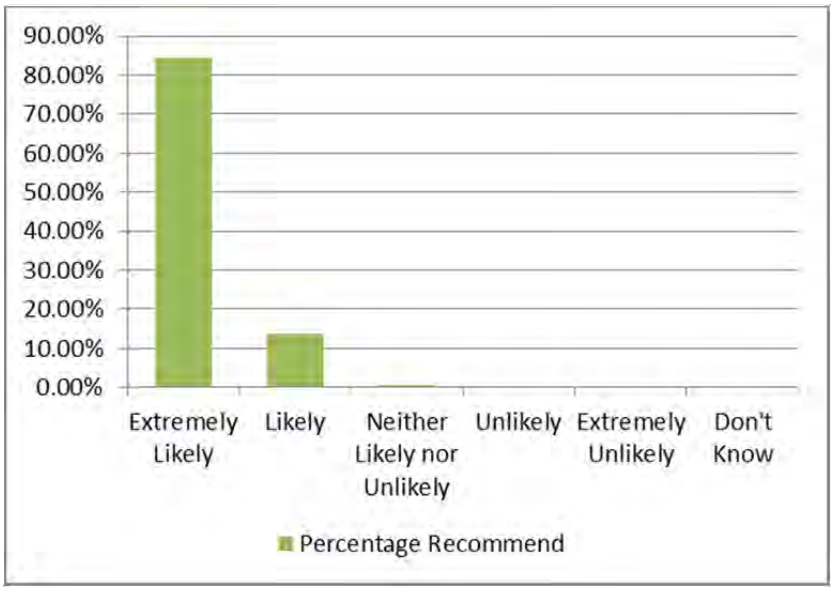
Compliments

When our patients take the time to write and express their thanks or compliment a team or a service we take great pride in sharing them with our staff. We keep a record of all the compliments we receive as these are a really important measure for us when we are thinking about quality of care. This year we logged 1,230 compliments, compared to 952 last year.

Friends and Family Test

The NHS Friends and Family Test was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give feedback after receiving care or treatment across the NHS.

The chart below shows that the overall percentage of patients who were 'Extremely Likely' or 'Likely' to recommend our services to friends and family was 98%. Compared to the same period last year there has been an increase of over 3,000 responses and the percentage recommending 'Extremely Likely' or 'Likely' has been maintained at 98%. The Quality Account details how these have been actioned.



2.2 Financial performance

This section includes:

Summary

The key elements of the Trust's financial plans for 2016/17 were to maintain the strong performance of 2015/16 through the generation of a £1.77m adjusted surplus supported by the delivery of an ambitious £5.4m efficiency programme.

The adjusted surplus actually delivered in 2016/17 was £2.695m, supported by £2.3m of recurrent efficiency savings delivered. The increased surplus from the original plan is primarily driven by £0.8m of additional income received from NHS England for achieving the planned surplus, this was received through the sustainability and transformation fund bonus and incentive scheme.

2.2.1 Efficiency programme

The recurrent efficiency savings of £2.3m were achieved during the year through the Trust's Cost Improvement Programme, against a recurrent target of £5.4m. Much of the saving was achieved through the continued redesign and modernisation of clinical services, as well as non-clinical savings from estates rationalisation and procurement initiatives. 50 different projects generated recurrent savings during the year. The shortfall against plan was mitigated by delivering non-recurrent savings during the year.

The sustainable delivery of savings continues to present a challenge to the Trust. Achieving sustainable recurrent efficiency savings enables the Trust to continue delivering sustainable services in the long-term, which is why it forms a key component of the long-term strategy.

2.2.2 Capital

During the year, NCHC invested £4.3m (£4.6m in 2015/16) in capital schemes, which was an under spend of less than 1% against the plan and Capital Resource Limit agreed with the Department of Health. One key area of investment to support the efficient delivery of patient care was the maintenance programme for the Trust's estate. In addition, the Trust has invested £0.6m in new and replacement clinical equipment to support the quality of patient care and £1.2m in Information Technology which includes investment in mobile working to maximise the time staff spend with patients.

2.2.3 Balance sheet and working capital

Both the balance sheet and working capital have been reasonably stable throughout the year and are consistent with 2015/16.

2.2.4 Better Payments Practice Code

The Trust is required to pay its non-NHS and NHS trade payables in accordance with the Confederation of British Industry (CBI) Better Payments Practice Code. This requires us to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later (see reference note 9.1 in the financial statements).

2016/17 saw a deterioration on the previous year's performance, with 85% of non-NHS trade payable invoices being paid within 30 days (90% in 2015/16). 77% of NHS payable invoices were paid within 30 days (92% in 2015/16). The reduction in performance relates to March 2017 where payments were at a reduced level in order to achieve the external funding limit set by NHS Improvement. Details of compliance with the Better Payment Practice code are detailed in note 9 to the financial statements.

2.2.5 Prompt Payments Code

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

2.2.6 Trend analysis

The table below shows the historic performance of the Trust for the period 2014/15 to 2016/17. Over this period:

- Income levels have increased by 7.5%.
- Pay growth (9.2%) has exceeded income growth by 1.6% over the period and accounts for 76% of the cost base (excluding depreciation and public dividend capital (PDC)).
- Non-pay growth has been 2.5%, 0.2% above the rate of inflation.
- Depreciation and amortisation has increased by 9.4% despite capital investment remaining at fairly modest levels (average £4.5m per year). The increase is as a result of the mix of our asset base moving towards faster depreciating IT assets and away from slower depreciating estate assets. The effect of an estate assets revaluation has reduced the 2016/17 depreciation from a forecast value of £4.4m to £3.9m.
- Public dividend capital payments have risen by 10.7% despite increased cash balances over the period.
- Although the surplus has averaged £2.6m over the period, this is after the introduction of Sustainability and Transformation Funding (STF) in the current year. Without the STF the surplus has fallen steadily over the period, decreasing by a movement of 0.8% between 2015/16 and 2016/17.

Table showing historic financial performance

Historic Performance	2014/15 Act	2015/16 Act	2016/17 Act
	£k	£k	£k
Income			
Block	101,035	107,526	108,088
C&V	4,062	3,288	5,456
Other	18,699	19,105	19,582
Total	**123,796**	**129,919**	**133,126**
Expenditure			
Pay	86,463	92,159	94,375
Non-Pay	28,971	29,550	29,685
Total	**115,434**	**121,709**	**124,060**
EBITDA	**8,362**	**8,210**	**9,066**
%	**6.8%**	**6.3%**	**6.8%**
Depreciation and amortisation	3,556	3,930	3,891
PDC Dividend	2,087	2,037	2,310
Surplus (incl STF)	**2,719**	**2,243**	**2,865**
%	**2.2%**	**1.7%**	**2.2%**
Adjusted Surplus (incl STF)	**2,628**	**2,129**	**2,695**
STF	-	-	1,586
Surplus (excl STF)	**2,628**	**2,129**	**1,109**
%	**2.1%**	**1.6%**	**0.8%**
CIP			
Recurring	3,618	5,683	2,329
Non-recurring		1,167	2,512
Total	**3,618**	**6,850**	**4,841**
Capital expenditure	**4,878**	**4,396**	**4,137**
Cash balance	**20,099**	**22,956**	**23,259**

2.2.7 Outlook

Over the coming year the Trust will be revisiting its financial strategy, with a focus on strengthening the financial and business position in order to continue to provide sustainable and high quality care to our customers. The timing of this review is particularly pertinent in the current landscape, following recent news that the Trust will be losing its contract for Suffolk Community Services midway through 2017/18. This will result in a significant drop in revenue (£10.3m estimated in 2017/18).

Ongoing financial sustainability will be achieved through the continued development and delivery of the Cost Improvement Programme, mitigation of cost pressures, strengthening core business and developing new service opportunities.

Additionally the Trust is working very closely with other providers and commissioners to develop proposals and make improvements to health and care within the Norfolk and Waveney region. These proposals, known as the Sustainability and Transformation Plan, will also support the Trust's future developments and strategy.

2.3 Sustainability Report

This section includes:

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

Introduction

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources, and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising costs of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

In order to fulfil our responsibilities for the role we play, NCHC has the following sustainability mission statement located in our sustainable development management plan (SDMP):

"To sustain our health and care services and provide economic, social and environmental value to the local community for a better tomorrow."

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

2.3.1 Sustainability policies

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

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

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

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Good Corporate Citizenship (GCC) tool. The last time we used the GCC self-assessment was in 2015-16, scoring 0.69. As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

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

2.3.2 Sustainability partnerships

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

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

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

2.3.3 Sustainability performance

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

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

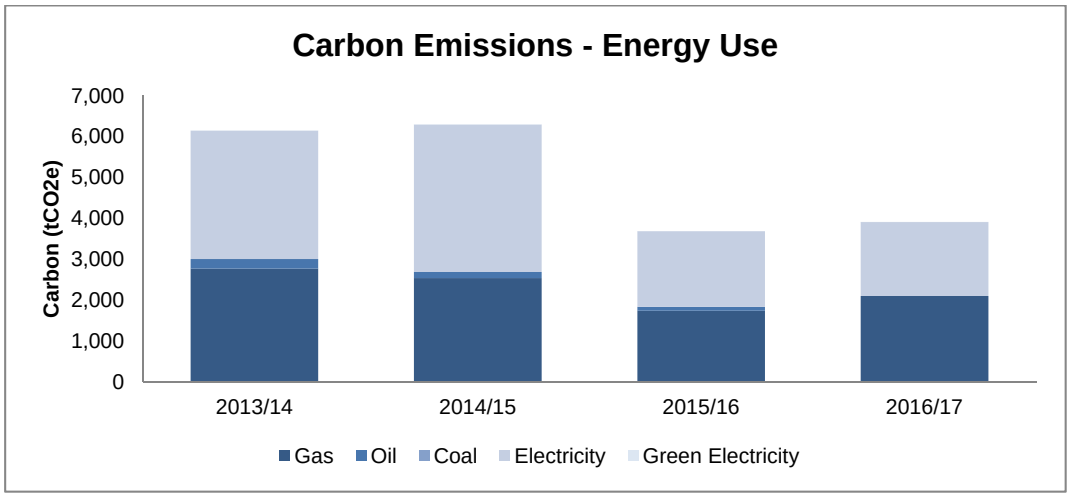
Energy

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

organisation and its performance on sustainability has changed over time.

Context info	2013/14	2014/15	2015/16	2016/17
Floor Space (m^2)	61,512	65,479	63,104	47,528
Number of Staff	2,235	2,695	2,472	2,874

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



Resource		2013/14	2014/15	2015/16	2016/17
Gas	Use (kWh)	13,057,968	12,116,536	8,327,070	10,063,392
	tCO_2e	2,770	2,542	1,743	2,103
Oil	Use (kWh)	741,200	457,800	294,000	0
	tCO_2e	237	147	94	0
Coal	Use (kWh)	0	0	0	0
	tCO_2e	0	0	0	0
Electricity	Use (kWh)	5,603,268	5,822,507	3,221,142	3,493,424
	tCO_2e	3,137	3,606	1,852	1,805
Green Electricity	Use (kWh)	20,570	20,570	20,570	20,408
	tCO_2e	5	5	5	4
Total Energy CO_2e		6,149	6,300	3,693	3,913
Total Energy Spend		£907,960	£960,054	£643,284	£498,060

At the start of the year, the Trust removed its oil fuelled boilers across key sites and replaced these with energy efficient gas heating. This change is reflected in the energy consumption figures for the year and can account for the slight increase in the use of gas. Please note that our energy consumption data is estimated for this report while we await confirmed information through our end of year invoices.

Travel

We can improve local air quality and improve the health of our community by promoting active travel – to our staff and to the patients and public that use our

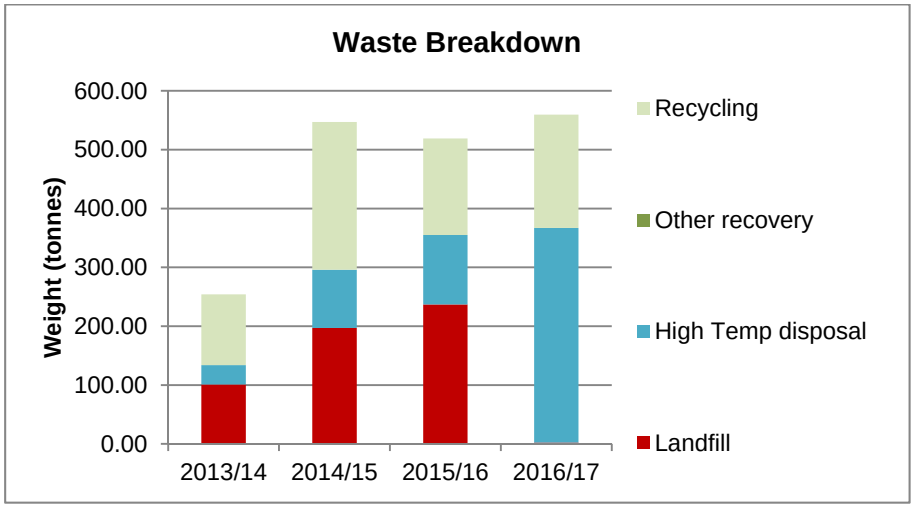
services.
Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our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

Category	Mode	2013/14	2014/15	2015/16	2016/17
Patient and visitor Travel	miles	61,932,006	53,350,763	52,518,096	58,097,178
	tCO_2e	22,882.22	19,602.63	18,992.42	20,996.92
Business Travel and fleet	miles	8,691,266	8,865,356	7,906,008	4,866,972
	tCO_2e	3,173.36	3,221.63	2,828.05	1,741.29
Staff commute	miles	2,052,015	2,588,864	2,374,647	2,760,815
	tCO_2e	758.16	951.22	858.76	997.79

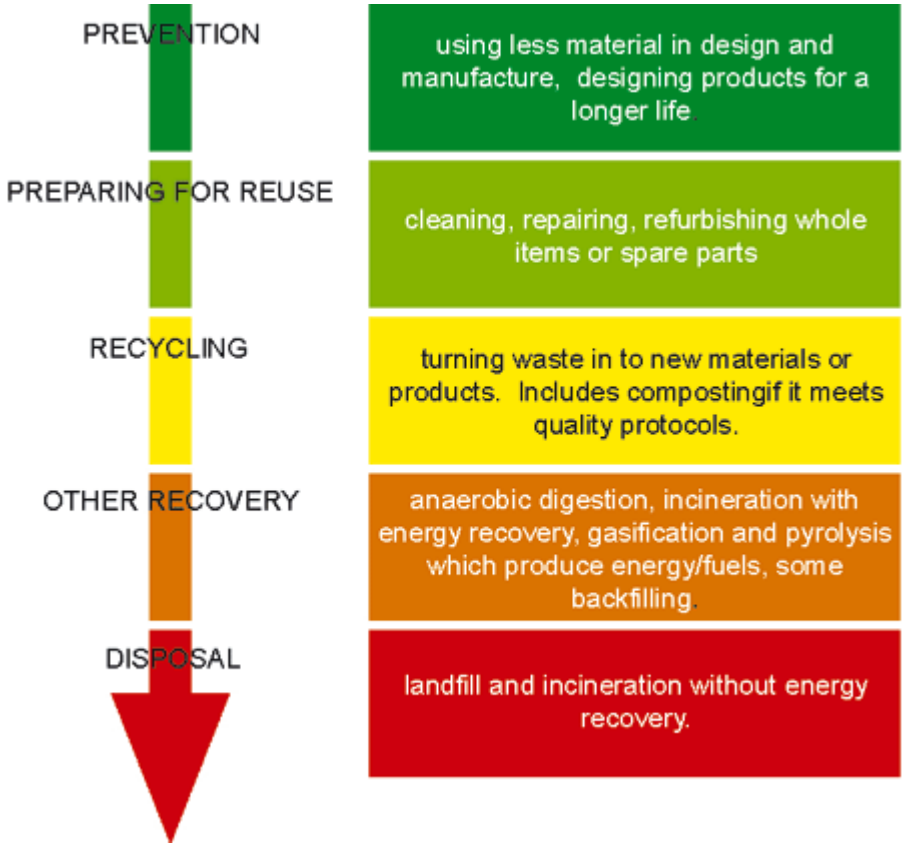
This year the Trust has seen a natural decrease in business mileage due to staff changes and better route planning and caseload management.

Waste management

Waste		2013/14	2014/15	2015/16	2016/17
Recycling	(tonnes)	120.00	251.00	164.00	192.71
	tCO_2e	2.52	5.27	3.28	4.05
Other recovery	(tonnes)	0.00	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00	0.00
High Temp disposal	(tonnes)	33.00	99.00	118.00	364.88
	tCO_2e	7.26	21.78	25.84	80.27
Landfill	(tonnes)	101.00	197.00	237.00	2.10
	tCO_2e	24.69	48.15	57.93	0.65
Total Waste (tonnes)		254.00	547.00	519.00	559.69
% Recycled or Re-used		47%	46%	32%	34%
Total Waste tCO_2e		34.47	75.20	87.05	84.97



The Trust is legally bound to follow the waste hierarchy when managing waste:



This means we are constantly striving to select more environmentally friendly alternatives for waste disposal. In doing so, the Trust has moved a large amount of waste disposal from Landfill (Red) to Other Recovery (orange), specifically to allow a contractor to create RDF (refuse derived fuel) which is sold to Europe for central heating. Whilst this method is more environmentally friendly overall, the Trust does not benefit within the carbon footprint as this only measures the initial process (high temperature disposal). Work is underway to review the scope of inclusion within the Trust's and contractors' carbon footprints.

The Trust has commenced a project to implement the Warp-It system by 2018 which will enable our Trust to re-use / re-cycle our furniture and equipment before considering disposal. This will further reduce the impacts for waste.

Water usage

Water		2013/14	2014/15	2015/16	2016/17
Mains	m^3	45,760	55,993	31,512	34,909
	tCO_2e	42	51	29	32
Water & Sewage Spend		£ 115,669	£ 127,579	£ 78,183	£ 65,341

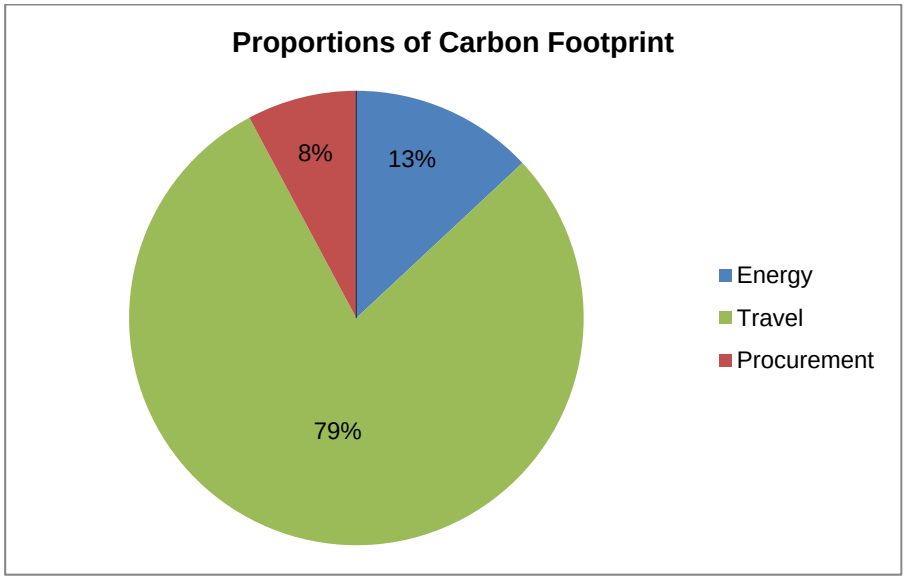
Unfortunately, the Trust experienced a significant leak at Adelaide Street Health Centre which, although dealt with as soon as identified, has caused a slight increase in this year's usage. Work is underway with the Trust's energy and water management contractor to improve on our ability to identify leaks and problems earlier where possible.

Modelled carbon footprint

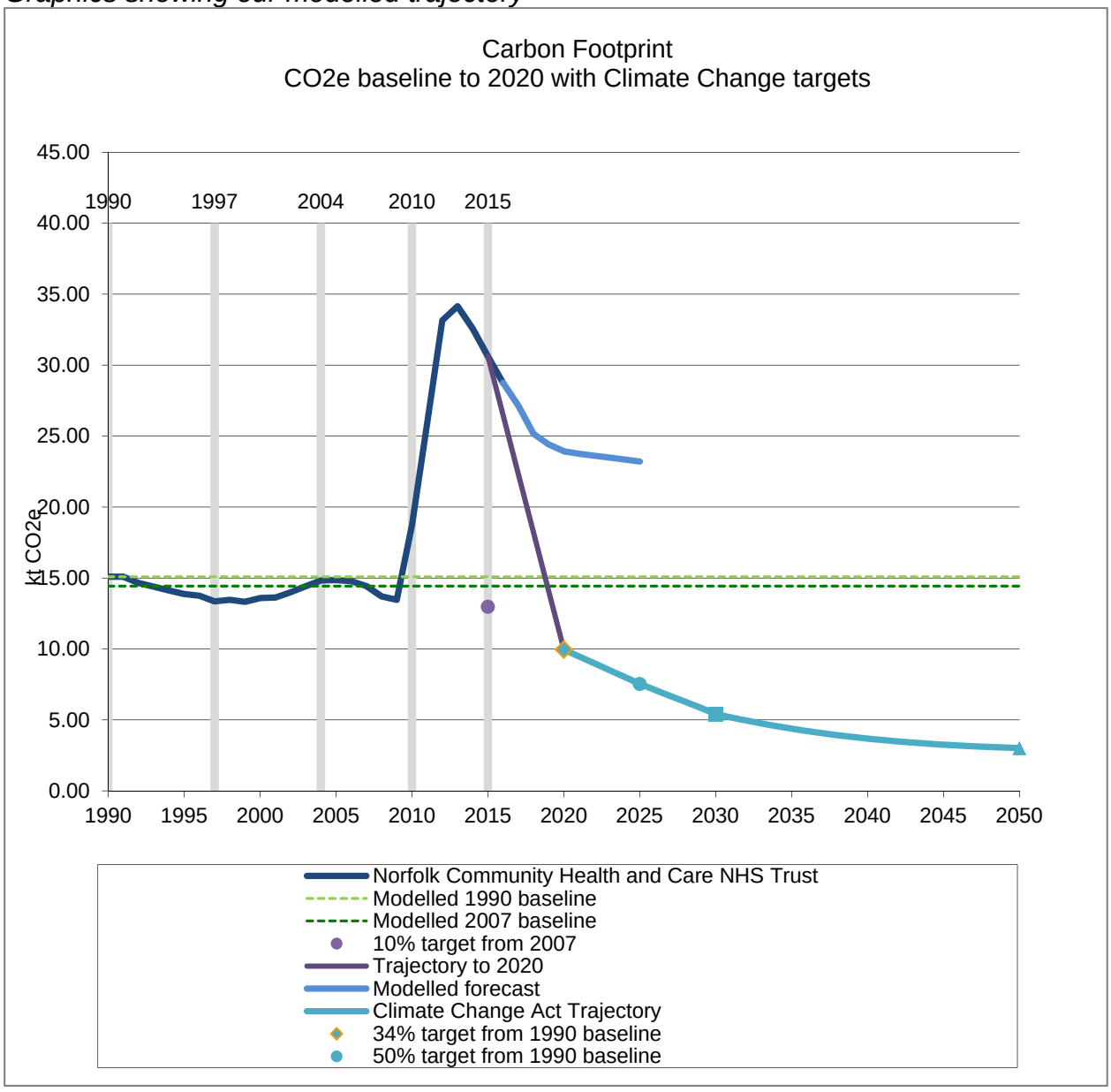
The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit (SDU) in 2009/10. More information is available on the SDU website.

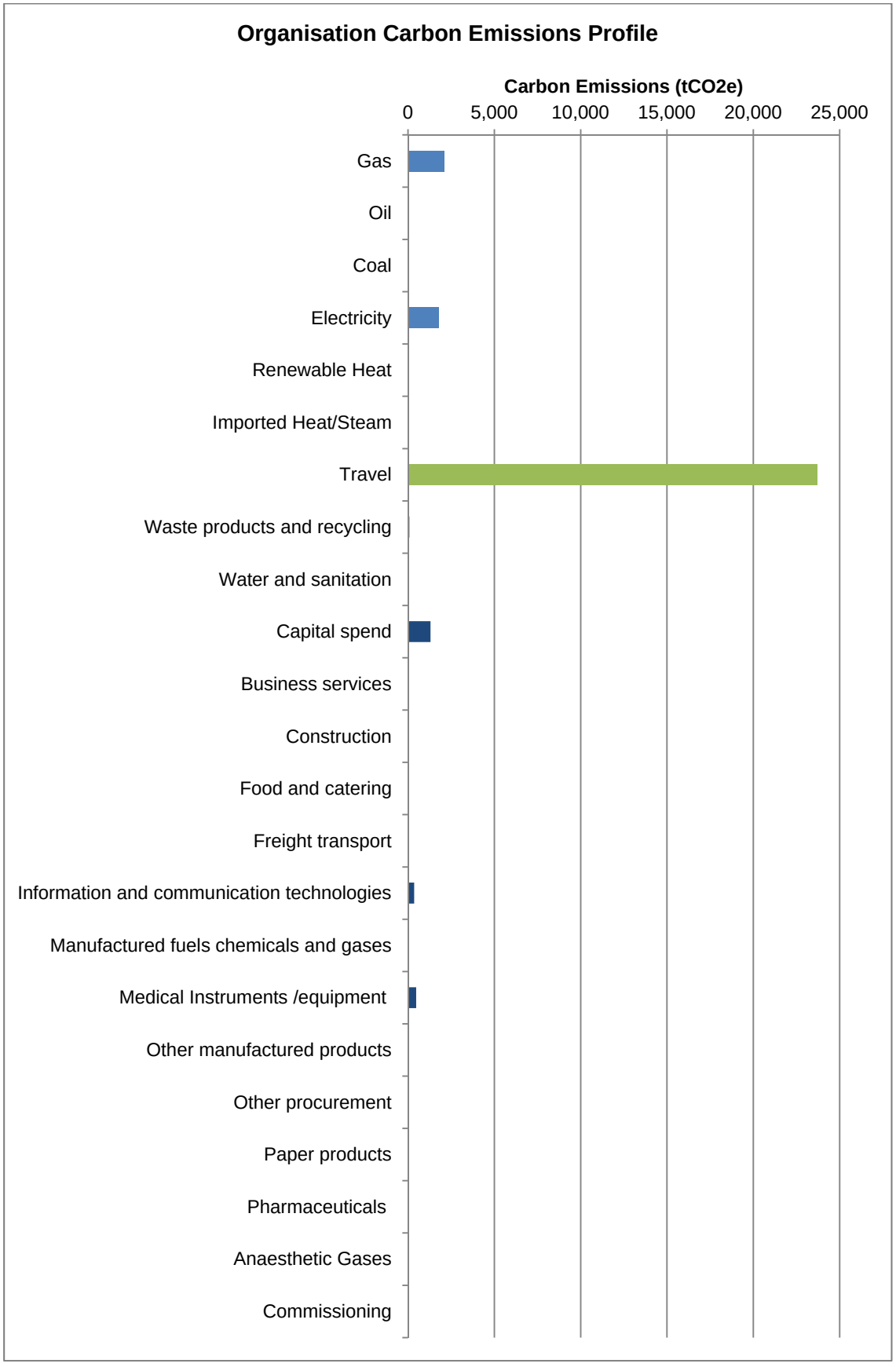
This results in an estimated total carbon footprint of 29,990 tonnes of carbon dioxide equivalent emissions (tCO_2e). Our carbon intensity per pound is 240 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO2e/£). Average emissions for community services is 160 grams per pound.

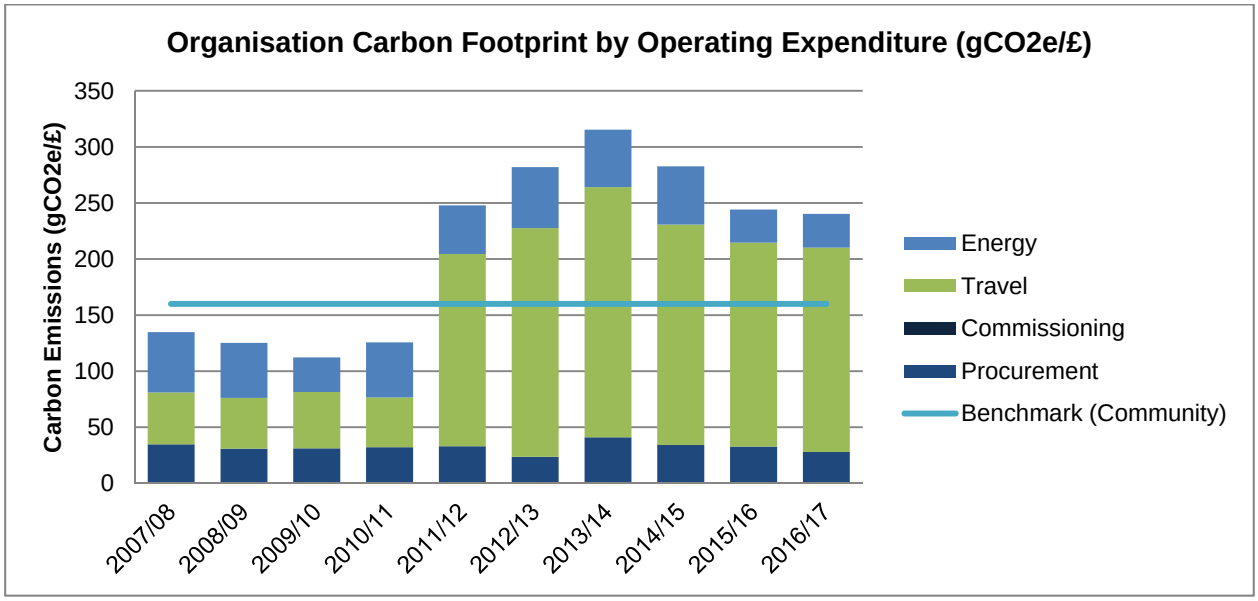
Category	% CO_2e
Energy	13%
Travel	79%
Procurement	8%
Commissioning	0%



Graphics showing our modelled trajectory




Organisation Carbon Emissions Profile
Carbon Emissions (tCO2e)
0
5,000
10,000
15,000
20,000
25,000
Gas
Oil
Coal
Electricity
Renewable Heat
Imported Heat/Steam
Travel
Waste products and recycling
Water and sanitation
Capital spend
Business services
Construction
Food and catering
Freight transport
Information and communication technologies
Manufactured fuels chemicals and gases
Medical Instruments /equipment
Other manufactured products
Other procurement
Paper products
Pharmaceuticals
Anaesthetic Gases
Commissioning



Outlook

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

Performance Report signature

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

Accountable Officer's signature
NB: sign and date in any colour ink except black

Signed:……..……

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

Date:……

B. ACCOUNTABILITY REPORT

The Accountability Report includes:

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

3. Corporate Governance Report

This section of the report includes:

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

3.1 Directors' Report

This section includes:

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

3.1.1 Board members and committee structure

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

Table showing Board of Directors and their declared interests

Name	Designation	Declared interests
Ken Applegate (until 31.05.16)	Non-Executive Chair	None
Geraldine Broderick (from 26.06.16)	Non-Executive Chair	Self-employed Holiday Lets and Property Development
Roisin Fallon-Williams	Executive	None
Derek Allwood	Non-Executive	None
Heather Peck	Non-Executive	Non-Executive Director, Food Standards Agency. Chair, Dog Welfare Trust. Education Volunteer, Blue Cross. Adviser, Citizens Advice
Amanda Reynolds	Non-Executive	Blend Associates Ltd – Management Consultancy, various private and public sector executive coaching contracts.

Geoff Rivers	Non-Executive	Director, Geoff Rivers Associates – local government work. Governor, Arch Bishop Sancroft High School, Harleston, Norfolk. Member of the Independent Monitoring Board, HM Prison Hollesley Bay, Woodbridge, Suffolk. Treasurer, WEA (Worker Education Associations), Pulham Branch, Norfolk.
Dr Iain Brooksby	Non-Executive	Chairman, Norfolk Heart Trust. Trustee, Norwich Consolidated Charities.
Stephen Pond	Non-Executive (non-voting)	Aviva Insurance Limited, Managing Director Prevention & Services
Lorrayne Barrett	Executive	Secretary, Friends of Lowestoft Library
Andrew Hopkins	Executive	Partner runs a consulting business that carry out work for the NHS on finance, contracts and commissioning
Paul Cracknell	Executive (non-voting)	Trustee, Cringleford Hub – charity sometimes working with Health Visitors and Children's Centres
Anna Morgan	Executive	Peer Reviewer for RCN Publications Review all articles that have Safeguarding/LD/Older People context. Advisor for mental health inspections for CQC, Clinical and Professional Advisor for CQC inspections.
Dr Penny Newman	Executive	Contracted for two days per week / Clinical Lead role / Health Coaching, Health Education East of England. Husband is CEO, Royal College of Surgeons

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

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

NCHC Committee Structure

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

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

Audit Committee

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

Table showing members of the Audit Committee

Name	Designation
Derek Allwood, Non Executive Director	**Committee Chair**
Amanda Reynolds, Non Executive Director	**Deputy Chair**
Heather Peck, Non Executive Director	**Member**

3.1.2 Disclosure of personal data related incidents

This is reported in the Governance Statement.

3.1.3 Counter fraud

The Local Counter Fraud Specialist (LCFS) has provided an annual report on anti-fraud, bribery and corruption work undertaken during the year. NHS Protect has developed a set of 'Standards for Providers' of NHS Services, setting out its expectations for counter fraud arrangements of any NHS or non-NHS organisation providing NHS care. The LCFS has worked with senior management to populate a self-assessment against these Standards. This assessment (the "Self Review Toolkit" or 'SRT') was submitted to NHS Protect prior to the submission deadline of 31 March 2017. The SRT details how the Trust complies with the NHS Standard Contract in relation to anti-fraud, corruption and bribery with a scoring system of red, amber or green against each standard, with green being fully compliant. Overall the SRT return was scored as green with a total of three standards scored as amber out of a total of 24 standards. The amber scores identify that the Trust partially complies with the standards. An action plan is being developed and shared with the Director of Finance and Performance for consideration where the standards were scored as amber.

3.1.4 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 the 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, recognised gains and losses and cash flows for the year. In preparing those accounts, 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.

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.

By order of the Board

NB: sign and date in any colour ink except black

.....Date.....Chief Executive

.....Date.....Director of Finance & Performance

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

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. 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 with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

I confirm that, 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 Trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

NB: sign and date in any colour ink except black

Signed.....Chief Executive

Date.....

3.3 Governance Statement

This section includes:

3.3.1 Scope of the Accountable Officer's responsibility
3.3.2 The governance framework of the organisation
3.3.3 Risk assessment
3.3.4 Risk and control framework
3.3.5 Review of the effectiveness of risk management and internal control
3.3.6 Significant issue

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 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, demonstrating an understanding of propriety and accountability issues. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the Accountable Officer Memorandum.

3.3.2 The governance framework of the organisation

Board committees: structure, attendance, coverage

The Board comprises the Chair and five Non-Executive Directors, and one non-voting Designate Non-Executive, drawn from a variety of backgrounds, the Chief Executive and four voting and one non-voting Executive Directors who lead the organisation. The Board is supported by a qualified company secretary who attends all Board meetings. The membership, designation and roles of each Board member are set out in the table below. All Board members were in post from 1 April 2016 to 31 March 2017, except where indicated.

Table showing the designation and roles of Board directors

Name	Designation	Role
Ken Applegate (until 31.05.16)	Non-Executive	Chair: Trust Board Chair: Remuneration Committee
Geraldine Broderick (from 26.06.16)	Non-Executive	Chair: Trust Board Chair: Remuneration Committee
Roisin Fallon-Williams	Executive	Chief Executive
Derek Allwood	Non-Executive	Chair: Audit Committee
Heather Peck	Non-Executive	Deputy Trust Chair and Senior Independent Director. Chair: Quality and Risk Assurance Committee
Amanda Reynolds	Non-Executive	Chair: Finance and Performance

		Committee
Geoff Rivers	Non-Executive	Chair: Charitable Funds Committee
Dr Iain Brooksby	Non-Executive	
Stephen Pond	Non-Executive (non-voting)	Designate NED
Lorrayne Barrett	Executive	Director of Norfolk Adult Operations and Integration
Andrew Hopkins	Executive	Director of Finance and Performance
Paul Cracknell	Executive (non-voting)	Director of Strategy and Transformation
Anna Morgan	Executive	Director of Nursing and Quality
Dr Penny Newman	Executive	Medical Director

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

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

Table showing attendance at Board meetings

Forename	Surname	Position	11/4/15 - ExtraO	27/4/15 - Public	27/4/15 - Private	25/5/15 - Public	25/5/15 - Private	27/5/15 - ExtraO	29/6/15 - Public	29/6/15 - Private	27/7/15 - Public	27/7/15 - Private	31/8/15 - Public	31/8/15 - Private	29/9/15 - Public	29/9/15 - Private	19/10/15 - ExtraO	26/10/15 - Public	26/10/15 - Private
Ken	Applegate	Chair (until 31.05.16)	Y	Y	Y	Y	Y	Y											
Geraldine	Broderick	Chair (from 01.06.16)							Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Roisin	Fallon-Williams	Chief Executive	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Derek	Allwood	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y	Y	Y	Y
Lorrayne	Barrett	Director of Norfolk Adult Operations and Integration	Y	Y	Y	Y	Y	APOLS	Y	Y	Y	Y	Y	Y	APOLS	APOLS	APOLS	Y	Y
Dr Iain	Brooksby	Non Executive Director	Y	Y	Y	Y	Y	Y	APOLS	Y	Y	Y	APOLS	APOLS	Y	Y	Y	Y	Y
Paul	Cracknell	Director of Strategy and Transformation	Y	Y	Y	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y	Y	Y	Y	Y	Y
Andrew	Hopkins	Director of Finance and Performance	Y	Y	Y	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y	Y	Y	Y	Y	APOLS
Mike	Jones	Trust Secretary	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Heather	Peck	Non Executive Director	Y	Y	Y	Y	Y	APOLS	Y	Y	Y	Y	Y	Y	Y	Y	APOLS	Y	Y
Dr Penny	Newman	Medical Director	Y	Y	Y	Y	Y	APOLS	Y	Y	Y	Y	APOLS	APOLS	Y	Y	APOLS	Y	Y
Anna	Morgan	Director of Nursing and Quality	Y	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y	Y	Y	APOLS	APOLS	Y	Y	Y
Stephen	Pond	Non Executive Director Designate	Y	Y	APOLS	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y	APOLS	APOLS	Y	Y	Y
Amanda	Reynolds	Non Executive Director	Y	Y	Y	Y	Y	APOLS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Geoff	Rivers	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	APOLS	APOLS	Y	Y	APOLS	Y	Y

Forename	Surname	Position	30/11/16 - Public	30/11/16 - Private	14/12/16 - Public	14/12/16 - Private	25/1/17 - Public	25/1/17 - Private	22/2/17 - Public	22/2/17 - Private	29/3/17 - Public	29/3/17 - Private
Geraldine	Broderick	Chair (from 01.06.16)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Roisin	Fallon-Williams	Chief Executive	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Derek	Allwood	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lorrayne	Barrett	Director of Norfolk Adult Operations and Integration	Y	Y	APOLS	APOLS	Y	Y	Y	Y	APOLS	APOLS
Dr Iain	Brooksby	Non Executive Director	APOLS	APOLS	Y	Y	Y	Y	Y	Y	Y	Y
Paul	Cracknell	Director of Strategy and Transformation	APOLS	APOLS	Y	Y	Y	Y	Y	Y	Y	Y
Andrew	Hopkins	Director of Finance and Performance	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mike	Jones	Trust Secretary	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Heather	Peck	Non Executive Director	APOLS	APOLS	Y	Y	Y	Y	Y	Y	Y	Y
Dr Penny	Newman	Medical Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Anna	Morgan	Director of Nursing and Quality	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Stephen	Pond	Non Executive Director Designate	Y	Y	Y	Y	Y	Y	Y	APOLS	Y	Y
Amanda	Reynolds	Non Executive Director	APOLS	APOLS	Y	Y	Y	Y	Y	Y	APOLS	APOLS
Geoff	Rivers	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

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

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

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

Audit Committee

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

Table showing Audit Committee members' attendance

Forename	Surname	Position	19/5/16	1/6/16	19/9/16	07/12/16	13/03/17
Derek	**Allwood**	**Chair and Non Executive Director**	Y	Y	Y	Y	Y
Amanda	**Reynolds**	**Deputy Chair and NED**	Y	Y	Y	APOLS	Y
Heather	**Peck**	**Non Executive Director**	APOLS	Y	Y	Y	Y

Quality and Risk Assurance Committee (QRAC)

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

Table showing QRAC members' attendance

Forename	Surname	Position	18/4/16	16/5/16	20/6/16	18/7/16	22/8/16	19/09/16	17/10/16	21/11/16	16/01/17	13/02/17	20/03/17
Lorrayne	Barrett	Director of Norfolk Adult Operations and Integration	APOLS	APOLS	Y	Y	APOLS	Y	Y	Y	APOLS	APOLS	Y
Dr Penny	Newman	Medical Director	APOLS	Y	Y	Y	APOLS	APOLS	APOLS	Y	Y	Y	Y
Anna	Morgan	Director of Nursing and Quality	Y	Y	Y	APOLS	Y	APOLS	Y	APOLS	Y	Y	Y
Derek	Allwood	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Iain	Brooksby	Non Executive Director	Y	APOLS	Y	Y	Y	APOLS	Y	Y	APOLS	Y	Y
Heather	Peck	Non Executive Director and Chair	Y	Y	APOLS	Y	Y	Y	Y	Y	Y	Y	Y

Finance and Performance Committee (FPC)

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

Table showing FPC members' attendance

Forename	Surname	Position	25/4/16	23/5/16	27/6/16	25/7/16	30/8/16	26/9/16	ExtraO - 11/10/16	24/10/16	28/11/16	12/12/16	23/1/17	20/2/17	27/3/17
Lorrayne	Barrett	Director of Norfolk Adult Operations and Integration	APOLS	APOLS	APOLS	APOLS	APOLS	APOLS	APOLS	Y	APOLS	APOLS	APOLS	APOLS	APOLS
Andrew	Hopkins	Director of Finance and Performance	Y	Y	Y	APOLS	Y	Y	Y	Y	Y	Y	Y	Y	Y
Paul	Cracknell	Director of Strategy and Transformation	Y	APOLS	Y	Y	APOLS	Y	Y	APOLS	APOLS	Y	Y	Y	Y
Anna	Morgan	Director of Nursing and Quality	Y	Y	Y	Y	Y	APOLS	APOLS	APOLS	Y	Y	Y	Y	Y
Geoff	**Rivers**	**Non Executive Director**	Y	Y	Y	Y	APOLS	Y	Y	Y	Y	Y	Y	Y	Y
Stephen	**Pond**	**Non executive Director Designate**	Y	Y	Y	Y	Y	Y	Y	Y	Y	APOLS	Y	Y	Y
Amanda	**Reynolds**	**Non Executive Director and Chair**	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	APOLS

Remuneration Committee (RC)

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

Table showing RC members' attendance

Forename	Surname	Position	20/4/16	20/7/16	19/10/16	18-Jan-17
Ken	Applegate	Chair (until 31.05.16)	Y			
Geraldine	Broderick	Chair (from 01.06.16)		Y	Y	Y
Derek	Allwood	Non Executive Director	Y	Y	Y	Y
Dr Iain	Brooksby	Non Executive Director			Y	Y
Amanda	Reynolds	Non Executive Director	APOLS	Y	Y	APOLS
Heather	Peck	Non Executive Director	Y	Y	APOLS	Y
Geoff	Rivers	Non Executive Director	Y	Y	APOLS	Y

Charitable Funds Committee (CFC)

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

Assessment of Board effectiveness

The Board has undertaken internal whole Board and individual member self-assessments and facilitated sessions. The Board reviewed the outcome of its annual self-assessment evaluation at its meeting on 22 February 2017. The learning points from the Board effectiveness activities have been taken forward and implemented throughout the year. The Board Development Programme continues to embed the lessons learned from the activities undertaken during the previous year. The assessments confirm that the Board is effective and that key learning points are being taken forward. Each committee has also undertaken a self-assessment on its effectiveness and performance against its delegated responsibilities as set out in the terms of reference. The Board reviews the annual assurance reports from each committee in May each year. These confirmed that they were effective in discharging their delegated responsibilities. The most recent external evaluation against the Well-led Framework was undertaken by Monitor, with a report dated November 2015.

Last year the Board identified three priority areas to focus on in order to improve its effectiveness and two of these have shown the biggest improvements this year: Board Assurance Framework and concise Board papers; the third area, diversity of the Board has shown a further small decline in score.

For the coming year the Board has agreed the following priority areas:

- Further improve the conciseness of Board papers including effective summaries.
- Allow sufficient challenge on each Board item.
- Involve and inform key stakeholders in the work of the Board, and take account explicitly of their views and those of staff in its strategy.
- Demonstrate more clearly the link between time spent at Board on strategy being

reflected in defined proposals for the Business Plan.
- Board diversity to be addressed through the Board's succession planning.

Board committee report highlights

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

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

Corporate governance

As an NHS Trust, NCHC is not required to comply with the UK Code of Corporate Governance nor the NHS foundation trust Code of Governance. However, NCHC is compliant with those sections of these codes that may be considered relevant to an NHS Trust, including those relating to Board composition, balance and independence, appointment and terms of office of directors, information, development and evaluation, director remuneration, accountability & audit, relationships with stakeholders, disclosure requirements, and the role of the Trust Secretary. The Board has also undertaken a self-assessment against the Well-led Framework issued by NHS I. The Trust's Governance Manual is fully compliant with the Department of Health's model Standing Orders for NHS Trusts, as updated to comply with changing legal and regulatory requirements. Internal Audit have noted that within NCHC's corporate governance the control environment areas reviewed remained strong.

NHS provider licence

As an NHS Trust, NCHC is exempt from the requirement to hold a NHS Provider Licence for the provision of NHS services under Statutory Instrument 2013 No. 2677 "The National Health Service (Licence Exemptions, etc.) Regulations 2013". However, NCHC is compliant with those licence conditions which NHSI have deemed relevant to an NHS Trust.

Quality governance

The Trust publishes an annual Quality Account, to enable the Board and the Trust's senior leadership to assess quality across all of the healthcare services it offers, to demonstrate the Trust's commitment to continuous, evidence-based quality improvement, and to explain the Trust's progress to the public. The Trust's draft Quality Account was received at the Trust Board in April 2017, and will be formally approved for publication in June 2017. It will then be published on NHS Choices and the NCHC website at the end of June 2017. Key stakeholders have been invited to

include their comments in the document.

NCHC has an NHS Resolution accredited and Board approved Incident Reporting and Management Policy in place which reflects the reporting requirements of the National Reporting and Learning System, which is monitored by NHS I 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.

Incident reporting and learning

Table showing the number of incidents reported on Datix per month and by category

Incident category	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Total
No Harm	163	180	197	220	272	253	206	233	220	281	257	242	2724
Low harm	300	333	308	338	290	312	314	288	287	366	337	398	3871
Moderate harm	113	70	66	67	74	90	61	91	98	93	81	87	991
Severe harm	12	8	3	7	6	3	6	3	7	5	12	10	82
Expected death	3	2	2	0	2	1	1	3	3	1	1	2	21
Unexpected death	0	0	1	0	1	0	0	0	0	0	1	2	5
Total	591	593	577	632	645	659	588	618	615	746	689	741	7694

All incidents, including actions and learning are reported to the Board each month.

During the year 255 SIRIs were reported, 220 of which were grade 3 and grade 4 pressure ulcers. In addition 73 PU SIRIs were reported in the Suffolk services. All SIRIs are investigated using root cause analysis methodology. We aim to submit our initial investigation report to our commissioners within 3 days of reporting a SIRI and aim to submit our full investigation together with any resulting action plan to the Norfolk commissioners within 40 days of the SIRI being reported and 60 days to our Suffolk commissioners. Please note that since May 2016 pressure ulcers reported as SIRI only if deemed to be preventable by NCHC, which may be a contributory factor in the drop in reported numbers over last year.

Clinical audit

NCHC has participated in the following national clinical audits

National and Clinical Audit & Enquiry project name	Lead Organisation
Child Health Clinical Outcome Review Programme – Chronic Neuro Disability	National Confidential Enquiry into a Patient Outcome and Death
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – Pulmonary Rehabilitation	Royal College of Physicians
National Diabetes Audit – Adults –	Health and Social Care Information

National Foot Care Audit	Centre
Sentinel Stroke National Audit Programme	Royal College of Physicians

Local clinical audits

19 Trust-wide and local clinical audits were undertaken during the year and NCHC is taking the following actions to improve the quality of healthcare provided:

- All staff in the South Locality initially, rolling out Trust-wide, who complete falls multi-disciplinary team assessments, will be competent in understanding and completing evidence-based balance exercise programmes, or knows how to refer to colleagues by November 2017.
- Externally and newly recruited clinical staff to have adequate support and gain experience in the complex assessment and documentation required for Looked After Children health assessments prior to carrying out assessment independently.
- All patients on Melatonin to have an annual review to determine if the treatment is still required. SystmOne template will be used in all patients undergoing annual review.
- Develop and deliver specific Clostridium Difficile training to all inpatient units
- Trust Tissue Viability Lead will attend team meetings to clarify the procedure for reporting on Datix and report on current position regarding the alternative pressure risk measure
- Nurse Champion role developed for Hepatitis C screening and follow-up in City Reach health Services.
- Review wording and number of care plans and provide evidence of patient involvement and personalisation of care plans
- Update recording template to allow better care for patients using a catheter
- Improve the process of reviewing patients with Down's Syndrome to support them in later life and have better discussions around dementia.

"Freedom to Speak Up"

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

FTSU aims to:

- Develop a communication plan to keep the agenda and reporting processes visible for staff.
- Provide ongoing training, development and support for our FTSU guardians and champions.
- Develop a variety of reporting options.
- Adopt the national FTSU integrated reporting template within our policies.

Statement on discharge of statutory functions

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

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

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

3.3.3 Risk assessment

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

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

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

The Trust's strategic risks

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

- Risks to improving our quality:
    - delivering harm free care,

    - adequate funding of the Suffolk services contract,
    - implementation of the Health and Care Strategy,
    - implementation of the Integration Programme.
- Risks to enabling our people:
    - change management,
    - staff engagement,
    - staff deployment.
- Risks to securing the Future
    - delivering the cost improvement programme,
    - managing high risk cost pressures,
    - maintaining good commissioner relations.

At the year-end the following risks remained above the target risk rating set by the Board: delivering the cost improvement programme, managing high risk cost pressures, commissioner relations, the Health and Care Strategy, and staff deployment. These risks will continue to be monitored at Board-level until the risk reaches the target residual level. The risk to the achievement of FT status was removed when the application was withdrawn in September 2016.

In addition, other key risks to quality are:

- Medical staffing: If NCHC fails to recruit to the Trust's medical staffing model then the quality and performance of service delivery may be compromised. This risk reflects a national shortage of doctors and local challenges in attracting medical staff to East Anglia. This risk is included in the BAF under the wider staff deployment risk. Mitigation: This risk is owned by the Medical Director and managed by a rolling recruitment plan and the employment of short-term locums to cover service gaps.
- Unsustainable demand: If demand for services increases over and above that which is funded then the quality of services may deteriorate, creating activity pressure over the five years of the financial model. Mitigation: This risk is owned by the Director of Finance and Performance and managed via contractual escalation which is triggered by activity variation thresholds. Mitigations include the robust negotiation of 2016/17 activity and funding to meet demand, establishment of cost and volume payment arrangements for some services, and close monitoring of demand and capacity throughout the year. This risk is also incorporated in the BAF within the wider commissioner relations and high risk cost pressures risks.

Newly identified in-year and future risks

There were no new risks added to the Board Assurance Framework during the year. The risk in relation to Suffolk was updated from one that described the mobilisation of services in taking over this contract to one that described a high risk cost pressure around the provision of dressings in community nursing services. Each Board Assurance risk was reviewed and updated to take into account the Single Oversight Framework and the Sustainability and Transformation Plan. The overall number of risks on the Board Assurance Framework was reduced due to a consolidation of risks where the Board had identified areas of overlap, in order to make monitoring more effective.

Data security

All data security breaches were reviewed by the Trust's Caldicott Guardian, and appropriate actions implemented. There were no level two information governance serious incidents requiring investigation (defined as sufficiently high profile cases or deemed a breach of the Data Protection Act or Common Law Duty of Confidentiality, and hence reportable to the Department of Health and Information Commissioner's Office). There were 11 level one information governance SIRIs recorded (defined as a confirmed SIRI but not reportable to ICO and Department of Health). They were categorised as follows:

Type	Number
Loss of sensitive information	4
Confidentiality breach	1
Inappropriate disclosure of information	4
Inappropriate breach by external agency	1
Other	1

3.3.4 The risk and control framework

Risk and control mechanism

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 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.

Assurance for risk prevention, deterrence, management and mitigation

All risk registers for the Trust are held within a centrally maintained electronic system (DATIX). This system is supported through regular risk review processes led by the Lead Director. Risk register reports are then scrutinised at service level and corporate meetings. A Risk Group, comprising Trust-wide risk leads, reports to the

Quality and Risk Assurance Committee. Risks that are not being successfully mitigated and controlled are escalated and discussed at executive directors' meetings in order to prioritise management action appropriately.

3.3.5 Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. I have been advised of the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Finance and Performance Committee and the Quality and Risk Assurance Committee. A plan to address any weaknesses identified, and to ensure continuous improvement of the system, is in place.

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the managers and clinical leads within the NHS Trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Account and other performance information available to me. My review is informed by the Head of Internal Audit Opinion and comments made by the external auditors in their management letter and other reports. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Risk Management system and on the controls reviewed as part of Internal Audit's work. The Board Assurance Framework itself provides me with evidence of the effectiveness of controls that manage the risks to the Trust achieving its strategic objectives.

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 BAF report quarterly.
- 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.

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

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

- Cost Improvement Programme (CIP): medium risk.
- Information Technology Audit: not risk rated.
- Follow-up review:
    - BAF and Risk Management follow-up
    - Clinical Audit
- Key Financial Systems: low risk
- Information Governance: medium risk.
- Staff Engagement and Retention: not risk rated.

There were no high or critical risk findings raised in reports Internal Audit have issued during the year.

The Head of Internal Audit Opinion states:

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

The opinion is based on:

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses; and
- Other relevant information, including the Trust's regulatory status.

Performance assessed by NHS regulators

As described in the Performance Summary section above, the CQC has rated the Trust as "Good" following an inspection in 2014 and NHS I has placed the Trust into segment two of the Single Oversight Framework.

Data quality

The Trust 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.

The Trust 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.

3.3.6 Significant issue

The Board has identified the delivery of its Cost Improvement Programme (CIP) as a significant issue impacting on the Trust's priorities.

There was a shortfall of £3.1m on the delivery of the Trust's recurrent CIP target of £5.4m. The Trust has become increasingly reliant on non-recurrent savings (which delivered £2.5m in the current year). The current forecast is that the Trust will be £5.2m below base case cumulatively (and recurrently) by March 2018. There are ideas in the pipeline in excess of this amount totalling £6.1m cumulatively by March 2018. However this puts a very high degree of pipeline conversion and delivery to achieve the base case of the strategy by the end of March 2018. The Trust continues to identify mitigations against this risk as part of its financial strategy, which is subject to ongoing monitoring by the Executive Directors, Finance and Performance Committee and Trust Board.

Accountable Officer's signature

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

NB: sign and date in any colour ink except black

Signature:……..……

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

Date:……..

4. Remuneration and Staff Report

This section includes:

4.1 Remuneration Report
4.2 Staff Report

4.1 Remuneration Report

This section includes:

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

4.1.1 Remuneration Policy

The Secretary of State for Health determines the remuneration of the Chair and Non-Executive Directors nationally.

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

4.1.2 Salaries and allowances

The following tables and narrative below have been independently audited by Ernst & Young LLP.

The salaries and other allowances of the senior managers who have held office for all or part of the 2016/17 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	2016/17					
		Salary (Bands of £5,000)	Expense Payments - Taxable (to nearest £100)	Performance Pay & Bonuses (Bands of £5,000)	Long-term Performance Pay & Bonuses (Bands of £5,000)	All Pension-Related Benefits (Bands of £2,500)	TOTAL (Bands of £5,000)
Ken Applegate	Chair (Until 31.05.16)	0-5	7	0	0	0	0-5
Geraldine Broderick	Chair (From 21.06.16)	20-25	21	0	0	0	25-30
Roisin Fallon-Williams	Chief Executive	140-145	6	0	0	35-37.5	175-180
Dr. Penny Newman	Medical Director *	125-130	13	0	0	7.5-10	135-140
Anna Morgan	Director of Nursing and Quality	105-110	12	0	0	30-32.5	135-140
Andrew Hopkins	Director of Finance & Performance	115-120	8	0	0	100-102.5	215-220
Paul Cracknell	Director of Strategy and Transformation	105-110	27	0	0	27.5-30	135-140
Lorrayne Barrett	Director of Integrated Care	105-110	4	0	0	25-27.5	130-135
Derek Allwood	Non-Executive Director	5-10	13	0	0	0	5-10
Heather Peck	Non-Executive Director and interim chair **	5-10	13	0	0	0	5-10
Geoff Rivers	Non-Executive Director	5-10	5	0	0	0	5-10
Stephen Pond	Designate Non-Executive Director	5-10	0	0	0	0	5-10
Amanda Reynolds	Non-Executive Director	5-10	0	0	0	0	5-10
Dr Iain Brooksby	Non-Executive Director	5-10	0	0	0	0	5-10

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

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

Name	Title	2015/16					
		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)
		£000s	£00s	£000s	£000s	£000s	£000s
Kenneth Applegate	Chair	20 - 25	19	0	0	0	20 - 25
Roisin Fallon-Williams	Chief Executive	135 - 140	8	0	0	157.5 - 160	295 - 300
Dr. Rosalyn Proops	Medical Director (Until 31.05.15)	15 - 20	0	0	0	0	15 - 20
Dr. Penny Newman	Medical Director (from 15.06.15)	55 - 60	0	0	0	0	55 - 60
Anna Morgan	Director of Nursing, Quality & Operations	105 - 110	3	0	0	40 - 42.5	145 - 150
Paul Cracknell	Director of Strategy and Transformation	105 - 110	19	0	0	0	105 - 110
Matthew Colmer	Director of Performance and Information (until 2.03.16)	90 - 95	0	0	0	0	90 - 95
Roy Clarke	Director of Finance (until 29.11.15)	65 - 70	0	0	0	0 - 2.5	65 - 70
Roy Jackson**	Director of Finance (from 02.11.15 until 29.02.16)	90 - 95	0	0	0	0	90 - 95
Andrew Hopkins	Director of Finance & Performance (from 01.03.16)	5 - 10	0	0	0	0	5 - 10
Lorrayne Barrett	Director of Integrated Care	105 - 110	3	0	0	0	105 - 110
Derek Allwood	Non Executive Director	5 - 10	13	0	0	0	5 - 10
Prof. Ian Harvey	Non Executive Director (until 03.02.16)	0 - 5	0	0	0	0	0 - 5
Alexander Robinson	Non Executive Director (until 30.04.15)	0 - 5	0	0	0	0	0 - 5
Heather Peck	Non Executive Director	5 - 10	9	0	0	0	5 - 10
Amanda Reynolds	Non Executive Director	5 - 10	0	0	0	0	5 - 10
Geoff Rivers	Non Executive Director	5 - 10	15	0	0	0	5 - 10
Stephen Pond	Designate Non Executive Director (from 01.12.15)	0 - 5	0	0	0	0	0 - 5
Dr. Iain Brooksby	Non Executive Director (from 04.01.16)	0 - 5	0	0	0	0	0 - 5

During the year there have not been any payments to past directors. During the prior year, the Trust appointed Roy Jackson as Interim Director of Finance through an off-payroll arrangement with an executive resourcing agency. He held the position for the period from 2 November 2015 to 29 February 2016.

4.1.3 Fair pay disclosure

The narrative below has been independently audited by Ernst & Young LLP.

NHS organisations are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in NCHC in the financial year was £140-£146k (£135-£140k in 2015/16). The mid-point of this band was 5.4 times (5.3 in 2015/16) the median remuneration of the workforce, which was £26,302 (£26,041 in 2015/16).

In 2016/17, no employees (no employees in 2015/16) received whole time equivalent remuneration in excess of the highest paid director. Remuneration ranged from £6,157 to £142,360 (2015/16 £6,157- £140,757).

For the purposes of this calculation, total remuneration includes salary, non-consolidated performance-related pay, employer pension contributions and benefits in kind. It does not include severance payments or the cash equivalent transfer value of pensions.

4.1.4 Pension benefits

The following tables and narrative below have been independently audited by Ernst & Young LLP.

Past and present employees are covered by the provisions of the NHS Pensions Scheme or other recognised pension schemes such as the National Employment Savings Trust. The accounting treatment in relation to pension liabilities is detailed in note 1.5 to the accounts.

Details of the benefits payable and rules of the NHS Pension Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. These 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 Trust 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 Financial Reporting Manual requires that "the period

between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these is provided below.

(a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017 is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant Financial Reporting Manual 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

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

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

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 (draft numbers under review).

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

2015/16		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 2016 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2015 (to nearest £1,000)	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016 (to nearest £1,000)	Employer's contribution to stakeholder pension*
Name	**Title**	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Roisin Fallon-Williams	Chief Executive	5.0 - 7.5	20.0 - 22.5	50 - 55	160 - 165	831	139	980	0
Anna Morgan	Director of Nursing, Quality & Operations	2.5 - 5.0	(30.0) - (27.5)	25 - 30	40 - 45	408	(55)	359	0
Paul Cracknell	Director of Strategy and Transformation	(2.5) - 0	(2.5) - 0	10 - 15	35 - 40	174	(3)	173	0
Matthew Colmer	Director of Performance & Information	(2.5) - 0	(2.5) - 0	25 - 30	80 - 85	444	(4)	446	0
Roy Clarke	Director of Finance	0 - 2.5	0 - 2.5	20 - 25	70 - 75	277	3	283	0
Andrew Hopkins	Director of Finance	(5.0) - (2.5)	(10.0) - (7.5)	30 - 35	100 - 105	624	(47)	585	0
Lorrayne Barrett	Director of Integrated Care	0 - 2.5	0 - 2.5	0 - 5	0 - 5	3	3	3	0

* The employer's contribution to stakeholder pension figures have been restated to show the correct figures.

4.1.5 Cash Equivalent Transfer Values

The following narrative has been independently audited by Ernst & Young LLP.

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

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes

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

4.2 Staff Report

The Staff Report includes:

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

4.2.1 Analysis of staff numbers and costs

The following tables and narrative below have been independently audited by Ernst & Young LLP.

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

Table showing number of Senior Management by pay band

Senior Management Banding	Number
Band 8A	80
Band 8B	31
Band 8C	14
Band 8D	7
Band 9	4
Very Senior Management	3

Tables showing an analysis of staff numbers and costs

Table below showing staff numbers

Staff Numbers	2016-17 Total Number	Permanently employed Number	Other Number	2015-16 Total Number
Average Staff Numbers				
Medical and dental	**29**	29	0	30
Administration and estates	**510**	498	12	503
Healthcare assistants and other support staff	**725**	689	36	707
Nursing, midwifery and health visiting staff	**847**	810	37	847
Nursing, midwifery and health visiting learners	**0**	0	0	10
Scientific, therapeutic and technical staff	**404**	398	6	404
Social Care Staff	**1**	1	0	1
Healthcare Science Staff	**4**	4	0	4
Other	**7**	7	0	6
TOTAL	2,527	2,436	**91**	2,512
Of the above - staff engaged on capital projects	**4**	4	0	4

Table showing employee benefits

Employee benefits	2016-17 Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**77,814**	71,110	6,704
Social security costs	**6,791**	6,568	223
Employer Contributions to NHS BSA - Pensions Divis	**9,901**	9,576	325
Termination benefits	**443**	443	0
Total employee benefits	**94,950**	**87,698**	**7,252**
Employee costs capitalised	**575**	152	423
Gross Employee Benefits excluding capitalised costs	**94,375**	**87,546**	**6,829**

Employee Benefits - Gross Expenditure 2015-16	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	77,749	70,409	7,340
Social security costs	5,053	4,872	181
Employer Contributions to NHS BSA - Pensions Divis	9,633	9,289	344
Termination benefits	351	351	0
TOTAL - including capitalised costs	92,786	84,921	7,865
Employee costs capitalised	627	179	448
Gross Employee Benefits excluding capitalised costs	92,159	84,742	7,417

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

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

of the employees' costs are met locally.

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

4.2.2 Staff composition

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

Table showing staff numbers by gender

Staff category	Female	Male
Directors	7	4
Non-voting directors and other VSMs	0	2
Other staff	2,472	366
Total	2,459	372

4.2.3 National Staff Survey

The staff survey is set within a national and local context of significant system change and cost pressures but has provided an invaluable insight into the views of our staff following publication of the results by NHS England. 316 NHS organisations, including 17 Community Trusts completed the 2016 survey. We adopted a mixed-method approach using electronic and paper surveys.

When comparing the 2016 survey to the 2015 results, there are 2 positive and 5 negative statistically significant changes in this year's results. In comparison to other Community Trusts we have not moved as far, or as fast as would have preferred. Analysis of the figures show that NCHC's overall staff engagement score is 3.71 compared with 3.70 in 2015 and the average for community trusts of 3.80 in 2015 (scores are between 1 to 5, with the highest figure being positive). Overall, of the 32 Key Findings, NCHC scored average or better than average in 9 and below average in 23 when compared to other community trusts.

Our highest ranking scores included:
77 % of staff reporting most recent experience of violence
93 % of staff reporting errors, near misses or incidents witnessed in the last month
Only 1 % of staff experiencing physical violence from staff in the last 12 months
Only 8 % of staff experiencing discrimination at work in the last 12 months
52 % of staff reporting most recent experience of harassment, bullying or abuse

Key Findings: comparisons	2016	2015
Response rate	48%	37%
Staff engagement	3.71	3.7
Staff attending work despite feeling unwell	64%	57%
Bullying, harassment and abuse experienced from patients	30%	24%
Staff experiencing discrimination	8%	6%
Staff confidence and security in reporting unsafe clinical practice	3.64	3.73

Furthermore, staff recommending our Trust as a place of work or to receive treatment was stable at 3.58 although below the community average of 3.72.

Key Findings in relation to the Workforce, Race and Equality Standard	NCHC 2016	NCHC 2015	Average Community Trusts
KF 26: % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White: 24% BME: 35%	White: 22% BME: 33%	White: 18% BME: 24%
KF 21: % of staff believing that the organisation provides equal opportunities for career progression or promotion	White: 89% BME: 78%	White: 91% BME: 89%	White: 90% BME: 79%

Results have been discussed at Board, leadership team and staff groups - initial actions include:

- A Trust wide campaign to address concerns of harassment and bullying by staff, adhering to the national call to action on this topic
- A Trust wide campaign about zero tolerance towards violence, abuse and discrimination by patients to staff
- Revise the Staff Champions Network to support local focus and actions
- Supporting Freedom to Speak Up Champions, increasing awareness and accessibility

4.2.4 Examples of workforce developments

This section includes:

- Your Voice Our Future
- Quality Champions Programme
- Talent Management
- Other initiatives

“Your Voice Our Future”

NCHC launched a staff engagement campaign called “Your Voice Our Future” which has 3 aims: (1) Stakeholder management: to build relationships with key staff groups to gather, understand and share their requirements. (2) Crowdsourcing campaign management: to design and manage targeted on-line crowdsourcing campaigns that achieve our objectives. (3) Catalysing change: to turn insight from each campaign into positive change. We have held online conversations with staff through this method covering: consistency of leadership, refreshing the behaviour framework and making practical changes to our environment and Information Technology.

Quality Champions Programme

NCHC launched the Quality Champions Programme which aims to give staff the opportunity to learn about quality improvement tools and techniques and put this knowledge into practice – learning by doing. A social movement will be created with staff who are equipped to build a quality improvement culture across the Trust.

As a champion, participants will be able to identify required improvements in their own area and then make small scale changes that can make a difference for patients and staff. Training and development is provided to improve skills at workshops and with additional coaching sessions and support available.

Talent Management

A Talent Management process has been introduced to help succession planning and support individual development needs for our leaders. So far this process has involved all band 7 and 8 staff, and will be rolled out to other levels.

Other initiatives

Other initiatives described in detail within the Quality Account 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.

4.2.5 Staff policies

This section includes:

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

Equal opportunities

NCHC's approach to equal opportunities is set out in the Equality and Diversity Policy and the Equality Delivery Scheme. The Board is committed to improving equal opportunities and equality performance by NCHC, making it embedded in mainstream business and for all staff to meet the evidential requirements of the Equality Act, especially the public sector equality duty, and the statutory duty to consult and involve patients and communities and other local interests (Health and Social Care Act 2012 and Equality Act 2010). NCHC has published Equality Objectives under the following headings:

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

Equality disclosures

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

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

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

adjustments are put in place to support the applicant.

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

The 2011 Census information (Norfolk) has been published and as a result, we are able to compare our ethnicity profile to the Norfolk population. The table shows a summary level comparison of the Black Minority Ethnic (BME) vs non-BME numbers. The data initially reflects that the Trust is not employing a workforce attributable to the BME population in Norfolk. However, as can be seen from the data, there is 19.1% of the organisation that has not stated what their ethnicity is.

Category	NCHC (%)	2011 Census Norfolk (%)
non-BME	77.7%	96.3%
BME	3.1%	3.8%
Not Stated / Undefined	19.1%	0.0%

Social, community and human rights issues

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

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

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

NCHC has carried out a range of equality analysis and human rights screening when carrying out their duties to ensure NCHC is paying 'due regard' to the three aims of the Public Sector Equality Duty and the Human Rights Act. NCHC is an early adopter of the Equality Diversity System 2 self-assessment tool. The EDS2 self-assessment was completed with the involvement of representatives from the local public sector,

NHS Employers, and voluntary sector organisations such as The Guide Dogs Association for East Anglia, West Norfolk Befriending Service, Norwich Mind, and the Community Relations and Equality Board. The Board approved the self-assessment and implemented an action plan in response this assessment. All actions with a deadline during the year have been completed.

NCHC has signed up to become a Diversity Champion with Stonewall, a lobbying organisation for Lesbian, Gay, Bi-sexual and 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.

Employee consultation

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

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

- Designing sustainable models of care.
- Making changes to the musculoskeletal service.
- Making changes to the Learning Disabilities service.
- Developing responses to service tenders.
- Programme of staff engagement events across the localities.

Health and safety

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

Sickness absence

The sickness absence rate for the year is 5.5%, compared to 5.3% for the previous year. These sickness figures are based on NCHC's internal reporting systems and cover the period 1st April 2016 to 31st March 2017. 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 2016 to 31st December 2016.

Staff sickness absence and ill health retirements		
	2016-17	2015-16
	Number	Number
Total days lost	25,388	22,468
Total staff years	2,460	2,361
Average working days lost	**10.32**	**9.52**
Source: NHS Digital - Sickness Absence Publication - based on data from the ESR Data Warehouse		

An updated Absence Management Policy is being implemented with changes to long term absence management and phased return to work, and introduction of Staff Physiotherapy. Template letters have been updated to reflect feedback from Trade Unions and Line Managers. We will also be reviewing the relevant Management Essentials training modules.

4.2.6 Staff recognition

Staff were shortlisted for a number of national awards. Three of our services were shortlisted for the annual Health Service Journal (HSJ) Value in Healthcare Awards, which reward improved value and efficiency in healthcare. The awards recognise and reward outstanding efficiency and improvement by the NHS across 20 categories. They also seek out examples of demonstrable improvement in outcomes, both within clinical initiatives and back office functions.

The services shortlisted were:

- Norwich Homeward: nominated in the Community Health Service Redesign category.
- Learning Disabilities Team East for their Learning Disability Annual Health Checks: nominated in the Specialist Services category.
- Estates and Facilities working with the Trust's Patient Environment Group: Delivering an enhanced patient environment across our estate: nominated in the Facilities and Estates Management category.

We were also a finalist in the Health Estates and Facilities Management Association national awards, and our Procurement Team was selected as finalists in the 2016/17 National Government Opportunities Procurement Awards.

4.2.7 Expenditure on consultancy

Expenditure on consultancy services is shown in the accounts Note 6 Operating Expenses. The expenditure in 2016/17 was £502k (£418k in 2015/16).

4.2.8 Off-payroll engagements

Table showing existing off-payroll payments

Engagements	Number
Existing engagements as of 31 March 2017	0
Of which, then number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	0
for more than four years at the time of reporting	0

There were no existing off-payroll engagements 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.

The table below sets out all new off-payroll engagements, where the equivalent daily charge is more than £220 per day and where the engagement lasts longer than six months:

Table showing new off-payroll engagements

Engagements	Number
Number of new engagements between 1 April 2016 and 31 March 2017	1
Number of new engagements which include contractual clauses giving Norfolk Community Health & Care NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	1
Number for whom assurance has been requested	1
Of which:	
assurance has been received	1
assurance has not been received	0
engagements terminated as a result of assurance not being received, or ended before assurance received	0

Table showing Board member and senior officer off-payroll engagements

Engagements	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed “board members, and/or senior officers with significant financial responsibility” during the financial year. This figure includes both off-payroll and on-payroll engagements	0

4.2.9 Exit packages

The following tables and narrative below have been independently audited by Ernst & Young LLP.

Table showing exit packages agreed in 2016/17

Exit Packages agreed in 2016-17

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	1	3,833	0	0	**1**	**3,833**	0	0
£10,000-£25,000	2	25,560	0	0	**2**	**25,560**	0	0
£25,001-£50,000	3	125,380	0	0	**3**	**125,380**	0	0
£50,001-£100,000	2	111,758	0	0	**2**	**111,758**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Total	**8**	**266,531**	**0**	**0**	8	**266,531**	**0**	**0**

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

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

Accountability Report signature

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

Accountable Officer's signature
NB: sign and date in any colour ink except black

Signed:……..

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

Date: ……..

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.

5.1 INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST

We have audited the financial statements of Norfolk Community Health and Care NHS Trust for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 27. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2016-17 Government Financial Reporting Manual (the 2016-17 FReM) as contained in the Department of Health Group Accounting Manual 2016-17 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

• the table of salaries and allowances of senior managers and related narrative notes on pages 52 to 54;
• the table of pension benefits of senior managers and related narrative notes on pages 54 to 56;
• the tables of exit packages and related notes on page 67;
• the analysis of staff numbers and costs and related notes on pages 57 to 59; and
• the table of pay multiples and related narrative notes on page 54.

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 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of the Trust 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 Directors, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor
As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 35, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

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. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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 its use of resources are operating effectively.

Scope of the audit of the financial statements
An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

• whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
• the reasonableness of significant accounting estimates made by the directors; and
• the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, 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. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on the financial statements

In our opinion the financial statements:

• give a true and fair view of the financial position of Norfolk Community Health and Care NHS Trust as at 31 March 2017 and of its expenditure and income for the year then ended; and
• have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Opinion on other matters

In our opinion:
• the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
• the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:
• in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
• 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; or
• we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in these respects

Certificate

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

Kevin Suter
for and on behalf of Ernst & Young LLP
Luton
31 May 2017

C. FINANCIAL STATEMENTS

Statement of Comprehensive Income for year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Gross employee benefits*	7	**(94,375)**	(92,159)
Other operating costs	6	**(33,576)**	(33,481)
Revenue from patient care activities	4	**127,731**	126,159
Other operating revenue	5	**5,395**	3,761
Surplus/(deficit) for the financial year		**5,175**	4,280
Public dividend capital dividends payable		**(2,310)**	(2,037)
Retained surplus/(deficit) for the year		**2,865**	2,243

Other Comprehensive Income

		2016-17 £000s	2015-16 £000s
Impairments and reversals taken to the revaluation reserve	10.1	**(700)**	(60)
Net gain/(loss) on revaluation of property, plant & equipment	10.1	**7,544**	0
Total comprehensive income for the year		**9,709**	2,183

* For further information on gross employee benefits, see the remuneration and staff report on pages 53 to 67.

Financial performance for the year**

Retained surplus/(deficit) for the year		**2,865**	2,243
Impairments	12	**(46)**	19
Adjustments in respect of donated government grant asset reserve elimination		**(124)**	(133)
Adjusted retained surplus/(deficit)		**2,695**	2,129

** Impairments and adjustments in respect of the elimination of donated asset reserves are excluded for the purposes of NHS financial performance assessment.

The notes on pages 77 to 101 form part of this account.

Statement of Financial Position as at 31 March 2017

	NOTE	31 March 2017 £000s	31 March 2016 £000s
Non-current assets:			
Property, plant and equipment*	10.1	**76,853**	69,551
Intangible assets*	11.1	**23**	29
Trade and other receivables	15.1	**0**	48
Total non-current assets		**76,876**	69,628
Current assets:			
Inventories	14	**362**	447
Trade and other receivables	15.1	**8,997**	6,386
Cash and cash equivalents	16	**23,259**	22,956
Total current assets		**32,618**	29,789
Total assets		**109,494**	99,417
Current liabilities			
Trade and other payables	17	**(14,670)**	(14,142)
Provisions	19	**(861)**	(1,043)
Total current liabilities		**(15,531)**	(15,185)
Net current assets/(liabilities)		**17,087**	14,604
Total assets less current liablilities		**93,963**	84,232
Non-current liabilities			
Provisions	19	**(233)**	(211)
Total non-current liabilities		**(233)**	(211)
Total assets employed		**93,730**	84,021
FINANCED BY:			
Public dividend capital		**15,414**	15,414
Retained earnings		**56,565**	53,700
Revaluation reserve	10.1	**21,751**	14,907
Total Taxpayers' Equity:		**93,730**	84,021

The notes on pages 77 to 101 form part of this account.

The financial statements on pages 73 to 101 were approved by the Trust Board on 31 May 2017 and signed on its behalf by:

Chief Executive: Date:

* Intangible assets work in progress has been separately classified for the first time this year.

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**15,414**	**53,700**	**14,907**	**84,021**
Changes in taxpayers' equity for 2016-17				
Retained surplus/(deficit) for the year	0	2,865	0	**2,865**
Net gain / (loss) on revaluation of property, plant and equipment	0	0	7,544	**7,544**
Impairments and reversals	0	0	(700)	**(700)**
Net movement in reserve balance	**0**	**2,865**	**6,844**	**9,709**
Balance at 31 March 2017	**15,414**	**56,565**	**21,751**	**93,730**
Balance at 1 April 2015	**15,414**	**51,457**	**14,967**	**81,838**
Changes in taxpayers' equity for the year ended 31 March 2016				
Retained surplus/(deficit) for the year	0	2,243	0	2,243
Net gain / (loss) on revaluation of property, plant and equipment	0	0	0	0
Impairments and reversals	0	0	(60)	(60)
Net movement in reserve balance	**0**	**2,243**	**(60)**	**2,183**
Balance at 31 March 2016	**15,414**	**53,700**	**14,907**	**84,021**

Statement of Cash Flows for the Year ended 31 March 2017

	NOTE	**2016-17 £000s**	2015-16 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**5,175**	4,280
Depreciation and amortisation	6	**3,891**	3,930
Impairments and reversals	6	**(46)**	19
(Increase)/Decrease in Inventories		**85**	(163)
(Increase)/Decrease in Trade and Other Receivables		**(2,563)**	(330)
Increase/(Decrease) in Trade and Other Payables		**(349)**	1,848
Provisions utilised		**(316)**	(973)
Increase/(Decrease) in movement in non cash provisions		**156**	981
Net Cash Inflow/(Outflow) from Operating Activities		**6,033**	9,592
Cash Flows from Investing Activities			
(Payments) for Property, Plant and Equipment		**(3,563)**	(4,756)
Net Cash Inflow/(Outflow) from Investing Activities		**(3,563)**	(4,756)
Net Cash Inflow / (Outflow) before Financing		**2,470**	4,836
Cash Flows from Financing Activities			
PDC Dividend (paid)/refunded		**(2,167)**	(1,979)
Net Cash Inflow/(Outflow) from Financing Activities		**(2,167)**	(1,979)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**303**	2,857
Cash and Cash Equivalents at the beginning of the period		**22,956**	20,099
Cash and Cash Equivalents at year end	16	**23,259**	22,956

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Accounting Manual 2016-17 issued by the Department of Health. The accounting policies contained in that manual 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 Group Accounting Manual permits a choice of accounting policy, the accounting policy which 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 by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

Going Concern

These accounts have been prepared on a going concern basis.

1.2 Charitable Funds

Under the provisions of IFRS10 and 11 *Consolidated and Separate Financial Statements*, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In previous financial years, the Trust has consolidated its Charitable Fund. However, for 2016-17, the Trust has determined that consolidation of its related Charitable Fund is not required as the Charitable Fund is not considered material in the context of the Trust's accounts. Consolidated financial statements have therefore not been presented for the current or previous period.

1.3 Critical accounting judgements and key sources of estimation uncertainty

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

1.3.1 Critical judgements in applying accounting policies

The following are the critical 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 a significant effect on the amounts recognised in the financial statements.

Recognition of other income from NHS bodies

The Trust has assessed that £400,000 of other income from NHS bodies which was confirmed after balance date should be recognised in these financial statements. This judgement is due to the events which give rise to the income occurring during the financial year ended 31 March 2017.

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

Further to Note 1.2 regarding the consolidation of charities, the Trust has determined that the Norfolk Community Health & Care NHS Trust Charitable Fund no longer meets the criteria required for consolidation into the Trust accounts. This is on the basis that, although the Trust continues to exercise control of the charity through its role as sole corporate trustee, the value of the Charitable Fund's net assets, revenue and expenses are not considered material to the consolidated financial statements.

Revaluation of the Trust's land and buildings

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

Land and buildings have been revalued as at 31 March 2017 and revisions to useful economic lives has been taken to be an indication of circumstances in existence at 1 April 2016 in calculating depreciation charges for the year to 31 March 2017.

1.3.2 Key sources of estimation uncertainty

The Trust conducts a triennial review of land and buildings valuations. See note 10.3 for key sources of estimation uncertainty arising from the revaluation of land and buildings.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.4 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners of healthcare services.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

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

1.5 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, except for bonuses earned but not yet taken which, like leave earned but not yet taken is not accrued for at the year end, as it is not significant to the financial statements.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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

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

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

1.6 Other expenses

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

Notes to the Accounts - 1. Accounting Policies (Continued)

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

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

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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

Fixtures and equipment are carried at depreciated historic cost less impairment as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

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

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust, where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Notes to the Accounts - 1. Accounting Policies (Continued)

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

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

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

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.9 Depreciation, amortisation and impairments
Freehold land is not depreciated.

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

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with HM Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by HM Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

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

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

Notes to the Accounts - 1. Accounting Policies (Continued)

1.11 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

The Trust as lessee

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

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

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

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

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

1.12 Inventories

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

1.13 Cash and cash equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.14 Provisions

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

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.95% (2015-16: negative 1.00%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

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

Notes to the Accounts - 1. Accounting Policies (Continued)

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

1.15 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 19.

1.16 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 the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.17 Carbon Reduction Commitment Scheme (CRC)

The Trust currently operates below the threshold for participation in the CRC Scheme Trading Scheme. Further information relating to the Trust's environmental policies are included within the Trust's Annual Report.

1.18 Contingencies

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

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

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

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

Notes to the Accounts - 1. Accounting Policies (Continued)

1.19 Financial assets

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

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

Loans and receivables

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

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

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

1.20 Financial liabilities

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

The Trust classifies all of its financial liabilities as 'other financial liabilities'.

Other financial liabilities

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

1.21 Value Added Tax

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

1.22 Foreign currencies

The Trust's functional currency and presentational currency is Pound Sterling. The Trust does not hold any monetary items denominated in foreign currencies.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 26 to the financial statements.

1.24 Public Dividend Capital (PDC) and PDC dividend

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

Notes to the Accounts - 1. Accounting Policies (Continued)

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

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

1.25 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).

1.26 Subsidiaries

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

The Trust has one subsidiary, the Norfolk Community Health & Care Charitable Fund. The Trust has not consolidated the Norfolk Community Health & Care Charitable Fund in 2016-17 following a decision that the Fund was not significant to the Trust's consolidated financial statements.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.27 Research and Development

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

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

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016-17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 due for implementation in 2018-19, and IFRS 14 not yet endorsed within the EU.

● IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRS 14 *Regulatory Deferral Accounts* – Not yet EU-endorsed and therefore not applicable to NHS bodies.
● IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.29 Gifts

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

Notes to the Accounts - 1. Accounting Policies (Continued)

1.30 Equity

1.30.1 Public dividend capital reserve

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

1.30.2 Retained earnings reserve

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

1.30.3 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.

2. Operating segments

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

3. Income generation activities

The Trust's income generating activities are not material.

4. Revenue from patient care activities

	2016-17 £000s	2015-16 £000s
NHS England	**11,774**	17,293
Clinical Commissioning Groups	**80,771**	81,229
Foundation Trusts	**26,115**	15,299
Non-NHS:		
Local Authorities	**8,553**	11,487
Private patients	**41**	0
Other Non-NHS patient care income	**477**	851
Total revenue from patient care activities	**127,731**	126,159

5. Other operating revenue

	2016-17 £000s	2015-16 £000s
Education, training and research	**696**	1,059
Receipt of charitable donations for capital acquisitions	**162**	184
Non-patient care services to other bodies	**1,050**	1,198
Sustainability & Transformation Fund Income	**1,586**	0
Income generation (Other fees and charges)	**564**	273
Rental revenue from operating leases	**937**	1,047
Other revenue from NHS bodies*	**400**	0
Total other operating revenue	**5,395**	3,761
Total operating revenue	**133,126**	129,920

* The Trust has assessed that this income should be recognised in these financial statements despite confirmation of this balance only being provided after 31 March 2017 as the events which give rise to the income occurred during the financial year ended 31 March 2017.

6. Operating expenses

	2016-17 £000s	2015-16 £000s
Services from other NHS Trusts	**151**	153
Services from other NHS bodies	**108**	61
Services from NHS Foundation Trusts	**1,247**	1,109
Total Services from NHS bodies*	**1,506**	1,323
Purchase of healthcare from non-NHS bodies	**939**	654
Trust Chair and Non-executive Directors	**68**	55
Supplies and services - clinical	**8,570**	7,474
Supplies and services - general**	**9,034**	9,149
Consultancy services	**502**	418
Establishment	**1,218**	1,336
Transport	**3,927**	3,738
Business rates paid to local authorities	**647**	546
Premises and insurance	**2,060**	3,165
Legal Fees	**161**	190
Impairments and Reversals of Receivables	**162**	602
Depreciation	**3,885**	3,922
Amortisation	**6**	8
Impairments and (reversals) of property, plant and equipment	**(46)**	19
Internal Audit Fees	**89**	89
Audit fees**	**59**	49
Other auditor's remuneration for assurance work**	**13**	13
Clinical negligence	**272**	231
Education and Training	**471**	501
Change in Discount Rate	**33**	(1)
Total Operating expenses (excluding employee benefits)	**33,576**	33,481
Employee Benefits		
Employee benefits excluding Board members	**93,549**	91,274
Board members	**826**	885
Total Employee Benefits	**94,375**	92,159
Total Operating Expenses	**127,951**	125,640

*Services from NHS bodies does not include expenditure which falls into a category below.

** The 2015-16 audit fees and 2015-16 other auditor's remuneration for assurance work figures have been restated to include unrecoverable VAT previously coded to supplies and services - general.

The 2016-17 audit fees figure includes £5,000 relating to the 2015-16 financial statements audit.

7. Employee benefits

7.1 Employee benefit analysis

	2016-17 Total £000s	2015-16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**77,814**	77,749
Social security costs	**6,791**	5,053
Employer Contributions to NHS BSA - Pensions Division	**9,901**	9,633
Other pension costs	**1**	0
Termination benefits	**443**	351
Total employee benefits	**94,950**	92,786
Employee costs capitalised	**575**	627
Gross Employee Benefits excluding capitalised costs	**94,375**	92,159

7.2 Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of people retired early on ill health grounds	7	3

	2016-17 £000s	2015-16 £000s
Total additional pensions liabilities accrued in the year relating to these retirements	438	212

8. Operating Leases

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.

8.1 Norfolk Community Health and Care NHS Trust as lessee

			2016-17 Total £000s	2015-16 £000s
Payments recognised as an expense				
Minimum lease payments			**1,098**	1,394
Total			**1,098**	1,394
	Buildings £000s	**Other £000s**		
Payable:				
No later than one year	1,032	634	**1,666**	1,751
Between one and five years	950	458	**1,408**	861
After five years	974	0	**974**	678
Total	**2,956**	**1,092**	**4,048**	3,290
Total future sublease payments expected to be received:			100	0

8.2 Norfolk Community Health and Care NHS Trust as lessor

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

	2016-17 £000s	2015-16 £000s
Recognised as revenue		
Rental revenue	**937**	1,047
Total	**937**	1,047
Receivable:		
No later than one year	**1,039**	1,093
Between one and five years	**612**	168
After five years	**0**	0
Total	**1,651**	1,261

9. Better Payment Practice Code

9.1 Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total non-NHS Trade Invoices Paid in the Year	**17,384**	**33,617**	18,692	32,004
Total non-NHS Trade Invoices Paid Within Target	**14,728**	**25,361**	16,877	24,461
Percentage of non-NHS Trade Invoices Paid Within Target	**84.72%**	**75.44%**	90.29%	76.43%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**810**	**8,336**	834	**7,354**
Total NHS Trade Invoices Paid Within Target	**622**	**7,225**	764	**6,621**
Percentage of NHS Trade Invoices Paid Within Target	**76.79%**	**86.68%**	91.61%	90.03%

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

9.2 The Late Payment of Commercial Debts (Interest) Act 1998

There have been no costs over £500 incurred during 2016/17 or 2015/16 in relation to the late payment of commercial debts.

10. Property, plant and equipment current year

10.1. Property, plant and equipment

2016-17	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:								
At 1 April 2016	10,184	55,944	4,480	4,347	76	9,144	374	**84,549**
Additions of Assets Under Construction			4,075					**4,075**
Additions Purchased	0	69		0	0	0	0	**69**
Additions - Purchases from Cash Donations & Government Grants	0	162	0	0	0	0	0	**162**
Reclassifications	0	2,594	(4,372)	587	0	1,191	0	**0**
Disposals other than for sale	0	0	0	(113)	(76)	(49)	(374)	**(612)**
Revaluation	1,247	1,812	0	0	0	0	0	**3,059**
Impairments/reversals charged to operating expenses	0	(2,342)	0	0	0	0	0	**(2,342)**
Impairments/reversals charged to reserves	0	(2,087)	0	0	0	0	0	**(2,087)**
At 31 March 2017	**11,431**	**56,152**	**4,183**	**4,821**	**0**	**10,286**	**0**	**86,873**
Depreciation								
At 1 April 2016	0	6,321		3,015	76	5,216	370	**14,998**
Disposals other than for sale	0	0		(122)	(76)	(35)	(370)	**(603)**
Revaluation	0	(4,485)		0	0	0	0	**(4,485)**
Impairment/reversals charged to reserves	0	(1,387)		0	0	0	0	**(1,387)**
Impairments/reversals charged to operating expenses	0	(2,388)		0	0	0	0	**(2,388)**
Charged During the Year	0	1,959		388	0	1,538	0	**3,885**
At 31 March 2017	**0**	**20**	**0**	**3,281**	**0**	**6,719**	**0**	**10,020**
Net Book Value at 31 March 2017	**11,431**	**56,132**	**4,183**	**1,540**	**0**	**3,567**	**0**	**76,853**
Asset financing:								
Owned - Purchased	11,290	54,479	4,183	1,520	0	3,567	0	**75,039**
Owned - Donated	141	1,264	0	20	0	0	0	**1,425**
Owned - Government Granted	0	389	0	0	0	0	0	**389**
Total at 31 March 2017	**11,431**	**56,132**	**4,183**	**1,540**	**0**	**3,567**	**0**	**76,853**

10.1. (cont). Property, plant and equipment

Revaluation Reserve Balance for Property, Plant & Equipment

2015-16	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	1,110	13,797	0	0	0	0	0	**14,907**
Movements:								
Net increase in the fair value of assets arising from revaluation	1,247	6,297	0	0	0	0	0	**7,544**
Impairments and reversals	0	(700)	0	0	0	0	0	**(700)**
At 31 March 2017	**2,357**	**19,394**	**0**	**0**	**0**	**0**	**0**	**21,751**

Additions to Assets Under Construction in 2016-17

Buildings excluding dwellings	2,241
Plant and machinery (including IT)	1,834
Balance as at YTD	**4,075**

10.2. Property, plant and equipment prior-year

2015-16	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:								
At 1 April 2015	10,184	53,538	3,932	4,330	76	7,649	374	**80,083**
Additions of Assets Under Construction	0	0	4,355	0	0	0	0	**4,355**
Additions Purchased	0	44	0	0	0	0	0	**44**
Additions - Purchases from Cash Donations & Government Grants	0	30	154	0	0	0	0	**184**
Reclassifications	0	2,420	(3,961)	17	0	1,495	0	**(29)**
Disposals other than for sale	0	(9)	0	0	0	0	0	**(9)**
Revaluation	0	0	0	0	0	0	0	**0**
Impairment/reversals charged to reserves	0	(19)	0	0	0	0	0	**(19)**
Impairments/reversals charged to operating expenses	0	(60)	0	0	0	0	0	**(60)**
At 31 March 2016	**10,184**	**55,944**	**4,480**	**4,347**	**76**	**9,144**	**374**	**84,549**
Depreciation								
At 1 April 2015	0	4,114	0	2,653	76	3,873	369	**11,085**
Disposals other than for sale	0	(9)	0	0	0	0	0	**(9)**
Charged During the Year	0	2,216	0	362	0	1,343	1	**3,922**
At 31 March 2016	**0**	**6,321**	**0**	**3,015**	**76**	**5,216**	**370**	**14,998**
Net Book Value at 31 March 2016	**10,184**	**49,623**	**4,480**	**1,332**	**0**	**3,928**	**4**	**69,551**
Asset financing:								
Owned - Purchased	10,048	48,626	4,326	1,305	0	3,928	4	**68,237**
Owned - Donated	136	750	154	27	0	0	0	**1,067**
Owned - Government Granted	0	247	0	0	0	0	0	**247**
Total at 31 March 2016	**10,184**	**49,623**	**4,480**	**1,332**	**0**	**3,928**	**4**	**69,551**

10.3. (cont). Property, plant and equipment

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

The valuations make a number of assumptions. The most significant of these assumptions include:
- Identification of appropriate market values for assets valued at market value;
- There being no unidentified deficiencies in the land and buildings subject to valuation;
- Total useful life and remaining useful life for assets valued on a depreciated replacement cost basis;
- The value of rebuilding an asset for assets valued on a depreciated replacement cost basis; and
- Residual values.

Revisions to building useful economic lives identified in the valuation at 31 March 2017 have been taken to be an indication of circumstances in existence at 1 April 2016 in calculating depreciation charges for the year to 31 March 2017. The range of economic lives of non-current assets are set out in the table below:

Economic lives of non-current assets	**2016/17**	
	Min Life Years	Max Life Years
Intangible assets		
Software licences	3	5
Property, plant and equipment		
Buildings	1	75
Plant & machinery	1	23
Transport equipment	7	7
Information technology	3	8
Furniture and fittings	5	8

During 2016/17, the Trust received donations of cash to purchase PPE additions of £162k for the completion of a multi-purpose training room at North Walsham Hospital. This donation was received from the Norfolk Community Health & Care NHS Trust Charitable Fund.

11. Intangible non-current assets

11.1 Intangible non-current assets current year

2016-17	Computer Licenses £000's	Intangible Assets Under Construction £000's	Total £000's
At 1 April 2016	**135**	**29**	**164**
Reclassifications	29	(29)	**0**
Disposals other than by sale	(135)	0	**(135)**
At 31 March 2017	**29**	**0**	**29**
Amortisation			
At 1 April 2016	**135**		**135**
Disposals other than by sale	**(135)**		**(135)**
Charged during the year	**6**		**6**
At 31 March 2017	**6**	**0**	**6**
Net Book Value at 31 March 2017	**23**	**0**	**23**
Asset Financing: net book value at 31 March 2017 comprises:			
Purchased assets	23	0	**23**
Total at 31 March 2017	**23**	**0**	**23**

11.2 Intangible non-current assets prior year

2015-16	Computer Licenses £000's	Intangible Assets Under Construction £000's	Total £000's
Cost or valuation:			
At 1 April 2015	135	0	**135**
Reclassifications	0	29	**29**
At 31 March 2016	**135**	**29**	**164**
Amortisation			
At 1 April 2015	127	0	**127**
Charged during the year	8	0	**8**
At 31 March 2016	**135**	**0**	**135**
Net book value at 31 March 2016	**0**	**29**	**29**
Net book value at 31 March 2016 comprises:			
Purchased	0	29	**29**
Total at 31 March 2016	**0**	**0**	**0**

12. Analysis of impairments and reversals recognised in 2016-17

	2016-17 Total £000s	2015-16 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI		
Loss or damage resulting from normal operations	**0**	0
Over-specification of assets	**0**	0
Abandonment of assets in the course of construction	**0**	0
Total charged to Departmental Expenditure Limit	**0**	0
Unforeseen obsolescence	**0**	0
Loss as a result of catastrophe	**0**	0
Other	**0**	19
Changes in market price	**(46)**	0
Total charged to Annually Managed Expenditure	**(46)**	19
Total Impairments charged to SoCI - DEL	**0**	0
Total Impairments charged to SoCI - AME	**(46)**	19
Overall Total Impairments	**(46)**	19
Donated and Government Granted Assets included above		
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**	0

13. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2017 £000s	31 March 2016 £000s
Property, plant and equipment	**324**	226
Total	**324**	226

14. Inventories

	Consumables	Energy	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**297**	**0**	**150**	**447**	**0**
Additions	3,793	8	2,479	**6,280**	0
Inventories recognised as an expense in the period	(3,936)	(8)	(2,421)	**(6,365)**	0
Balance at 31 March 2017	**154**	**0**	**208**	**362**	**0**
Balance at 1 April 2015	**147**	**7**	**130**	**284**	**0**
Additions	3,573	16	1,877	5,466	0
Inventories recognised as an expense in the period	(3,423)	(23)	(1,857)	(5,303)	0
Balance at 31 March 2016	**297**	**0**	**150**	**447**	**0**

15. Receivables

15.1 Trade and other receivables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS receivables - revenue	**3,842**	2,598	**0**	0
NHS prepayments and accrued income	**3,521**	2,174	**0**	0
Non-NHS receivables - revenue	**1,348**	2,043	**0**	0
Non-NHS receivables - capital	**0**	117	**0**	0
Non-NHS prepayments and accrued income	**886**	631	**0**	48
Provision for the impairment of receivables	**(931)**	(1,624)	**0**	0
VAT	**198**	381	**0**	0
Operating lease receivables	**133**	66	**0**	0
Total	**8,997**	6,386	**0**	48
Total current and non current	**8,997**	6,434		

The great majority of trade is with NHS commissioning organisations (Clinical Commissioning Groups and NHS England) who purchase NHS patient care services from the Trust. As NHS commissioning organisations are funded by government to purchase NHS patient care services, no credit scoring of them is considered necessary.

15.2. Receivables past their due date but not impaired

	31 March 2017 £000s	31 March 2016 £000s
By up to three months	**1,534**	554
By three to six months	**850**	0
By more than six months	**477**	377
Total	**2,861**	931

15.3. Provision for impairment of receivables

	2016-17 £000s	2015-16 £000s
Balance at 1 April	**(1,624)**	(1,027)
Amount written off during the year	**855**	5
Amount recovered during the year	**184**	47
(Increase)/decrease in receivables impaired	**(346)**	(649)
Balance at 31 March	**(931)**	(1,624)

The Trust has reviewed its outstanding receivables and determined that a number of items are unlikely to be collected. In conducting this review, the Trust has considered the age of the debt, any disputes that have been or are expected to be lodged by customers, and any other relevant credit control information.

16. Cash and Cash Equivalents

	31 March 2017 £000s	31 March 2016 £000s
Opening balance	**22,956**	20,099
Net change in year	**303**	2,857
Closing balance	**23,259**	22,956
Made up of		
Cash with Government Banking Service	**23,237**	22,936
Commercial banks	**11**	9
Cash in hand	**11**	11
Cash and cash equivalents in the statement of financial position	**23,259**	22,956
Cash and cash equivalents in the statement of cash flows	**23,259**	22,956

17. Trade and other payables

	Current	
	31 March 2017 £000s	31 March 2016 £000s
NHS payables - revenue	**2,324**	3,159
NHS accruals and deferred income	**1,686**	1,564
Non-NHS payables - revenue	**3,990**	3,406
Non-NHS payables - capital	**1,551**	808
Non-NHS accruals and deferred income	**3,325**	3,623
Social security costs	**1,614**	1,545
PDC Dividend payable to DH	**180**	37
Total payables (current)	**14,670**	14,142
Included above:		
Outstanding pension contributions at the year end	**1,307**	2,064

18. Deferred income

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Opening balance at 1 April	**547**	549	**0**	33
Deferred revenue addition	**55**	480	**0**	0
Transfer of deferred revenue	**(423)**	(482)	**0**	(33)
Closing balance at 31 March	**179**	547	**0**	0

19. Provisions

	Total	Comprising: Early Departure Costs	Legal Claims	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**1,254**	224	142	397	491
Arising during the year	**765**	0	88	0	677
Utilised during the year	**(316)**	(11)	(38)	0	(267)
Reversed unused	**(642)**	0	(11)	(397)	(234)
Change in discount rate	**33**	33	0	0	0
Balance at 31 March 2017	**1,094**	**246**	**181**	**0**	**667**
Expected Timing of Cash Flows:					
No later than one year	**861**	13	181	0	667
Between one and five years	**42**	42	0	0	0
Later than five years	**191**	191	0	0	0
Balance at 31 March 2017	**1,094**	**246**	**181**	**0**	**667**

	31 March 2017 £000s	31 March 2016 £000s
Comprising:		
Current	**861**	1,043
Non current	**233**	211
Total	**1,094**	**1,254**

The provision for early departure costs relates to an injury benefit claim for a former employee. Its carrying amount is the present value of the expected future cash flows discounted using the HM Treasury rate of 0.24% (2015/16: 1.37%). There is no uncertainty in respect of timings of

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

The other provision related to a Benjamin Court service charge. Agreement has been reached in year in respect of the charges and no liability (over and above the charges the Trust currently pays) has been incurred, so the provision has been reversed in full during 2016/17.

The redundancy provision relates to employees whose roles have been disestablished following service reconfiguration. These payments are all expected to be made within the next 12 months. Costs have been identified based on the affected individuals where identifiable, or an estimate based on the most likely outcome where a group of employees are affected.

The following amounts are included in the provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities, and are not included in the Trust's provisions shown above:

As at 31 March 2017	1,042
As at 31 March 2016	668

20. Contingencies

	31 March 2017 £000s	31 March 2016 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**20**	0
Employment Tribunal and other employee related litigation	**0**	90
Net value of contingent liabilities	**20**	90

There were no contingent assets at 31 March 2017 and 31 March 2016.

21. Financial Instruments

21.1 Financial risk management

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

Currency risk

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

Interest rate risk

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

Credit risk

As the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

21.2 Financial Assets

	Loans and receivables £000s	Total £000s
Receivables - NHS	6,938	**6,938**
Receivables - non-NHS	1,513	**1,513**
Cash at bank and in hand	23,259	**23,259**
Total at 31 March 2017	**31,710**	**31,710**
Receivables - NHS	1,512	1,512
Receivables - non-NHS	1,622	1,622
Cash at bank and in hand	22,956	22,956
Total at 31 March 2016	26,090	26,090

21.3 Financial Liabilities

	Other £000s	Total £000s
NHS payables	3,939	**3,939**
Non-NHS payables	8,778	**8,778**
Total at 31 March 2017	**12,717**	**12,717**
NHS payables	3,196	3,196
Non-NHS payables	2,105	2,105
Total at 31 March 2016	5,301	5,301

22. Events after the end of the reporting period

The following non-adjusting event has occurred after the end of the reporting period. This does not affect the financial statements for the year ending 31 March 2017.

Notice has been given to the Trust that the current contract between the Trust and West Suffolk Foundation Trust for the provision of Suffolk community services will cease with effect from 30th September 2017. This will reduce revenue by circa £10.3m in 2017/18.

23. Related party transactions

The Department of Health is regarded as a related party. During the year 2016/17 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. These entities are:

Great Yarmouth and Waveney Clinical Commissioning Group
Ipswich and East Suffolk Clinical Commissioning Group
North Norfolk Clinical Commissioning Group
Norwich Clinical Commissioning Group
South Norfolk Clinical Commissioning Group
West Norfolk Clinical Commissioning Group
West Suffolk Clinical Commissioning Group
NHS England
Norfolk and Norwich University Hospitals NHS Foundation Trust
Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
West Suffolk NHS Foundation Trust
NHS Litigation Authority
James Paget University Hospitals NHS Foundation Trust
East of England Ambulance Service NHS Trust
Health Education England
NHS Improvement

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with:

NHS Business Services Authority
HM Revenue and Customs
Norfolk County Council
Norwich City Council
North Norfolk District Council
Broadland District Council
Borough Council of Kings Lynn and West Norfolk
Breckland District Council
South Norfolk District Council

The Trust is the Corporate Trustee of the Norfolk Community Health & Care NHS Trust Charitable Fund (the Charitable Fund). In the year to 31 March 2017, the Trust received £237k (2015/16: £644k) in income from the Charitable Fund. The Trust did not pay the Charitable Fund for any goods or services during 2016/17 or 2015/16. At 31 March 2017, the Charitable Fund owed the Trust £19k (31 March 2016: £20k).

24. Losses and special payments

The total number of losses cases in 2016-17 and their total value (in pounds) was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	0	0
Special payments	10,344	6
Total losses and special payments and gifts	**10,344**	**6**

The total number of losses cases in 2015-16 and their total value (in pounds) was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	5,219	4
Special payments	1,734	3
Total losses and special payments	**6,953**	**7**

25. Financial performance targets

25.1 Breakeven performance

	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s	2016-17 £000s
Turnover	130,709	127,725	124,843	123,266	123,796	129,920	**133,126**
Retained surplus/(deficit) for the year	528	545	2,683	3,107	2,719	2,243	**2,865**
Adjustment for:							
Timing/non-cash impacting distortions:							
Adjustments for impairments	24	92	0	1,477	0	19	**(46)**
Adjustments for impact of policy change in respect of donated/government grants assets		0	0	46	(91)	(133)	**(124)**
Break-even in-year position	**552**	**637**	**2,683**	**4,630**	**2,628**	**2,129**	**2,695**
Break-even cumulative position	**552**	**1,189**	**3,872**	**8,502**	**11,130**	**13,259**	**15,954**

	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	2016-17 %
Materiality test (is it equal to or less than 0.5%):							
Break-even in-year position as a percentage of turnover	0.42	0.50	2.15	3.76	2.12	1.64	**2.02**
Break-even cumulative position as a percentage of turnover	0.42	0.93	3.10	6.90	8.99	10.21	**11.98**

25.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

25.3 External financing

The External Financing Limit (EFL) is a control on the net cash flows of the Trust. The Trust is given an external financing limit which it is permitted to undershoot. 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.

	2016-17 £000s	2015-16 £000s
External financing limit (EFL)	(303)	(1,441)
Cash flow financing	(303)	(2,857)
External financing requirement	**(303)**	(2,857)
Under/(over) spend against EFL	**0**	1,416

25.4 Capital resource limit

The capital resource limit controls the amount of capital expenditure the Trust may incur in a year. The Trust is given a capital resource limit which it is not permitted to exceed.

	2016-17 £000s	2015-16 £000s
Gross capital expenditure	4,303	4,580
Less: donations towards the acquisition of non-current assets	(166)	(184)
Charge against the capital resource limit	**4,137**	4,396
Capital resource limit	4,172	4,400
(Over)/underspend against the capital resource limit	**35**	4

26. Third party assets

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

	31 March 2017 £000s	31 March 2016 £000s
Third party assets held by the Trust	**2**	0

27. Comparatives

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