Norfolk Community Health and Care NHS Trust

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Annual Report and Accounts 2013/14

FINAL 30th May 2014

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1 Chair and Chief Executive's Foreword

It is with pleasure that we introduce this Annual Report for 2013/14. As ever, it has been a year of many successes and challenges for the Trust and these pages report the fantastic achievements of our staff in improving services for patients. It has been a year in which we have been delighted to introduce a number of new services at the request of our local commissioners, the Clinical Commissioning Groups. In Children's Services we have extended our Children's Community Nursing services. This enables even more children to stay at home with their families during periods of ill-health rather than being admitted to hospital. In adult services we have supported our local acute hospitals in regards to pressures they experience every winter. In west Norfolk we now run a virtual ward. This enables patients to come home earlier from hospital in a safe and planned manner. It is particularly pleasing to note how the team leader and staff involved in this initiative got it off the ground in a very short timeframe. In central Norfolk, in support of the Norfolk and Norwich University Hospital NHS Foundation Trust, we have a number of new community schemes. Most notable perhaps is the Urgent Care Unit which we have developed in conjunction with partners at the front door of the hospital to take pressure off A&E. However, there are many new and innovative schemes in the community which are less visible, such as community administration of IV antibiotics and rapid response that have played their part in keeping people safe and well at home.

The Board continue to closely monitor patient experience. At every Board meeting we welcome a patient or staff member who tells us of a particular success of a patient service, or perhaps where there has been a complaint that we have had to resolve and improve services. For many Board members, this sets the tone for our debate and reminds us why we provide the services we do. The Board also closely monitors patient feedback through tools such as the Family & Friends Test. Every single piece of patient narrative is read by the Board and moreover where there are negative comments, action is followed through to ensure improvement.

All of these successes are delivered by our most important asset – our staff. Throughout the year we have worked hard on engaging and communicating with staff, and the Board has been increasingly visible out in our services. We are pleased to note that through our regular staff surveys people feel more engaged, better trained and better motivated. However, we must note with disappointment that staff also report working increasingly long hours – something that staff do willingly but is an issue we must tackle in the coming year.

The Trust continues its long journey to Foundation status and has passed some significant milestones in the last year. Following a Board to Board meeting with the Trust Development Authority, they assessed us as fit to progress to the Monitor phase. We subsequently completed Phase One of the Monitor assessment and we await the commencement of Phase Two.

All of the above would not have been possible without the support and endorsement of our partners throughout the county. These are many ranging from local voluntary bodies, Clinical Commissioning Groups and NHS England but in

particular Norfolk County Council. We have had very positive discussions with the County Council concerning next steps on us working even more closely together on adult services and we look forward to reporting more progress on this important agenda in our next report.

Ken Applegate
Chair

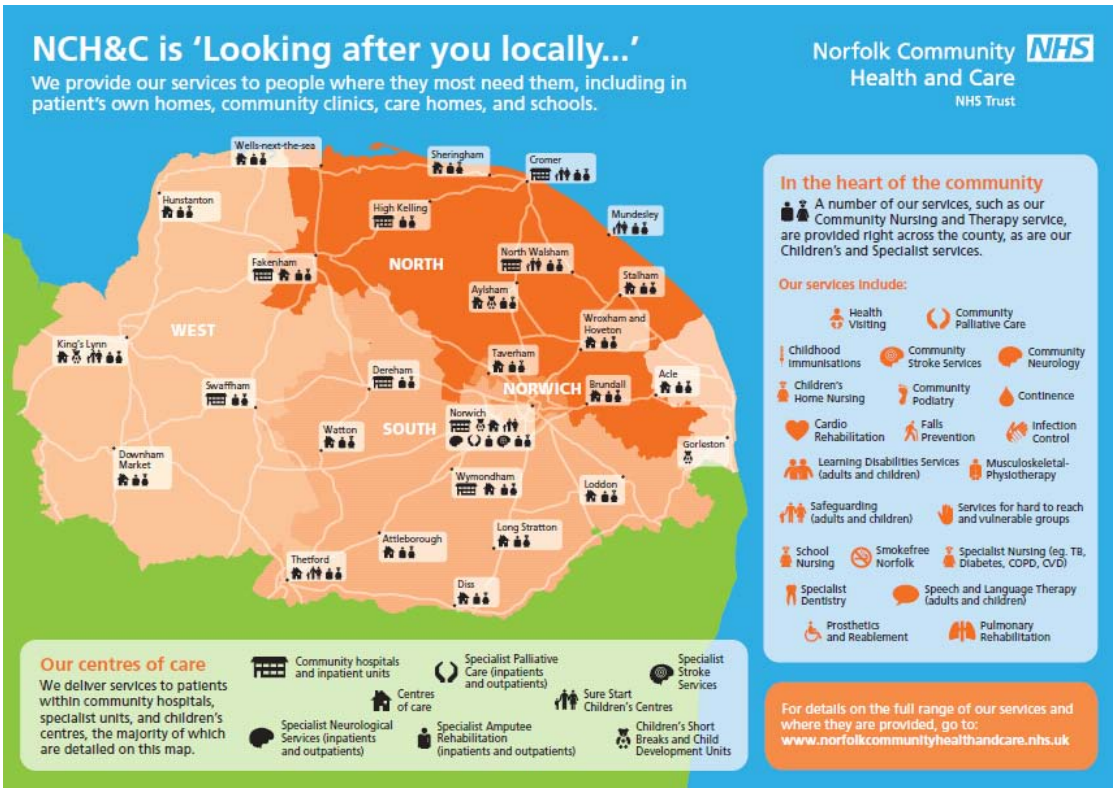
Mark Easton
Interim Chief Executive

Did you know?

Our contacts with the people we serve are extensive and diverse. Each year:

1. Our nursing staff have **1.3 million** face to face appointments with patients;
2. We receive **200,000** referrals from GPs and other health professionals;
3. Our health visitors have more than **20,000** initial appointments and **120,000** follow up appointments;
4. Our musculoskeletal physiotherapists receive **25,000** referrals;
5. Our school nurses hold **20,000** face to face appointments with children;
6. Our orthopaedic triage team assesses **6,000** patients;
7. We have over **3,000** admissions to our community hospitals, including **300** to our palliative care service;
8. Our City Reach team, working with a range of vulnerable and often homeless people, receives around **600** referrals;
9. Our community learning disability service receives nearly **400** referrals;

The Trust's key locations



2 About the Trust

2.1 Our vision and values

Our vision will be delivered through the achievement of the Trust's longer-term strategic objectives and Quality Goals. We have refreshed our strategic objectives to reflect the 'three main challenges': Maintaining quality, responding to demographic pressures, rising public expectations; doing so against the background of financial austerity and funding challenges in the NHS; securing our future in a rapidly changing world. Our recently refreshed strategic objectives are:

1. **Improving quality** through:
    a. Delivering harm free, clinically effective care.
    b. Integrating delivery with social and primary care.
    c. Involving patients and the public and delivering excellent patient experience.
    d. Effective partnerships with other organisations.
    e. Effective clinical leadership.
    f. Transforming services.

2. **Enabling our people** through:
    a. Inspiring staff.
    b. Empowering staff to speak out and put things right.
    c. Ensuring the right staff, with the right skills are available to deliver care.

3. **Securing our future** through:
    a. Ensuring continuity of service.
    b. Delivering a financially sustainable organisation.
    c. Building reputation and confidence with commissioners.
    d. Investing in infrastructure.
    e. Growth.

During the year, the Trust refreshed its well established values as follows:

1. **Community**
    a. As one Trust, we enhance the lives of our patients through our commitment, support and education.
    b. We are proud to serve our local Community by providing integrated quality services with our partner organisations.
    c. We respect and value the trust we are given to enter our patients' homes.

2. **Compassion**
    a. We provide compassionate, co-ordinated and personalised quality care that is safe and effective.
    b. We empower and educate our patients and their carers in the effective delivery and management of their own independence, health and wellbeing.

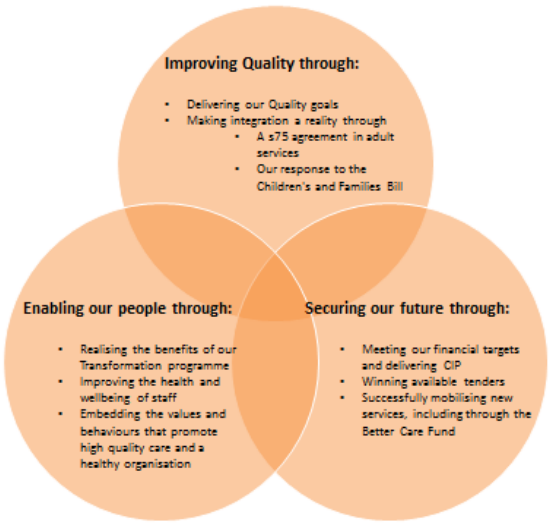
c. We are dedicated to holistic, compassionate care and demonstrate this through our commitment to our personal and professional development.

3. **Creativity**
   a. Our expertise, commitment and creativity are key to the successful delivery of our services.
   b. We are always open to new ideas that support us in delivering effective compassionate care to our patients.
   c. We continuously innovate and implement efficient delivery of care.

2.2 Strategic objectives

Strategic objectives

Annual objectives



Our business development strategy is to defend our market share, grow our core services and diversify our business:

a. We aim to defend the Trust's dominant share of the current community healthcare market in Norfolk,
b. We will grow our share of the Norfolk community healthcare market,
c. We will diversify our business and move away from overreliance on Norfolk CCG funded activity, notably through seeking social care funding and operating in new geographies.

2.3 What we do

The Trust's business units provide:

1. Children's services, which includes prevention and health promotion services;
2. Specialist services, such as neurological rehabilitation or re-ablement services; and,
3. Adult community services, delivered on a locality basis co-terminous with the areas covered by clinical commissioning groups (CCGs), and working in an integrated way with social care.

In summary, the Trust:

- Serves 750,000 people, across Norfolk and Waveney.
- Provides services commissioned by the Norfolk Clinical Commissioning Groups and Norfolk County Council.
- Employs 2,250 whole time equivalent staff.
- Delivers care in people's homes, as well as from over 200 different locations, and through over 400 schools.
- Manages 10 community hospitals, 255 beds and 28 community "virtual" beds, also known as the Hospital at Home Care Service.
- Has income of £123.3m.

The services provided by the Trust include:

- Community nursing and therapy
- Stroke rehabilitation
- Palliative care - inpatient, day care and at home
- Children's general and specialist services
- Specialist and general rehabilitation for patients with loss of independence and/or function
- Stop smoking services
- Wheelchair and prosthetic limb services
- Outreach services for vulnerable and hard to reach groups
- Podiatric (foot and lower leg) surgery
- Dental services

CQC registration

The Trust 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 has not taken any enforcement action against the Trust during the year.

Norfolk

Norfolk is a relatively large and low-lying coastal county in the east of England. Norwich is centrally located within Norfolk and is a city of regional importance. The geographical area covered by the Trust excludes Great Yarmouth, although some of its services are based there. The relatively long distances and travel times to hospital sites make the development of a comprehensive range of community-based healthcare services essential for improving the quality of life and healthcare outcomes in Norfolk. The Trust has developed expertise in delivering health and care services in these dispersed rural communities, where there may also be issues of rural isolation and deprivation.

2.4 How we are organised

The Trust delivers a diverse range of clinical services that are organised into three main business units. The table below sets out the main services provided by the Trust.

Locality/business unit	Service
North, South, West, Norwich Localities	Community Nursing Care Admissions Avoidance Rehabilitation Palliative and end of life care Long term conditions management Case Management
Specialist Services (Adults)	Specialist Neuro-rehabilitation Stroke Rehabilitation Amputee and Post Surgical Rehabilitation Community Care for the Hard to Reach Diagnostics Adult Speech and Language Therapy Musculoskeletal Services Podiatry Podiatric Surgery Wheelchair Assessment Continence Care Smoking Cessation Dentistry Adult Community Learning Disability
Community Children's Services	Health Visiting School Nursing Contraceptive and sexual health service Sure Start children centres Looked after children

	Parent - infant mental health Children's community nursing Children's therapies Child development team Community paediatrics Children's short breaks

The community drug and alcohol services and the integrated community equipment store transferred to other providers for 2013/14.

2.5 More about the Trust

The organisation was created by the merger of five primary care trusts in Norfolk that became NHS Norfolk. Norfolk Community Health and Care was established as an NHS arm's length trading body of the primary care trust in 2008. This allowed the Trust to develop independent commercial and governance operations. The organisation became an independent corporate body as an NHS Trust in 2010.

The Trust is the major provider of community services in Norfolk, including care of vulnerable people, specialist rehabilitation, palliative care and learning disabilities services. Most of the Trust's income is received from the Norfolk clinical commissioning groups, with a smaller proportion from Norfolk County Council. A range of smaller contracts make up the remainder.

In January 2011, the Trust launched its public consultation on the proposals to become a Foundation Trust (FT). The consultation exercise was very successful and received positive feedback on the proposals. The Trust was successfully navigating its FT application through the Department of Health and Strategic Health Authority processes until national structures changed. In July 2013, the Trust Development Authority (TDA) approved the Trust's application for FT status to proceed to Monitor for assessment. The Trust successfully completed phase 1 of the Monitor assessment process in December 2013. The Trust will be assessed by the Care Quality Commission under its new inspection regime before proceeding to the second and final phase of Monitor's assessment process.

The TDA's approval of the Trust's application to Monitor triggered the commencement of the election and nomination process for its future Council of Governors. All 14 public and four staff seats were contested in an election and filled in October 2013. The six appointed Governors were also nominated by the appointing partner bodies. The Council of Governors will continue to operate in shadow form until authorisation as an FT, at which time it will take on the full range of legal and governance duties and responsibilities, as determined by legislation and good practice. Governors have undergone both local Trust induction and national training for their role. The Trust will continue to improve its governance arrangements with a view to becoming a Foundation Trust within the next year.

3 Improving quality and patient safety

3.1 Quality goals

The Trust publishes two important documents annually on quality: Quality Account and Quality Goals. These provide much more detail on the quality of services provided by the Trust. The commentary provided here is a brief summary of the key quality indicators taken from those reports. It is an important way for local NHS services to report on quality and show improvements in the services delivered 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.

The Trust has improved the quality of its services in 2013/14, delivering better health outcomes, high standards of safety, leading to excellent patient experience. This was in line with our Quality Improvement Strategy which was approved in September 2013. The Quality Goals have helped deliver excellent and harm-free care. The 2013/14 Goals were:

- To continue to embed a culture of compassionate care by integrating the 6 Cs Care, Compassion, Competence, Communication, Courage and Commitment. and act on the learning from the Francis Report,
- Developing and promoting our approach to Clinical Effectiveness,
- Meeting our Commissioning for Quality & Innovation (CQUIN) goals.

These Quality Goals are underpinned by a number of elements including:

- Treating all patients with care and compassion,
- Ensuring that every patient is treated with respect, privacy and dignity,
- Raising the organisational visibility of all our vulnerable adults and children to improve their safety,
- Being open and transparent, including implementing the new Duty of Candour,
- Implementing regular mortality reviews.

Performance against the 2013/14 Quality Goals is summarised in the table below.

Performance measure	**Achieved**
We will treat all our patients with care and compassion	
Fewer complaints about staff attitude	**YES**
We will ensure that every patient is treated with respect, privacy and dignity	
Implementation of a privacy and dignity policy	**YES**
We will raise the Trust visibility of all our vulnerable adults and children to improve their safety	
Demonstrate an increase in % of staff undertaking safeguarding adults and children's training	**YES**
Review of safeguarding referrals	**Partially**

We will be open and transparent with our patients/relatives/carers when things go wrong (Duty of Candour)	
Implementation of Duty of Candour	**YES**
Development of mortality review panel	**YES**
Clinical Effectiveness measures	
Beech Ward - patient centred goals.	**Partially**
Colman Centre for Specialist Rehabilitation Service (CCSRS) - Review Goal attainment scaling (GAS) outcomes and evaluate practice	**YES**
Early Supported Discharge - Review outcome of questionnaire	**YES**
Essence of care	**YES**
In-patients - Barthel quality marker of outcomes for our patients.	**YES**

The two amber rated (partially completed) actions were: (1) Review of Safeguarding Referrals. An action plan monitored the Safeguarding Adults Group will ensure that this is fully met in 2014/15. (2) Patient Centred Goals on Beech Ward: new goal setting sheets were trialled by the Therapy Team on Beech ward, starting July 2013. They involved detailing a long term Goal and short term Goals set during admission with an action plan for each Goal. An audit in December 2013 showed that only 25% of sheets were being completed. It was decided at this point to disestablish the Keyworker role for as workloads were becoming unequal leading to lack of time to complete paperwork (including Goal Setting) and difficulties in maintaining communication with Patients and their families. Workshops were held for the Therapy team and including senior nursing staff to determine how communication could be improved on the ward to help streamline the Patient's journey through the Stroke Unit. Goal setting in the weekly Multidisciplinary Team meetings has commenced and this will be reviewed and audited in June 2014.

3.2 Patient experience

The Trust builds its services around the patient, and quality is our priority. Patient experience is a main pillar of the Trust's strategy to keep the patient at the centre of all that the Trust does through delivery of the Patient Experience and Involvement Strategy. The Trust uses a range of measures to assess the patient experience, including the Friends and Family Test.

Friends and Family Test

The Friends and Family Test was included in our Quality Goals for 2013/14 and asks "How likely are you to recommend our ward/department to friends and family if they needed similar care or treatment?" With response categories from a six point scale to answer the question:

1 Extremely Likely
2 Likely
3 Neither likely nor unlikely

4 Unlikely
5 Extremely unlikely
6 Don't know

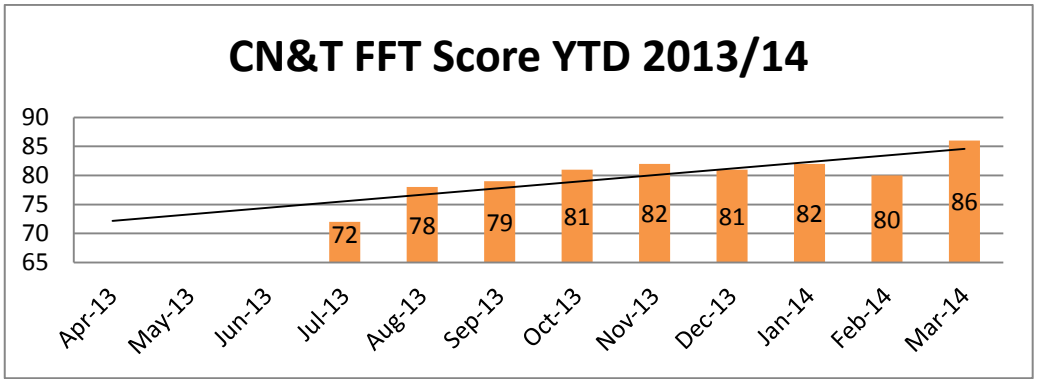
This includes a follow up question "Could you tell us why you gave that score? Your comments are invaluable to us?"

The FFT is expressed as a score and is derived from the proportion of respondents who would be extremely likely to recommend minus the proportion of respondents who would not recommend.

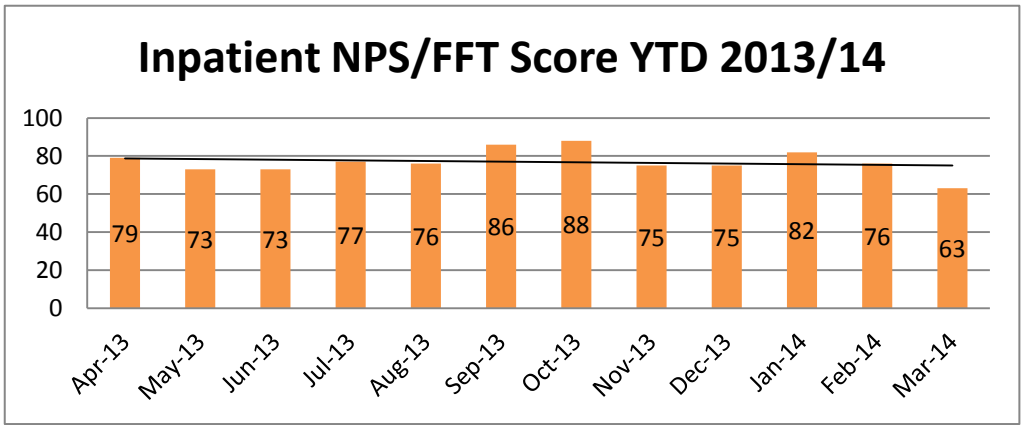
Results for 2013/14

In total, for all services participating in the FFT survey, the Trust has received 2541 responses and an overall score of 77 since it commenced in July 2013. This is just above the benchmark target of 76 set for CN&T teams.

For community nursing and therapy teams, since July 2013 to end of March 2013 the overall score is 79 with a continuing upward trend from 72 in July peaking to 86 in March:-



The inpatient ward results for April to November 2013 are based on the Net Promoter Score (NPS). From December they moved over to the FFT. From April 2013 to March 2014 (Combined NPS and FFT) their overall score for FFT is 74 with a more erratic pattern rising to 88 in October and falling to 63 in March.



In addition to the scores, patients are asked for comments as to why they gave those scores. The majority of comments are extremely positive. Comments on being helpful, friendly and kind are among the most frequent, indicating a continued high level of care and compassion given by our staff.

An additional question has been included which is 'Is there anything specific that we, as a team, could improve on? This was added in December 2013 and a total of 130 responses to this question have been received. 59% of these comments responded positively with words such as 'No', 'Nothing' or 'No, I was entirely satisfied with the care I received'. Of the remaining 41% the top three themes from improvements comments were staffing levels, time spent with patient and times not provided for appointments. Improvement comments are reviewed at team, locality and Trust level.

Patient Opinion

Patient Opinion (PO) is a website www.patientopinion.org.uk where patients and the public can publish their experiences of local health services. The website allows health service staff to interact with these patients to help improve care. There is also the option of giving patients a hard copy feedback card or they can call a freephone number and tell their story over the phone.

NCH&C conducted a small pilot from March – July 2013 in 4 services to trial Patient Opinion. These were City Reach, Community TB service and MSK Physiotherapy services in Dereham and Thetford. The MATRIX project was subsequently added to the pilot and went live in July 2013. Services were issued with credit sized cards which included the website address that they could leave in clinic areas and also a supply of hard copy Freepost feedback cards which could be written on and posted back to Patient Opinion.

For each of the services taking part in the pilot, the Service Leads would receive an alert about a posting relating to their specific service, they could also log on to review stories and give responses. There was excellent feedback about all of the services included in the pilot and service leads had being encouraged to respond to comments regardless of content to demonstrate that we are actively engaging with patient feedback to improve care. Service leads were also encouraged to link into free webex training session offered by Patient Opinion to support raising awareness with patients, responding to comments and how to use reports within the service and the Trust.

Examples of Promoter comments (Extremely likely):-

- *Care and attention to myself and witnessing the care of other patients made me feel safe and reassured – nothing too much trouble and everyone very cheerful.*
  Improvements: *Nothing comes to mind.*
- *From the medical staff through to the nursing staff the standard of care has been excellent. Courtesy as been great. A mention for the cleaners who*

work hard so cheerfully. I could not fault anything and I am very grateful for all the care given.
Improvements: *I think you could do with a few more wheelchairs, meal times can be a bit chaotic! Put pressure on the powers that be for them.*

- *I found the care and patience of all the staff very good indeed, especially at night.*
  Improvements: *I was not happy with the organisation of the meals at the dining room. Being with a walking frame it was tiresome to be there 1/2 hour before the due time and often left till last to be taken out after all the wheelchairs. Sometimes 2 hours in all I was wanting the loo, unable to be taken in time.*

3.3 Patient Led Assessments of the Care Environment (PLACE)

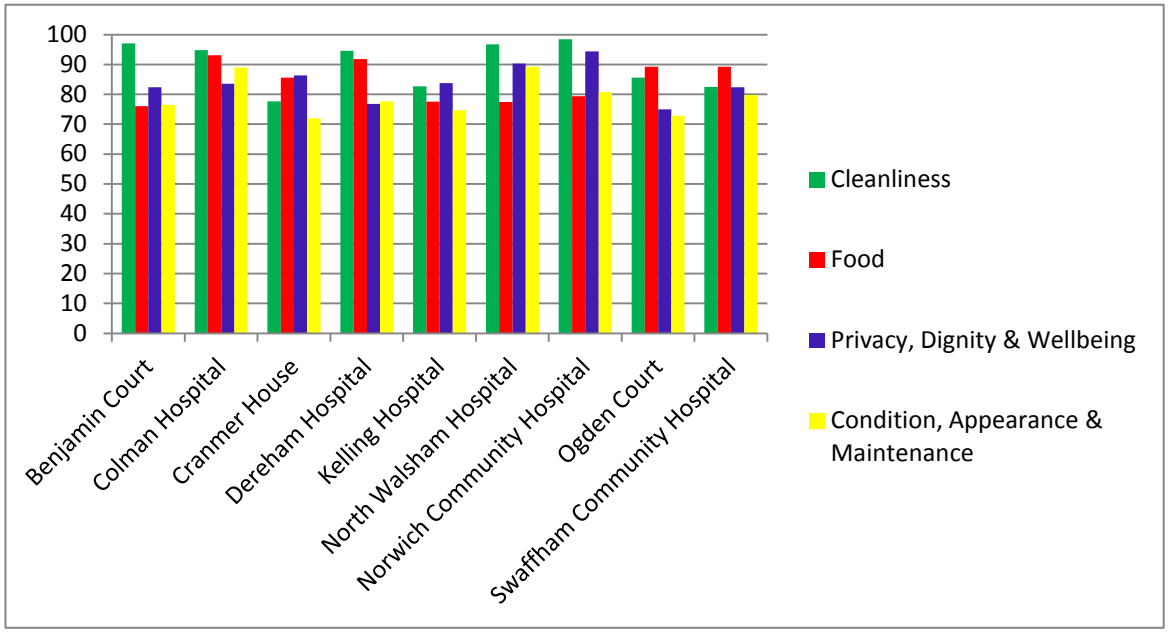
The Government introduced PLACE (Patient Led Assessments of the Care Environment) assessments in 2013 replacing the previous PEAT (Patient Environment Action Team) assessment process. The Trusts undertook PLACE assessments between April-June 2013.

The main changes to the assessment process are summarised below:

- Nationally, the assessment programme was determined by the Health and Social Care Information Centre (HSCIC) who provided 6 weeks' notice of the week in which they required each assessment to take place during the period 2 April – 21st June.
- The PLACE team comprises at least 50% representation from Patient Assessors, who are recruited locally.
- If Patient Assessor representation was less than 50% on the day, the assessment would not be accepted as valid by the HSCIC and would need to be re-arranged with the appropriate ratio of 50:50 Patient Assessor/Staff Assessor in attendance. The Trust met this standard and no inspections were declared invalid during this year's inspection programme.
- The scoring of the assessments changed from a 1-5 score to a 'Pass/Qualified Pass/Fail' or 'Yes/No/Not Applicable' score with the results provided as a percentage score in four categories of Cleanliness, Food, Privacy, Dignity & Wellbeing and Condition Appearance & Maintenance for each site assessed.
- The assessments included a section on the dementia friendly ward environment. This section was incorporated into the 2013 assessment as an information gathering exercise and does not contribute to the Hospital's score. However, this will be a scored element of the assessment in future years.
- As part of the PLACE process, the Trust has responded formally to the assessments and developed action plans for improvement.

Site Name	Cleanliness %	Food %	Privacy, Dignity & Wellbeing %	Condition, Appearance & Maintenance %
Benjamin Court	97.01	76.02	82.35	76.47
Colman Hospital	94.81	93.08	83.53	89.06
Cranmer House	77.66	85.59	86.36	72.03
Dereham Hospital	94.59	91.85	76.84	77.70
Kelling Hospital	82.72	77.51	83.78	74.66
North Walsham Hospital	96.73	77.41	90.35	89.19
Norwich Community Hospital	98.49	79.34	94.33	80.73
Ogden Court	85.56	89.26	75.00	72.81
Swaffham Community Hospital	82.45	89.26	82.40	79.82

2013 PLACE Assessment scores



4 Strategic Review of 2013/14

The Trust developed its services during the year, in line with its five year Integrated Business Plan and the Annual Plan. To continually improve the quality of provision, the Trust:

- Started a major transformation programme that has included deploying over 640 mobile devices to community-based clinical staff to enable greater productivity and increased patient facing time,
- Increased the number of Health Visitors as part of health visitor expansion programme,
- Developed with commissioners, in response to winter pressures, a virtual ward model in the west of the county and an urgent care unit in our Norwich locality,
- Repositioned our Matrix service for sex workers alongside our other services for vulnerable adults and won the tender,
- Invested significantly in the size of our Children's Community Nursing team in order to shift care from the acute to the community setting,
- Piloted a number of new innovations through our commissioning for quality and innovation (CQUIN) programme.

4.1 Achievement of key performance indicators and performance targets

The Trust has a performance monitoring framework in place including integrated performance reporting to the Board. This allows routine scrutiny against a range of key performance indicators (KPIs) in key areas. KPIs are the nationally recognised method for calculating performance in the NHS and highlights are summarised in the table below. These include the national performance measures relevant to the Trust's services from the Trust Development Authority Accountability Framework 2013/14.

The table below shows the key performance indicators that have been achieved

Indicator	Target or upper ceiling	2012/13	2013/14
MRSA cases	6	2	0
Clostridium difficile cases	12	3	3
Injurious falls	Number of falls resulting in harm per 1,000 Occupied Bed Days to be less than 4.0	3.41	3.65
Venous Thromboembolism (VTE) assessments	Percentage of patients risk assessed for VTE	96.7	97.3%

18 week wait referral to treatment	95% patients receiving definitive treatment within 18 weeks of referral	98.4%	99.8%
Health visiting	Over 95% of mothers receiving a New Birth Visit within 28 days	97.9%	97.9%

Areas of non-delivery

Missed targets 2013/14

The table below shows the targets that have not been achieved.

Indicator	Target or upper ceiling	2012/13	2013/14
Smoking cessation service	Achieve a minimum of 2,000 quits per annum	1,606	1,525
Delayed transfers of care	No more than 5.4% of beds occupied by patients whose discharge is delayed for non-medical reasons	5.4%	6.1%

The Smoking Cessation service agreed an annual target for 2013/14 of 2,000 quits with its commissioner, Norfolk County Council. It became apparent during the autumn that the Trust was deviating from its trajectory and a contract query notice was issued by the commissioner in November 2013. The Trust then developed a remedial action plan to address performance to improve referrals rates and the number of quits. However, the number of subsequent referrals generated was not sufficient to recover the level of quits required towards the end of the year, and as such the Trust failed this target, with an outturn of 1,525 quits. However, it is anticipated that a change in the structure of the service coupled with a number of actions will place the Trust in a strong position to improve performance during 2014/15.

Throughout the year, the number of patients whose discharge was delayed for non-medical reasons occupied an average of 6.1% of the Trust's community hospital beds. However, during the year the overall trend has been decreasing, with a rate of just 5.0% compared to the upper ceiling of 5.4%. Whilst there are no contractual targets in place for this performance measure, analysis of the data has shown delays have been attributable to both health service related reasons (including patient and family choice), as well as social care delays.

The average level of community hospital beds occupied by patients whose discharge was delayed for non-medical reasons was 6.1% of beds, compared to

5.2% the previous year. Whilst there are no contractual targets in place for this measure, this is above the local target of 5.4%. There have been improvements in the discharge process as a result of the implementation of the 'Productive Ward' across the Trust's community hospitals. Analysis indicates health system-wide pressures, including patient and relative choice, and the provision of social care packages and undertaking continuing healthcare assessments, as having contributed to the increase in delayed discharges.

Explanation of KPIs

MRSA screening elective patients: MRSA is responsible for several difficult-to-treat infections. Many MRSA infections occur in hospitals and healthcare facilities, with a higher incidence rate in nursing homes or long-term care facilities. Hand-washing is essential to prevent cross infection. The Trust continues to apply strict infection controls measures to aim for no cases of MRSA. There is a de minimis level set nationally for hospital acquired infections.

Cases of Clostridium difficile: is one of the most common causes of infection of the large bowel (colon). It is recognised as the chief cause of hospital-acquired diarrhoea in the US and Europe. A prolonged course of antibiotics or the use of two or more antibiotics in combination increases the risk of C.diff diarrhoea. There is a de minimis level set nationally for hospital acquired infections.

Injurious falls: this indicator provides the rate of patients falls on inpatient units resulting in harm to the patient reported compared to the number of occupied bed days (OBDs) on each inpatient unit.

Venous Thromboembolism (VTE) assessments: All patients should be assessed for risk of developing blood clots on admission to hospital and given tailored preventative treatment, according to new NICE guidelines developed jointly with the National Clinical Guideline Centre for Acute and Chronic Conditions. This indicator provides a measure of the percentage of patients who have a VTE assessment undertaken following admission to community hospitals.

18 week wait referral to treatment: compliance against the 18 week wait Referral to Treatment Target.

New birth visit made within 28 days of birth: target for all postnatal women to receive a new birth visit by day 28 by a health visitor. This is in line with national policy and best practice guidance. The new birth visit is to ensure the provision of on-going postnatal care and advice to mothers as they are discharged by the midwifery service.

Smoking cessation: this is a local Trust contractual target agreed with commissioners that monitors the level of successful four week quits delivered by the Smoke-free service.

Delayed transfers of care: provides a measure of the percentage of beds occupied by patients whose transfer is delayed for non-medical reasons. Delays result in

patients staying in a hospital bed for longer than is medically necessary and is often a result of patients waiting for care assessments. This indicator is used as a measure as to how effectively a health and care system works, given these patients often have complex health and social care needs.

4.2 Partnership working

Our continued commitment to integration with appropriate Norfolk County Council provided care services was further demonstrated with the appointment of a Joint Assistant Director for Integrated Services in our west locality. This post is responsible for the delivery of health and social care services including direct line management of integrated health and social care teams. This model will inform the roll out of integration across the county. A new specification for the delivery of locality based community nursing and therapy was developed in partnership with clinicians, GP colleagues and CCGs. The Trust continues to pursue integration opportunities with Norfolk County Council.

4.3 Becoming a Foundation Trust (FT)

Becoming an FT promotes the Trust's purpose, by:

- Improve the quality of care – through the new governance arrangements local people, represented by FT members and Governors, will be at the heart of the Trust, and their active participation in the Trust will be focused on improving the quality of care;
- Improving outcomes – financial independence will allow the Trust to invest in new solutions that make a real difference; for example, by investing in premises to improve the patient environment;
- Strengthening the business – FT status demonstrates that the Trust is financially secure and a well organised business, which patients and commissioners can trust;
- Attracting and retaining talented staff – staff can continue to have confidence that the Trust will be an important provider of NHS services for years to come;
- Supporting service integration – FT status will reinforce our expertise and credibility to work with partner organisations in order to provide services to a range of people across Norfolk and beyond;
- Promoting system sustainability – the Trust will work with commissioners to stimulate co-operation and competition with other health care providers. This supports the supply of good quality, cost-effective services at a local level.

4.4 Foundation Trust Membership

The Trust has two categories of membership, in preparation for FT status. Public membership is open to anyone aged 14 years and over living in Norfolk and surrounding areas. Our strategy is to build a broad membership that is evenly spread geographically across the local area we serve and reflects the ages and diversity of our population. The Trust has over 9,000 public members. The second category is staff membership. This is open to staff on permanent or fixed term contracts that run for 12 months or longer. Staff automatically become members, unless they opt out although few

choose to do so. Staff members are aligned to one of five constituencies according to their work base. The Trust has exceeded its target to recruit 1% of the population served as public members.

Members continue to:

- receive information about the Trust;
- be consulted on plans for future developments and services;
- have the opportunity to participate in a wide range of Trust activities.

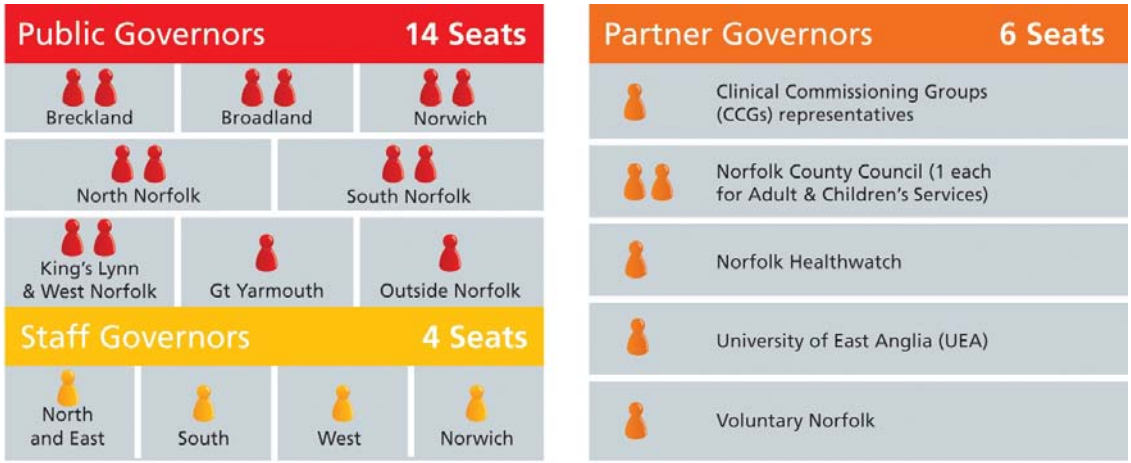
In preparation for FT status, members have:

- elected their representatives onto the Council of Governors;
- had the opportunity to stand as a Governor (as long as they meet minimum basic criteria).

During the year the Trust held a number of events encouraging members to express an interest in standing as Governors. This was very successful, and as a result a Members Forum was established as a regular meeting for those interested in becoming a Governor. Topics are chosen by members and it provides an opportunity to learn more about the role of Governor, the work of the Trust and to meet with senior clinicians and the Board of Directors.

4.5 Shadow Council of Governors

The Trust's Council of Governors has operated in shadow form since November 2013, in preparation for Foundation Trust status.



Our Governors are:

Public Constituency	Name
Breckland	Frances Haywood

Breckland	Adele Walton
Broadland	Tony Barber
Broadland	Geoff Sadler
South Norfolk	Howard Gill
South Norfolk	Adrian Lemmon
Rest of England	Carl Hayden
North Norfolk	Mary Granville- White
North Norfolk	Jeanne Norman
Norwich	Martin Langdon
Norwich	Mary Ledgard
Kings Lynn & West Norfolk	Jade Houlton
Kings Lynn & West Norfolk	Vicki Hopps
Great Yarmouth	Patrick Thompson

Staff Constituency	Name
North and East	Julie Baggott
West	Jayson Elkins
Norwich	Judy Manson
South	Steven Whitton

Partner Governors	Organisation
Dr Graham Clark,	Clinical Commissioning Groups

Alex Stewart, Chief Executive.	Norfolk Healthwatch
Brian Horner, Chief Executive.	Voluntary Norfolk
Charlene Lobo, Senior Lecturer	University of East Anglia
Vacant	Norfolk County Council children's services
Cllr Deborah Gihawi.	Norfolk County Council adult services

4.6 Managing our principal risks

The Trust has implemented a Risk Management Strategy that clearly outlines the leadership, responsibility and accountability arrangements for risk management. It covers risk identification, evaluation, recording, control review and assurance. The Trust maintains a Board Assurance Framework, a Corporate Risk Register and local risk registers, and has adopted a Board Assurance and Escalation Framework and an Early Warning Trigger Tool.

The Board Assurance Framework provides a structured approach to Board oversight of the following strategic risks to the achievement of its objectives:

- Improving quality for patients and the public: risks to patient safety, clinical effectiveness and patient experience;
- Transforming services: risks to operational performance, and risks arising from the changing commissioning landscape;
- Building the Trust: risks to clinical leadership, achieving Foundation Trust status, workforce assurance and human resources;
- Building sustainability: economic and demographic funding risks, and local Trust risks including the cost improvement programme, IM&T strategy implementation and the transfer of estates to the Trust;
- Building reputation: risks to providing appropriate alternative care to acute hospital admission, locally responsive services and competition risks.

4.7 Financial performance

The key elements of the Trust's financial plans for 2013/14 were to build on the strong performance of 2012/13 through the generation of a £1.8m surplus and the delivery of an ambitious £7.7m efficiency programme. The Trust has exceeded both of these targets. The Trust has generated a £3.1m surplus this year (£2.7m in 2012/13) and remained within its resource limits set by the Department of Health.

Significant efficiency savings of £7.9m were achieved during the year through the Trust's Cost Improvement Programme (£10.0m in 2012/13). This was an overachievement of £0.2m against plan. Much of the savings were achieved through the continued redesign and modernisation of clinical services, as well as non-clinical savings from procurement initiatives. However, the sustainable delivery of savings continues to present a challenge to the Trust, with £3.3m of the total savings delivered in 2013/14 being through non-recurrent means. Achieving sustainable recurrent efficiency savings means the Trust is able to continue delivering services in the long-term, and this is why it forms a key component of the Trust's long-term strategy.

A defining feature of the 2013/14 financial year has been the inward transfer of community healthcare property assets on 1st April 2013. This happened as part of national structural changes within the NHS that resulted in the closure of Norfolk Primary Care Trust. The transfer significantly increased the Trust's asset base by £53.8m and gives the Trust more opportunities to make the best use of its estate.

During the year, the Trust invested £6.6m in capital schemes which was an underspend of £0.3m against the Trust's plan and Capital Resource Limit set by the Department of Health. Key areas of investment were the improvement of clinical environments and IT infrastructure to support the efficient delivery of patient care. The Trust was successful in being awarded £0.5m of additional funds by the Department of Health to invest in its 'mobile working' strategy, which enables clinical staff to access IT services through mobile devices.

Working capital has been stable throughout the year. The Trust remains committed to prompt payment of suppliers by aiming to comply with the Confederation of British Industry (CBI) Better Payments Practice Code and is a signatory to the government's Prompt Payments Code. 2013/14 saw a reduction on the previous year's performance, with 83% of non-NHS trade payables being paid within 30 days (86% in 2012/13). 80% of NHS payables were paid within 30 days (79% in 2012/13). Details of compliance with the Better Payment Practice code are detailed in note 10.1 to the accounts.

Over the coming year the Trust plans to continue building on the strong financial position delivered over the past two years, in line with its long-term financial strategy and annual plan (both of which are available on the Trust's website). Focus remains on strengthening the Trust's business platform as the basis for providing sustainable, high quality care to its patients. This will be achieved through the continued delivery of the Cost Improvement Programme, strengthening core business and developing new service opportunities.

Financial disclosures

The Trust is required to highlight specific information in its Annual Report in the interests of transparency. This information is set out below:

- External audit fees

The Trust's external statutory audit for the 2013/14 financial year has been provided by Ernst & Young LLP at a cost to the Trust of £70,080 (inclusive of VAT). In addition, Ernst & Young LLP were engaged to provide a report on whether sums expended by the Trust in 2012/13 on its Sure Start services were spent in accordance with the Trust's contract with Norfolk County Council. This report is a standard requirement of all Sure Start service providers. The fee for this work has not been finalised but is estimated at between £10,800 and £13,200 (inclusive of VAT).

- Legacy balance transfers

In accordance with the Health and Social Care Act 2012, Strategic Health Authorities and Primary Care Trusts were dissolved on 1 April 2013 and their assets and liabilities transferred to successor bodies in the NHS or to other entities. Under the terms of the Norfolk Primary Care Trust Property Transfer Scheme 2013 and its supporting Schedules, a number of assets and liabilities were transferred from Norfolk PCT to the Trust on that date. These are property assets across Norfolk that relate to the delivery of community healthcare, which had a combined book value on transfer of some £53.8m.

The accounting arrangements in respect of the transfer are outlined in Note 1.3 and Note 1.5.1 to the Annual Accounts, and further detail in relation to the assets is provided in Note 14 to the Annual Accounts.

- Charitable Fund consolidation

For 2013/14, the Department of Health Manual for Accounts requires consolidation of related charitable funds where they are determined as being under 'common control' as outlined in the provisions of IAS 27 Consolidated and Separate Financial Statements. The Trust has determined that , as the sole corporate trustee of the charity, consolidation of its related charitable fund is appropriate. Therefore, the 2013/14 Annual Accounts present the financial position of the consolidated group for the first time. To aid the user's understanding of the underlying financial performance of the Trust alone, the main financial statements and the relevant disclosure notes are presented with figures both before and after consolidation. The area of the accounts that is materially impacted by the consolidation is non-current assets (financial instruments) due to the charity holding £1.1m of investment assets as at 31st March 2014.

The accounting arrangements in respect of the consolidation are outlined in Note 1.4 and Note 1.5 to the Annual Accounts. Charitable investments are outlined in further detail in Note 27 to the Annual Accounts.

- ‘Off-payroll’ engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, departments and their arm’s length bodies must publish information on their highly paid and/or senior off-payroll engagements. The table below sets out all off-payroll engagements as of 31 March 2014, where the equivalent daily charge is more than £220 per day and where the engagement lasts longer than six months:

Number of existing engagements as of 31 March 2014	4
Of which, the number that have existed:	
for less than one year at the time of reporting	2
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	2

All existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought. This process is overseen by the Remuneration Committee.

The table below sets out all new off-payroll engagements between 1 April 2013 and 31 March 2014, where the equivalent daily charge is more than £220 per day and where the engagement lasts longer than six months:

Number of new engagements between 1 April 2013 and 31 March 2014	2
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	2
Number for whom assurance has been requested	2
Of which:	
assurance has been received	2
assurance has not been received	0
engagements terminated as a result of assurance not being received, or ended before assurance received	0

None of the engagements outlined in the tables above related to board members, senior officers or officers with significant financial responsibility.

5 Strategic Review: our prospects for 2014/15 and beyond

5.1 Focus on quality

The Trust's Quality Goals are:

	Quality Goal	Metrics	Quality improvement initiative
1	**Safe, harm free care**		
	a. Safety thermometer	a. We will increase the percentage of patients with harm free care (new harms only) on the day surveyed to exceed 97% throughout the year.	a. Harm Free Care project (Care homes)
	b. Falls causing harm in our inpatient units	b1. We will maintain the number of falls causing harm to patients in our inpatient units at 4.0 falls or less per 1,000 occupied bed days. b2. We will ensure that 100% of all patients are assessed for their risk of falling on admission. (Cf NICE CG161).	b. Falls prevention programme Harm Free Care project (Care homes)
	c. Pressure ulcers	c1. We will ensure that 100% of patients in our inpatient units have a Waterlow risk assessment c2. We will ensure that patients in our inpatient units will not acquire avoidable pressure ulcers c3. Our community nursing and therapy teams will assess patients in the community (patient homes) for the risk of a pressure ulcer using the Waterlow system. (Standard is 95%). c4. We will ensure that all patients who require equipment will be referred within agreed guidelines. (Standard is 98% of all relevant patients).	c. Pressure ulcer prevention programme Harm Free Care project (Care homes)

	Quality Goal	Metrics	Quality improvement initiative
1 (cont)	**Safe, harm free care (cont)**		
	d. Venous thrombo-embolisms (VTEs)	d. We will ensure that 100% of appropriate patients in our inpatient units will have a VTE risk assessment undertaken during their inpatient stay	d. Prevention of VTEs programme
	e. Catheter acquired urinary tract infections (CAUTI)	e. We will reduce the incidence of CAUTIs using the Safety Thermometer survey data in 2013/14 as the benchmark	e. Development of a plan to minimise the incidence of CAUTIs.
	f. Effective use of medicines	f. 100% of inpatient will have medicines reconciliation during their inpatient stay	f. Development of a Medicines Optimisation strategy and action plan
	g. Children Safeguarding supervision	g. All clinical staff in Children's Services will receive safeguarding supervision in accordance with the NCH&C Safeguarding Children Policy.	g, Implementation of the 'Sustain Appraisal' action plan
	h. Referrals to Local Authority Children's Services	h. All staff in Children's Services will undertake referrals to Local Authority Children's Services in accordance with the NCH&C Safeguarding Children Policy / Norfolk Safeguarding Children Board Policy.	h. Implementation of the 'Sustain Appraisal' action plan

	Quality Goal	Metrics	Quality improvement initiative
2	**Effective services** Measures of clinical effectiveness	A review of Trust services against key NICE Quality Standards(a-e) a. Dementia (QS1) b. Stroke (QS2) c. VTE prevention (QS3) d. End of life care for adults (QS13) e. Health and wellbeing of looked-after children and young people (QS31) f. Undertake clinical audits of NICE guidance applicable to our services (clinical audit plan)	a-f. Development of clinical effectiveness measures programme
3	**Care and compassion** a. Friends and family test – how likely are you to recommend our service (using the National Single Metric) b. Patient opinion website	a. We will maintain or improve our FFT score of 76 for our Community Nursing & Therapy services b. We will respond to 100% of submissions by the public/patients.	a-b. We will demonstrate/provide examples where feedback from patients is used to drive improvements.
4	**Responsive services** a. 18 week referral to treatment (RTT) b. Length of stay c. Community Nursing and Therapy response times	a. 95% of patients referred to us to commence definitive treatment within 18 weeks of referral b. We will reduce the average length of stay in our community rehabilitation hospitals to 22 days or less c. A minimum of 95% of patients will be seen with 4 hours of referral for an immediate assessment of their care needs (Category 'A')	Implementing the 'hub and spoke' model Roll out of Foxley Ward discharge liaison model

	Quality Goal	Metrics	Quality improvement initiative
5	**A well led organisation**		
	a. Friends and family test for staff	a. Staff recommendation of the trust as a place to work or receive treatment (Staff survey KF24). We will improve our summary score of 3.47 to ensure that we meet or exceed the average for community trusts (3.59 out of 5.0).	Implementation of Organisational Development Strategy
	b. Mandatory training	b1. 100% of clinical staff will receive relevant mandatory training on induction to the Trust. b2. At least 90% of clinical staff will receive on-going mandatory training. b3. At least 90% of clinical staff will receive training in Safeguarding adults basic awareness, which includes domestic abuse and PREVENT agenda. b4. At least 90% of clinical staff will receive training in safeguarding children	
	c. Safer staffing levels	c. We will ensure that daily staffing levels and skill mix against assessed patient acuity levels are displayed publicly on each ward/clinical area. (Standard is 95% reported quarterly).	Development of the 'eGARB' tool to implement learning from Francis and 'Hard Truths' (NHS England)

5.2 Transformation programme

The Trust's five-year transformation programme is themed around:

- Mobile working;
- Streamlined systems;
- Workforce and service planning;
- Supply chain management;
- Travel and estates rationalisation.

	Now	Future
Theme 1: Mobile working	A delay in recording clinical activity can occur due to staff needing to return to base to access the system	Clinicians update patient's electronic clinical record contemporaneously with care delivery, improving safety and experience
Theme 2: Streamlined systems	SystmOne inputting requires longhand entry and is not consistently recorded	SystmOne updating will be relevant and single touch templates, wherever possible
Theme 2: Streamlined systems	Clinicians have to access several different systems to undertake admin and workforce management tasks	Streamlined IT admin will allow quick and easy use with single direct access
Theme 3: Workforce planning	Budget and commissioning driven workforce models	Activity driven models based on contractual requirements
Theme 3: Workforce planning	Clinicians have to share out work based on staff availability on the day within a team / service and rota produced manually each month	Pan Norfolk availability will be identified through e-rostering and all work will be directed through a single channel scheduled accordingly and issued to clinicians
Theme 3: Workforce planning	Whoever is available being deployed to see the patient	The most appropriate person with the most appropriate skills will see the patient
Theme 4: Supply chain management	Differences and inefficiencies in stock storage, ordering and usage, leading to avoidable cost	Standardisation and streamlining of procurement practices, ensuing the right product / service is available
Theme 5: Travel / Estates	Excessive travel time between office and community which reduces available clinical time	Spending majority of time with patients

5.3 Clinical strategy

The key objectives of our clinical strategy are to:

- Continuously look for new and practical ways to ensure that the transformation of services and delivery of the local integration agendas are achieved, and that the Trust can demonstrate long-term improvements in patient care;
- Develop a flexible and innovative professional clinical workforce, always striving to build effective multidisciplinary teams;
- Support clinical teams to maintain and improve standards by routinely evaluating and transforming patient care;
- Ensure that national standards and initiatives are central to clinical practice;

- Support and develop the clinical expertise of the teams working with patients.

The Trust has included a service development improvement plan within its contract with the main commissioner for 2014/15. The main elements of this are:

- Review of inpatient beds;
- Children's services specification review;
- Musculoskeletal physiotherapy specification and cost and volume review;
- Development of a commissioners performance dashboard;
- Response to the Francis Report recommendations;
- Community nursing deep dive;
- New metrics for the reduction of pressure ulcers;
- Full service specification review.

5.4 Patient experience in 2013/14

The Trust aims to build on another excellent year of patient experience by developing the following projects:

- Demonstrating improvements in patient experience using the net promoter score;
- Reviewing results from the community services survey and implementing actions as required;
- Continuing to embed patient stories within the Trust ensuring the methodology is utilised where there is a targeted need for in depth information, deliver more training and consider involving Healthwatch members as interviewers alongside Trust staff;
- Working in partnership with services to support locally managed surveys and other methodologies for capturing patient/carer experiences;
- Working in partnership with Trust members and external voluntary organisations ensuring effective patient engagement/involvement;
- Developing all staff to have the core skills, beliefs and values necessary for a good patient or carer experience.

5.5 Competition assessment

The Trust faces competition for the delivery of community health and care services from local foundation trusts providing acute services in Norwich, King's Lynn, Great Yarmouth and Bury St Edmunds, as well as from the mental health services provider, Norfolk and Suffolk NHS Foundation Trust. Additional competition comes from private providers, social enterprises, and the practice based provision of GP companies. The Trust faces competition from the exercising of choice and ease of market entry through "any qualified provider", which also provides opportunities for the Trust.

In providing services, the Trust works alongside other providers as partners, and at other times as competitors. Our key partners are CCGs, GPs, local authorities, the voluntary sector, education providers and other providers of health and care services.

6 Our Staff

The Trust employs 2,250 staff, together with over 600 volunteers working within its services. Most volunteers are managed through a partnership with Voluntary Norfolk, a registered charity. Trust staff work from over 200 sites across Norfolk, in addition to providing services in over 400 schools and within people's homes. They include 10 community hospitals, GP surgeries and healthcare centres. The Trust also currently manages services from five Sure Start Children's Centres.

6.1 Staff engagement

Staff engagement is an important component of achieving the Trust's aspiration to deliver high quality patient care. The Trust's response to the recent NHS staff survey results is to prioritise staff engagement.

The Trust's workforce planning is informed by a number of principles. They include a focus on quality; being patient centred; clinically driven; the need for a flexible workforce; corporate values of valuing and enabling people; promoting lifelong learning and promoting equality and diversity. This means taking into account the needs of the total workforce and ensuring equality and diversity in all recruitment, training and development activities, and being an exemplary corporate citizen.

The Workforce Strategy contains a number of objectives:

To truly inspire staff
The Trust's Organisational Development (OD) Strategy is about ensuring the processes, structures, systems and culture necessary to achieve the Trust's vision are achieved. Central to this strategy is staff engagement.

The Trust has well developed and shared organisational values including a supporting Behaviour Framework.

Promote staff health and wellbeing
The Trust's Health and Wellbeing Strategy supports the Workforce Strategy and acknowledges that the work, health and wellbeing of employees are interlinked.

The Trust will ensure that managers have the key skills, knowledge and ability to support employees at work, to manage absence and also work with staff to ensure issues which may impact negatively on staff health are identified and minimised. During the year, the Health and Wellbeing Strategy, supporting policies and procedures were launched.

Develop clinically-led workforce planning
The Trust aims to establish clinically-led workforce planning with full integration between corporate and operational services. Recently more integrated workforce planning has taken place, for example, project teams were set up to support tenders. The Trust will encourage and build on this successful model in all workforce planning activities.

Provide quality education and development opportunities to all our staff
The strategy describes how the Trust will provide high quality education, training and development for the workforce, ensuring that skills are developed to support the provision of high quality, patient-focused care. The Trust's approach to training includes a focus on care, compassion and personalised care, technical skills as well as leadership and management.

6.2 Sickness absence

Two Internal Audit reviews were undertaken during the year on sickness absence. The first review had an overall classification of high risk, with two high risk recommendations. The second, follow-up, report was classified overall as medium risk with the same two high risks as before. These are described in the Annual Governance Statement, together with the management actions taken to address the high risk recommendations. In summary, the high risks were: line managers are not always completing absence forms in a timely manner, and line managers are not monitoring the sickness absence records of their teams and taking action where individuals have hit trigger points for repeated sickness absence. Management action has ensured that the 12-month sickness absence figure has decreased to 4.3%, which is the lowest absence rate since the Trust was established in 2010. Data presented to the Board evidences a consistently improving sickness absence rate when comparing the 12-month rolling total over the last 12-months to the previous year.

6.3 Staff surveys

The 2013 full staff survey was carried out from October to December 2013 and sent to a sample of 786 staff. Our response rate was 55% slightly down on the 2012 figure of 59%. Results from the national NHS Staff Survey 2013 have shown that our Trust is steadily moving in the right direction. However, while the progress we are making in many areas is positive, it is also slower than we would want and leaves us with more to do. A total of 92% of our staff agreed that their role makes a difference to patients, higher than the national average.

Key indicators such as staff engagement, recommendation of the Trust as a place to work or receive treatment and staff job satisfaction have all continued to improve for another year although remain below average. For 28 key findings and in comparison with other Community Trusts, the Trust was either better than or average for 20 of the 28 key findings, specifically 5 were better than average and 8 of the 28 key findings in comparison with other Community Trusts were below average. This is an improvement on our position from the previous year's results when in 2011 23 were below average and 15 in 2012. The Trust also scores highly on appraisals and effective teamwork as well as seen significant increase in ability to make a contribution to improvements at work and support from immediate line managers.

We deteriorated on 9 Key findings, 2 of which showed a statistically significant deterioration. These were:

- The % of staff experiencing harassment, bullying or abuse from staff in the last 12 months has risen from 16% to 22%. This makes us the 9th worst out of 20 Community Trusts.
- The % of staff experiencing physical violence from patients, relatives or the public which has risen from 10% in 2012 to 15% in 2013. For this key finding we were the worst of 20 community Trusts although ranked 3rd best in comparison to 6 local Trusts.

The overall Engagement score for NCH&C improved from 3.5 in 2011 to 3.61 in 2012 and now to 3.65 in 2013. The most recent short staff survey in Specialist services shows an engagement score of 3.68.

Staff satisfaction improved from 3.38 in 2011 to 3.55 in 2012 to 3.58 in 2013. The most recent short staff survey in Specialist services shows Satisfaction of 3.63 showing a continuing rise in engagement and satisfaction across NCH&C.

The following link has all the Community Trust Surveys, http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2013-Results/

6.4 The Trust's policy in relation to disabled employees.

Employing people with a disability is important for the Trust as a provider of services for the public, as they need to reflect the many and varied experiences of the public that we serve. In the provision of community health services it is perhaps even more important, as disabled people comprise a significant proportion of the population, and those with long term medical conditions are significant users of the services that we provide.

The Trust's policy towards people with a disability includes:

- Disabled people who meet the minimum criteria for a job vacancy are guaranteed an interview;
- We proactively consider the adjustments that disabled people may require in order to take up a job or continue working in a job;
- Our mandatory equality and diversity training includes awareness of a range of issues impacting upon disabled people;
- We ensure that any employee who needs training either because they work with disabled people or because they have acquired an impairment or medical condition receives the necessary training;
- Fundamentally, employment of disabled people on an equal basis is a legal imperative and simply right in a modern society. For us it goes beyond this and is something we positively encourage in order to better reflect the population we serve and to help us to understand that population fully.

6.5 The Trust's policy on equal opportunities.

The Board is committed to improving the equality performance of the Trust, making it part of its 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). The Trust has published Equality Objectives under the following headings:

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

The Board has adopted the Equality Delivery System (EDS), which has been further updated and refined in 2013/14 to EDS2. By recognising that every patient, carer and service user has different needs and circumstances, the Trust can best meet those needs and improve outcomes by delivering a personal form of care, using and supporting the diverse talents and experiences of its workforce. The EDS is a nationally developed process to help all staff and NHS organisations understand how equality can drive improvements, strengthen the accountability of services to those using them, and bring about workplaces free from discrimination.

6.6 Recognition of Excellence and Achievement in Community Health (REACH)

Every day our NHS staff and volunteers go the extra mile for local patients and their families, dedicating their careers to ensuring that local people get the very best NHS care in their homes and communities across Norfolk. We held our **REACH Awards** - a gala awards evening - at Sprowston Manor on Thursday, March 27, to give our staff the opportunity to recognise their colleagues who 'go above and beyond' the call of duty and who are often the hidden heroes of the NHS. We have received countless nominations and heart warming examples of our staff who do an exceptional job and who are prepared to go the extra mile to deliver excellent services to our patients.

The winners were:

- Clinical Excellence - Christine Harvey, Modern Matron (South).
- Good Corporate Citizen - Sharon Duneclift, Health Visitor, North and Broadland Health Visiting Team.
- Emerging Talent - Nicola Smith, Community Physiotherapist, North Walsham CN&T Integrated Team.
- Governors' Recognition Award - Ann Yaxley, Registered Nurse, Pineheath Ward, Kelling Hospital.
- Innovation - Talk About Project, Children's Speech and Language Therapy Service.
- Team of the Year - Caroline House: Specialist Neurological Rehabilitation Inpatients Service.

- Inspirational Leader - Becky Cooper, Assistant Director (North).
- Looking After You Locally - Starfish+, Children's Learning Disabilities, Mental Health and Child and Adolescent Service.
- Integration and Partnership (joint winners) - Integrated Team, Children with Complex Health and Disability (Central) and Starfish West, Children's Learning Disabilities, Mental Health and Child and Adolescent Service.
- Unsung Hero - Carla Nobrega-Holloway, Community Assistant Practitioner, City 2 CN&T Integrated Team.

7 About the Trust Board

7.1 Board of Directors

The Board provides leadership to the Trust, setting strategic direction, ensuring management capacity and capability, monitoring and managing performance and setting the appropriate culture. It defines the vision of the Trust and champions and safeguards its values, keeping the safety of patients at the centre of its work and ensuring obligations to all key stakeholders are met. By ensuring the effective and efficient use of resources it safeguards public funds.

Non-Executive and Executive Directors have responsibility to constructively challenge the decisions made at the Board. Non-Executive Directors have a particular duty to ensure appropriate challenges are made and in holding the Executive Directors to account. As well as bringing their own expertise to the Board, Non-Executive Directors scrutinise the performance of management in reaching goals and objectives, and monitor the reporting of performance. They need to satisfy themselves as to the quality and integrity of financial, clinical and other information, and ensure that the financial and quality controls of risk management are robust.

Two Designate Non-Executive Directors joined the Board in January 2013 as part of our succession planning, to complement the skills of the Board, and to provide additional independent scrutiny and expertise at committee level. Derek Allwood has actuarial, accountancy and commercial strategy skills, and Professor Ian Harvey, Dean of the Faculty of Health and Medicine at the University of East Anglia has medical and public health expertise. In October 2013, Derek was appointed a full voting NED by the Trust Development Authority on the retirement of James Ross.

Ken Applegate Chair

Ken joined the Trust from the Norfolk and Waveney Mental Health NHS Foundation Trust where he held the role of Non-Executive Director for four years. During his career, Ken held various director roles leading large scale strategic change at Aviva. In his role as Chairman, Ken is responsible for leading the Board of Directors and ensures the Board is transparent in its processes, is held to account and continues to make decisions which are in the best interests of the public.

Michael Scott Chief Executive

Michael has over 30 years of leadership experience across social care, the NHS and Department of Health – including 10 years as an NHS Chief Executive. Having started his career within social services, Michael has since been chief executive of an acute hospital trust, regional director within the Audit Commission and a director of the NHS Modernisation Agency.

While Chief Executive at a primary care trust, he also managed community services and their successful transition to an aspirant Foundation Trust.

Dr Rosalyn Proops Medical Director

Dr Proops has held a number of senior positions, including the role of Medical Director at Norwich Community Health Partnership and Senior Lecturer at The Medical School at the University of East Anglia.

Over the last 20 years as a consultant, Rosalyn has been involved in the development of a number of policies, as well as teaching and training across a range of health and social care organisations, the police, and the judiciary. Dr Proops keen interest in law and ethics saw her appointed as the first Paediatrician to the Family Justice Council in the summer of 2004, which she held until 2010. She was also appointed as the first Child Protection Officer at the Royal College of Paediatrics and Child Health in November 2006, a post she held until 2011.

Anna Morgan Director of Nursing, Quality and Operations

Anna is a nurse with over 25 years experience which includes working in adults and older peoples' services. Anna has also worked within private care homes as

well as managing homes specialising in care for older people, people with dementia and young people with physical disabilities.

Anna was the Service Director of an Essex-based healthcare provider and has vast experience in the modernisation of health services, and integration of teams. Most recently she has fulfilled a secondment to the Department of Health and is currently developing health guidance for Safeguarding Adults.

Paul Cracknell Director of Strategy and Transformation

Paul has been Director of Strategy and Transformation since May 2012. Prior to this he was interim Chief Executive and interim Director of Business Development with NCH&C. His prior board experience includes positions at both NHS Norfolk (commissioning organisation) and Norfolk and Waveney Mental Health NHS Foundation Trust, including experience of the FT application process as well as being twice runner up in the national Healthcare People Management Association HR director of the year.

Paul also brings voluntary sector experience having previously been the Chief Executive of a youth-work charity and current Director/Trustee of the Open Youth Trust. He is also vice-chair of governors at the Open Academy, Norfolk's first high school academy. He held various roles in the commercial insurance industry, including project management and relationship management roles.

Roy Clarke Director of Finance

Roy is a chartered Management Accountant who has worked in healthcare for 15 years and has particular experience of developing and implementing organisational strategies, financial recovery and estate development. He joined us from Mid Essex Hospital Services NHS Trust, where he was Deputy Director of Finance, and Acting Director of Finance.

Non voting corporate Executive Director

Matt Colmer Director of Performance and Information

Previous to becoming Director of Performance and Information, Matt was Associate Director of Finance for NCH&C, fulfilling this role since the organisation was formed in 2008. Prior to the merger of five Norfolk PCTs into one to create NHS Norfolk, Matt spent five years with South Norfolk PCT as Director of Finance. Immediately following the merger, he took on responsibility for the financial management of the provider element of NHS Norfolk, as Assistant Director of Finance (Provider).

Non-Executive Directors (NED)

The Chair and Non-Executive Directors are not full-time members of staff. They come from a range of professional backgrounds, but they share a common interest in wishing to serve the local health system and provide a link with the community.

Vivienne Clifford-Jackson

Vivienne is a Registered Nurse and has worked in a variety of nursing and nurse teaching roles in the UK and abroad. A former Fellow of the Institute for Learning, Vivienne has a Diploma in Nursing, Certificates in clinical and classroom teaching and a Masters Degree. She has a keen interest in mental health and trained at the Tavistock Institute; she is also a graduate of the Common Purpose and LEAD East leadership programmes. Vivienne lectured at the University of East Anglia until 2012, and has experience in marketing, counselling and business consultancy. She has worked with Voluntary Norfolk, scoping Advice and Advocacy across Norfolk. She has held political leadership roles in local government, stood for Parliament twice as well as being a Vice-President of the Norfolk Show. She is currently working for the Methodist Church in Wymondham on projects.

Neil Harrison

Mr Harrison brings a wealth of experience, including 20 years as a finance director in the private sector. He has spent 17 years working for multinational company, Unilever, culminating in a role as a finance director of a Unilever subsidiary in the Netherlands. Neil came to Norfolk in 1993 where he worked as finance director at Bernard Matthews. More recently, he has been a Non-Executive Director with another local foundation trust. Neil has previously been a NED at the Queen Elizabeth Hospital NHS FT, including being chair of their Audit Committee.

James Ross

James studied Geography at Durham University before qualifying as an Associate of the Chartered Institute of Bankers. He spent most of his career with Barclays, during which he undertook the role of Programme Director for a range of major change initiatives at Barclaycard and Barclays Retail. He has a keen interest in equality and diversity issues and led the racial diversity working group at Barclaycard. Since 2005, James has been running his own project management consultancy business supporting clients in financial services and local government. James retired at the end of September 2013.

Derek Allwood

Mr Allwood has significant experience of working within the fields of strategy, finance and risk, having spent his career as both an actuary and an accountant within the financial services industry. Since 2003, Derek has worked as an independent management consultant, working with several large UK and international insurance company clients, both in the UK and Ireland. Prior to that, he worked for Aviva (and Norwich Union) in a number of senior roles within finance, operations, corporate development and strategy. Derek was appointed a Designate NED in January 2013, and was subsequently appointed a full voting NED to replace James Ross in October 2013.

Alex Robinson

Alex joined the Trust following a 22-year career within Information Technology (IT) and business change management. He has previously held the role of interim Chief Executive of the National Skills Academy for IT and has worked as Chief Information Officer, the executive responsible for IT, at Aviva Europe and Norwich Union.

During his time at Aviva, Alex was Chairman of the Supervisory Board of Aviva Russia, a Non-Executive Director of subsidiaries in Romania and Canada, and a director of a national insurance broker. Before joining Norwich Union he worked within IT in local government and in marketing and communications for a national newspaper. He has also served as a Non-Executive Director for software company Polaris UK Ltd, where he was Chairman of the Board for five years.

Lisa Gamble

Lisa is an HR professional with over 19 years' experience in human resources, business change integration, mergers and acquisitions, executive coaching and leadership development. During her career she has worked extensively in the financial sector as well as working for not-for-profit organisations, including the NHS. For the past 10 years Lisa worked as a Senior Manager in a FTSE 30 company. Lisa has volunteered for The Princes Trust for over 15 years and held a number of roles including the Chairman of the Norfolk Development Awards Panel, member of the Norfolk, Hertfordshire and Cambridge Boards.

Designate Non-Executive Director

NHS Trusts preparing for foundation trust (FT) status often require additional expertise quickly and wish to prepare to appoint additional Board members to the aspirant FT in advance of authorisation. Legally, Designate NEDs are not full voting Board members. However, where the terms of reference allow, they may vote on Board Committees. There is a clear expectation that the successful candidate will take up a substantive NED position on the Board in the future. In order to strengthen the Board in the run up to FT status the Board has made two appointments of Designate NEDs. This was done for two reasons:

- To strengthen the Board in preparation for FT status. This will allow the Trust to rely on the skills of the individuals at the stage of application and in the critical early stages of becoming an FT. The future Council of Governors would be assured that they can appoint the designate to a full voting NED role knowing that an open competition based on merit has been conducted. The recruitment and selection process followed by the Trust is an assurance that their recruitment has been conducted in line with the best practice for public appointments;

- Planned succession for when NEDs stand down either at the end of their term or resign before/when FT status is achieved; so the Trust is effectively anticipating a vacancy. The appointment of Designate NEDs fully supports our Board succession planning, and is in line with best practice, as advised by the former Appointments Commission, Trust Development Authority and Monitor.

Professor Ian Harvey

Professor Harvey brings with him a wealth of clinical experience, having worked within the NHS and medical teaching roles for over 30 years. He lives in Norwich and is currently the Dean of the Faculty of Health and Medicine at the University of East Anglia (UEA) and a member of the Board at the Norfolk and Suffolk Dementia Alliance. During his career, Ian has also worked within hospital medicine and general practice in south Wales and as a senior lecturer in both Cardiff and Bristol.

Register of Directors

Name	Designation	Role
Ken Applegate	Non-Executive	Chair
Alex Robinson	Non-Executive	Deputy Chair
James Ross (retired 30.09.13)	Non-Executive	Chair of Finance & Performance Committee until his retirement.
Lisa Gamble	Non-Executive	
Neil Harrison	Non-Executive	Audit Chair
Vivienne Clifford-Jackson	Non-Executive	Senior Independent Director
Michael Scott (until 30.05.14)	Executive	Chief Executive
Roy Clarke	Executive	Director of Finance
Anna Morgan	Executive	Director of Nursing, Quality and Operations
Dr Rosalyn Proops	Executive	Medical Director
Derek Allwood	Non-Executive	Designate Non-Executive Director (non voting)from January 2013 to end of September 2013.Voting NED

		from October 2013.
Professor Ian Harvey	Non-Executive (non voting)	Designate Non-Executive Director
Matt Colmer	Executive (non voting)	Director of Performance and Information
Paul Cracknell	Executive	Director of Strategy and Transformation
Mark Easton (from 01.05.14)	Executive	Interim Chief Executive

Register of Directors' Interests

Name and Position	**Interest Declared**	
Ken Applegate Chair	Travel Guard EMEA Limited / UNAT Direct Insurance Management Limited (also operating under the trading names of Direct Travel Insurance and Travel Guard Europe) Partner works as a Specialist nurse at NNUH	Non Executive Director
Michael Scott Chief Executive	Barrowby Management Solutions Limited (No current NHS contracts)	Director
Derek Allwood Non Executive Director	Abacus Management Consultants Limited	Owner (not Director)
Roy Clarke Director of Finance	None	
Vivienne Clifford-Jackson Non Executive Director	Residential landlord – small monthly rental income Clifford Consulting – training and comms Town Green Centre, Wymondham Methodist Church Norfolk and Norwich University Hospitals NHS Foundation Trust	 Layworker (staff member) Quality Assurance Audit External Assessor
Matt Colmer Director of Performance and Information	City College, Norwich	Chair of Governing Body
Paul Cracknell Director of Strategy and Transformation	The Open Youth Trust	Trustee / Director of Charitable Company
Lisa Gamble Non Executive Director	Circle Living Ltd and Invicta Telecare Ltd. These companies are part of Centra which is the commercial	Non Executive Director

	services partner of the Circle Housing Group. The Princes Trust Consultancy work	 Mentor Associate and self employed
Neil Harrison Non Executive Director	The Florida Group (Footwear) University of East Anglia	Non Executive Director Lay member of Audit Committee
Professor Ian Harvey Designate Non Executive Director	Executive Dean of the Faculty of Medicine and Health Sciences, University of East Anglia	Responsible for overseeing three UEA schools of NSC (School of Nursing Sciences), MED (Norwich Medical School) and AHP (School of Allied Health Professionals). Attendance at regular meetings of the Executive Team of which he is a member. Attendance at University meetings of Senate and UEA Council. Chairs regular meetings of the FMH Executive.
Anna Morgan Director of Nursing, Quality and Operations	Peer Reviewer for RCN Publications	Review all articles that have Safeguarding/LD/ Older People context
Dr Rosalyn Proops Medical Director	Spouse is Chair of Age UK, Norfolk	
Alex Robinson Non Executive Director	Millfield Primary School Alex Robinson Limited	Governor Director

	Ortoo Technologies Limited	Director
James Ross Non Executive Director (retired on 30.09.13)	Novartis Pharmaceuticals UK Ltd	Participation in focus groups and clinical trials
Mark Easton (from 01.05.14)	Octopus Health Limited (a private company specialising in health management consultancy)	Owner

This section provides an attendance record of the Board and its committees. The greyed areas indicate that the person was not in post during this time.

Board attendance

The Board met in public on the following occasions throughout the year.

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Ken Applegate	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alex Robinson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vivienne Clifford-Jackson	✓	X	X	✓	✓	✓	✓	✓	✓	✓	✓	✓
Neil Harrison	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
James Ross	✓	✓	✓	X	✓	✓						
Lisa Gamble	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Derek Allwood	✓	X	✓	✓	✓	X	✓	✓	✓	✓	✓	✓
Prof Ian Harvey	✓	✓	✓	✓	X	✓	X	✓	✓	✓	✓	✓
Michael Scott	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Roy Clarke	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Rosalyn Proops	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
Anna Morgan	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Paul Cracknell	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Matt Colmer	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓

The Trust Secretary attended all Board meetings as a mandatory attendee.

In addition, the Board also met in closed session on the same dates as above, immediately following he meeting in public, where members of the public were excluded. The Board also held extraordinary meetings in private on the following dates:

19 June 2013
23 July 2013

7.2 Board Committees

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 organisation's objectives.

Membership and attendance

The Committee's membership during the year was: Neil Harrison (NH), Non-Executive Director and Committee Chair, Vivienne Clifford-Jackson (VCJ), Non-Executive Director and Deputy Committee Chair, Lisa Gamble (LG), Non-Executive Director.

The Audit Committee met on five occasions during the year and the attendance of Committee members is shown below. All meetings have been quorate.

Date	NH	VCJ	LG
22 May 2013	✓	✓	✓
7 June 2013	✓	X	✓
20 Sept 2013	✓	✓	✓
20 Dec 2013	✓	✓	X
28 March 2014	✓	✓	✓

The Director of Finance and the Trust Secretary attend the Audit Committee as mandatory attendees. Representatives of Internal and External Audit and the local counter fraud specialist also attend meetings.

Quality and Risk Assurance Committee

The committee's role is to enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and

appropriate clinical governance structures, quality assurance, clinical audit, and risk processes and controls are in place throughout the Trust to:

- Promote safety and excellence in patient care;
- Identify, prioritise and manage risk arising from clinical care;
- Ensure the effective and efficient use of resources through evidence-based clinical practice; and
- Protect the health and safety of Trust staff.

Membership and attendance

The Committee's membership during the year was: Alex Robinson (AR), Non-Executive Director and Committee Chair, Non-Executive Director Neil Harrison, Professor Ian Harvey (IH), Designate Non-Executive Director and Deputy Chair, Anna Morgan (AM), Director of Nursing, Quality and Operations, Dr Rosalyn Proops (RP), Medical Director, and Paul Cracknell (PC), Director of Strategy and Transformation.

The Committee met on ten occasions during the year. The table below provides an attendance record for these meetings. All meetings have been quorate.

Date	AR	IH	NH	AM	RP	PC
15 April 2013	✓	✓	✓	✓	X	✓
20 May 2013	✓	X	✓	✓	X	X
17 June 2013	✓	✓	✓	✓	✓	✓
22 July 2013	X	✓	✓	✓	✓	✓
16 September 2013	✓	✓	X	X	✓	✓
21 October 2013	✓	✓	✓	✓	✓	✓
18 November 2013	✓	X	✓	X	✓	✓
15 January 2014	✓	✓	✓	✓	✓	✓
17 February 2014	✓	X	✓	✓	✓	X
17 March 2014	✓	✓	X	X	✓	✓

The Trust Secretary, the Deputy Director of Quality and the Deputy Director of Nursing, Quality and Operations have attended QRAC meetings as mandatory attendees.

Finance and Performance Committee

The committee's role is to:

- Monitor, advise on and recommend to the Board matters relating to financial strategy and policies.
- Advise the Board on the effective and efficient use of resources
- Critically appraise annual budgets (revenue and capital) for the Board's approval.
- Consider the Cost Improvement Plans and QIPP plans for the Board's approval.
- Provide a forum for financial issues to be debated and recommendations made for potential resolution.

- Review performance reporting and support the development of appropriate performance measures and KPIs.
- Review in-year performance and any plans for corrective action.
- Oversee and evaluate the performance management strategy to ensure a framework is in place which allows the performance management against business plan.

Membership and attendance

The Committee's membership during the year was: James Ross (JR), Non-Executive Director and Committee Chair until October 2013; Alex Robinson (AR), Non-Executive Director and Deputy Committee Chair; Derek Allwood (DA) from January 2013 as Designate Non-Executive Director and a full voting NED and Committee Chair from October 2013; Roy Clarke (RC), Director of Finance; Anna Morgan (AM), Director of Nursing, Quality and Operations; Paul Cracknell (PC), Director of Strategy and Transformation, and Matt Colmer (MC), Director of Performance and Information.

The Committee met on twelve occasions during the year. The table below provides an attendance record for these meetings. All meetings have been quorate.

Date	JR	AR	DA	RC	AM	PC	MC
22 April 2013	✓	✓	✓	✓	✓	✓	✓
28 May 2013	✓	✓	X	✓	✓	✓	✓
24 June 2013	✓	✓	✓	✓	✓	✓	✓
29 July 2013	✓	✓	✓	✓	X	✓	X
27 August 2013	✓	✓	✓	✓	✓	X	✓
23 September 2013	✓	✓	X	✓	✓	✓	✓
28 October 2013		✓	✓	✓	X	✓	✓
25 November 2013		✓	✓	✓	✓	✓	✓
16 December 2013		✓	✓	✓	✓	✓	✓
27 January 2014		✓	✓	✓	✓	✓	x
24 February 2014		✓	✓	✓	X	✓	✓
24 March 2014		✓	✓	✓	X	✓	✓

Charitable Funds Committee

The committee has delegated responsibility to make and monitor arrangements for the control and management of charitable funds. The Trust is a corporate trustee and the Board acts on behalf of the corporate trustee in the administration of the charitable funds – they are not themselves individual trustees. When acting on behalf of the corporate trustee, the Board recognises that the charitable funds they are managing are distinct from exchequer monies of the Trust. In acting on behalf of the corporate trustee, there are separate and distinct responsibilities for the administration of the charitable funds. The Board has decided that this is best done by creating a separate committee, known as the Charitable Funds Committee, that

deals with matters relating to the charitable funds and that is accountable to the Board acting as corporate trustee.

Membership and attendance

The Committee's membership during the year was: Lisa Gamble Non-Executive Director and Chair, Vivienne Clifford-Jackson, Non-Executive Director, Roy Clarke, Director of Finance and Anna Morgan, Director of Nursing, Quality and Operations. Derek Allwood, attended as a Designate NED until 30 September 2013 and as a Non-Executive Director from October 2013.

The Committee met on four occasions as follows. All meetings were quorate.

Date	LG	VCJ	RC	AM
10 April 2013	✓	✓	✓	✓
10 July 2013	✓	X	✓	X
16 October 2013	✓	✓	✓	X
15 January 2014	✓	✓	✓	X

The Deputy Director of Finance, The Fundraising Manager and the Trust Secretary attend Charitable Funds Committee meetings as mandatory attendees. Other Trust and external professional advisers also attend meetings.

Remuneration and Nominations Committee

The committee's role is to:

- Ensure there is a fair and transparent procedure for developing and maintaining the policy on executive remuneration and for setting the remuneration packages of individual Directors.
- Decide on behalf of the Board on the appropriate remuneration and terms of service for the Chief Executive, Executive Directors and Very Senior Manager posts.
- Reach decisions taking account of best practice, national guidance, and Standing Orders.
- Be informed of the implementation of national pay arrangements for all medical and dental staff employed by the Trust, and be advised by the Trust as appropriate on any relevant matters.
- Ensure there is adequate succession planning in place.

Membership and attendance

All Non-Executive Directors and the Chair are members of the Remuneration and Nominations Committee which is chaired by Vivienne Clifford-Jackson. To avoid any possible conflicts of interest, and in accordance with good practice guidelines, the Audit Committee Chair has opted not to be a member of the Committee but can attend on occasion. Ian Harvey, Designate Non-Executive Director may attend in a non-voting consultancy capacity, although he chose not to attend any meetings in 2013/14.

The Committee met on five occasions. All meetings were quorate.

Date	VCJ	KA	AR	JR	LG	DA
10 April 2013	✓	✓	✓	✓	✓	✓
10 July 2013	X	✓	✓	✓	✓	✓
2 October 2013	✓	✓	✓		✓	✓
15 January 2014	✓	✓	✓		✓	✓
17 March 2014	✓	✓	✓		X	✓

The Director of Strategy and Transformation and Head of Human Resources attend as mandatory attendees, as required, to provide professional HR advice. The Chief Executive may also attend, except when attendance would be inappropriate.

Each director has stated that as far as he/she is aware there is no relevant audit information of which the Trust's auditors are unaware and he/she has taken all the steps that he/she ought to have taken as a director in order to make himself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

8 Emergency preparedness and resilience planning

The Trust has a Major Incident Plan in place that is fully compliant with the requirements of the NHS Emergency Planning Guidance 2005 and all associated guidance. The Trust's accountable emergency officer is the Director of Nursing, Quality and Operations. The Trust contributes to area planning for emergency preparedness through local health resilience partnerships and other relevant groups. It has suitable, up to date plans which set out how it plans for, responds to and recovers from major incidents and emergencies as identified in the risk registers.

The Trust tests its plans through: a communications exercise every six months, a desktop exercise once a year, and a major live or simulated exercise every three years. The Trust has suitably trained, competent staff and the right facilities available round the clock to effectively contribute to the management a major incident or emergency. The Trust will share its resources as required to respond to a major incident or emergency.

The Trust also has suitable, up to date service resilience plans which set out how it will maintain continuous service when faced with disruption from identified local risks, and resume key services which have been disrupted by, for example, severe weather, IT failure, an infectious disease, a fuel shortage or industrial action.

9 Complaints handling

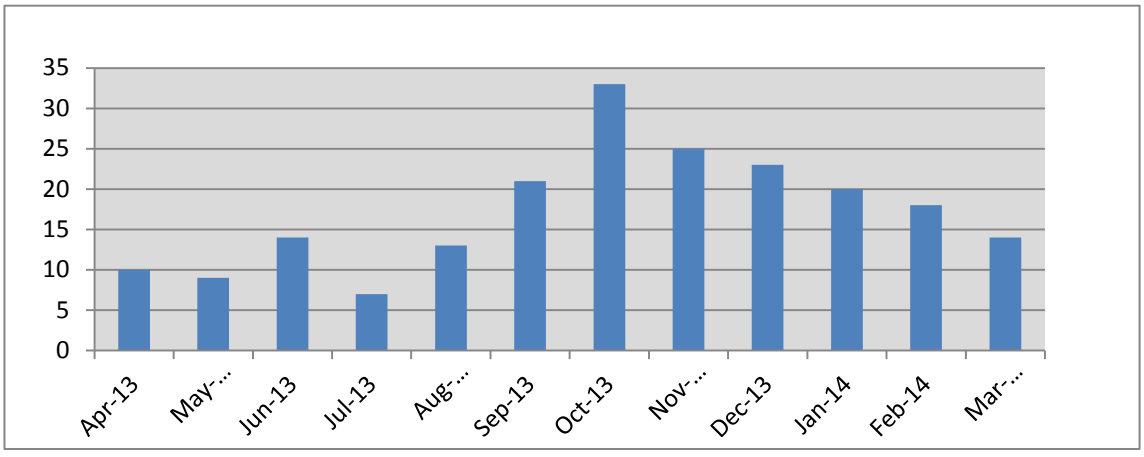
The Trust has adopted the *Principles for Remedy* published by the Parliamentary and Health Service Ombudsman in May 2010 and these form part of the Trust's complaints handling procedure. This sets out six principles that represent best practice and are directly applicable to NHS procedures. These are:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

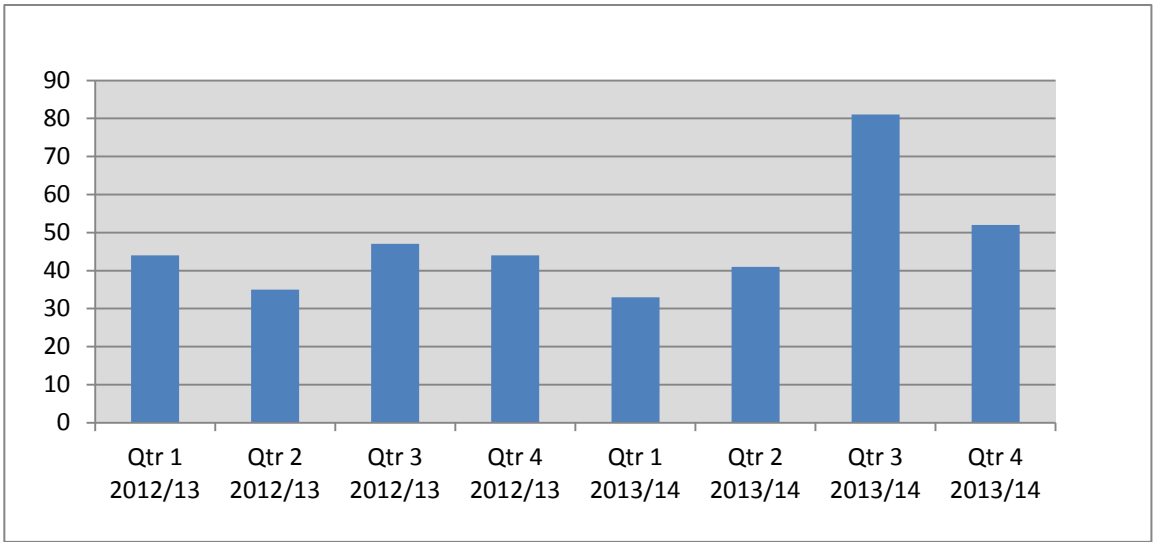
The Trust received 207 complaints this year compared to 170 the year before. The total of 207 complaints included nine complaints where the complainant was not happy with the original response, and asked further queries. Complainants who are unhappy with the Trust's final response may ask the Parliamentary and Health Service Ombudsman to review their case. The Trust was notified of three such requests this year. After review the Ombudsman took no further action on two of these, and the third is still with the Ombudsman for their investigation.

The Trust reviewed the lessons learned form the Clwyd/Hart Report: "A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture", and has an action plan in place to implement all recommendations relevant to the Trust.

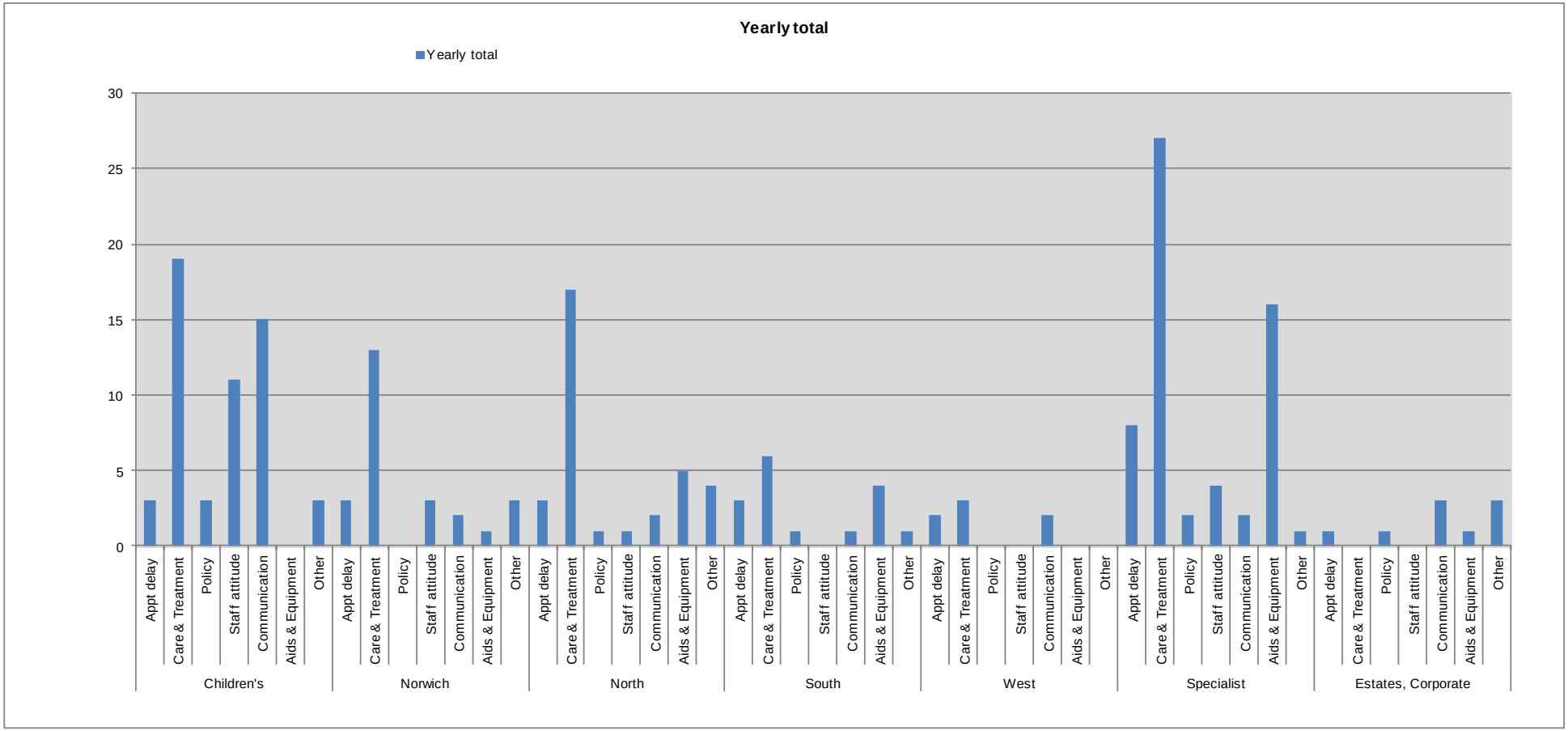
The table below shows the number of complaints received on a monthly basis



The table below shows the number of complaints received on a quarterly basis for the last two years.


90
80
70
60
50
40
30
20
10
0
Qtr 1 2012/13
Qtr 2 2012/13
Qtr 3 2012/13
Qtr 4 2012/13
Qtr 1 2013/14
Qtr 2 2013/14
Qtr 3 2013/14
Qtr 4 2013/14

The table below shows the number of complaints received by each locality divided into topics



A continual process of learning from complaints is in place and overseen by both the Quality and Risk Assurance Committee, and the Trust Board.

Compliments

A total of 1,100 compliments were received across all localities during the year. These were divided as follows:

	Locality - Norwich	Locality - Children's	Locality - North	Locality - South	Locality - Specialist	Locality - West	Total
Total	120	55	185	154	458	128	1100

10 Sustainability report

The Trust is fully committed to building a sustainable, low carbon organisation which meets the needs of today without compromising the needs of the future. The Trust's Sustainable Development Framework recognises the health benefits to staff and public, the importance of cost reductions and adaptation and energy resilience. The Trust has been awarded Most Sustainable Public Sector Organisation by the Public Sector Sustainability Awards of 2012 and continues to drive towards becoming a leading public sector exemplar.

10.1 Carbon Footprint

The Trust has successfully managed a sustainable development process for the last five years, taking a leading role in partnership with NHS Norfolk, before establishment as an NHS Trust in 2010. The Trust has Board level leadership with a nominated Executive Director and Non Executive Director leads for sustainable development.

The Trust seeks to report and promote sustainable development and mitigate climate change in line with the Climate Change Act targets set in 2008. In order to meet the requirements of the Climate Change Act, the NHS needs to achieve a 34% reduction in carbon by 2020 and 80% by 2050 on a 1990 baseline. The interim target for the NHS is to reduce its 2007 footprint by 10% by 2015.

The Trust has developed specific reduction targets for each year relating to the initial NHS target of 10% by 2015 e.g. 6.25% reduction in activity, carbon and cost by 2012/13. All others reductions are outlined below.

2008	2009	2010	2011	2012	2013	2014	2015
1.25%	2.50%	3.75%	5.00%	6.25%	7.50%	8.75%	10.00%

The Trust has completed carbon footprint assessments for each year between 2007 and 2012 and is about to evaluate its carbon footprint for 2013. The Trust now assesses on the basis of financial year and actual Trust occupancy at each location. Performance against the Climate Change Act Targets is measured against this 2007 assessment – see figure 1.

GHG Emissions - CO2e		2007/08	2011/12	2012/13
Non Financial	Gas	2,531	1,911	1,994
	Oil	248	139	136
	Electricity	1,811	2,353	2,120
	Lease	861	820	1,190
	Grey Fleet	1,595	834	825
	Waste	95	99	71
	Water	18	21	63
	Supply Chain	2,317	2,127	2,327
	TOTAL	9,478	8,305	8,727
	TARGET	9,478	9,004	8,885
Financial	Gas	£260,212	£274,517	£339,861
	Oil	£32,557	£24,966	£31,937
	Electricity	£263,441	£374,790	£355,552
	Lease	£368,309	£368,945	£484,318
	Grey Fleet	£1,655,385	£1,719,388	£1,234,376
	Waste	£253,371	£263,168	£145,372
	Water	£49,786	£59,385	£56,533
	Supply Chain	£4,527,500	£4,168,240	£5,293,864
	TOTAL	£7,410,561	£7,253,398	£7,941,813
	TARGET	7,410,561	7,040,033	6,947,401
Avg Cost per tCO2e		£781.90	£873.41	£910.02

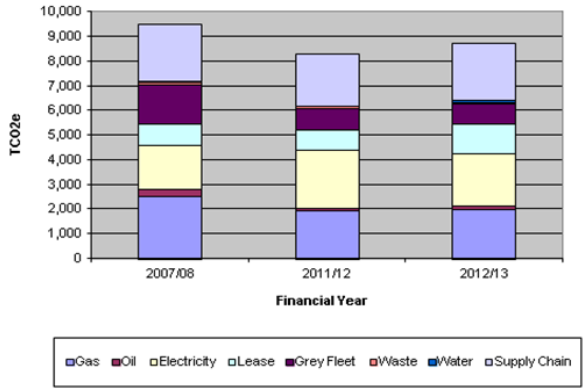


Figure 1: 2007/08, 2011/12 and 2012/13 Carbon Footprint Performance

Figure 1 demonstrates that NCH&C have over achieved by just under 2% on its GHG emission target for 2012/13. The Trust has also achieved an 8% carbon footprint reduction against its 2007/08 baseline. Although, the Trust is still on track to achieve the interim NHS target of 10% by 2015, current performance has reduced from 9% in 2011/12. This is largely due to the improvement in accuracy of data. However the average cost per equivalent ton of CO2 (TCO2e) has increased by 16% (£128) since the baseline year demonstrating that as carbon usage increases, so does cost to the Trust of the utilities and drivers of carbon usage. There is a clear financial benefit to Trusts reducing its carbon footprint as well as the wider societal benefits.

Supply chain expenditure is still the largest contributor to the NCH&C footprint for 2012/13. Ongoing Cost Improvement Programmes aim to reduce expenditure through the rationalisation of product catalogues and greater spending control. The Procurement Department actively discusses spending activity and stock control with service users to identify product requirements and encourage better spending behaviour.

The Trust aims to include outstanding areas such as air and rail travel under the scope of passenger transport and refrigeration and air conditioning under the scope of energy within its carbon footprint evaluation for 2014/15. This will lead to a fully comprehensive carbon footprint measuring all areas required.

10.2 Sustainable Development Management Plan

Since the plan was developed and approved by the Board in 2010, the Trust has reviewed and updated its content in line with current Sustainable Development Unit guidance and shared best practice. The management plan now focuses on four key areas, which reflect the content of the Department of Health's Good Corporate Citizenship Model and public sector requirements as outlined by the Sustainable Development Unit. Each area is managed by a committee attended by key Trust personnel.

Estates & Facilities

Buildings – This component is tasked with ensuring built environments are resilient to the effects of climate change through the implementation of low cost and carbon efficient technologies.

Utilities - This workstream is tasked with the monitoring and reporting of energy and water consumption and engaging with staff to create awareness and promote the behaviours to support the reduction in energy and water consumption.

Waste - This workstream is tasked with the monitoring and reporting the use of landfill, recycling and incineration and engaging with staff to create awareness and promote the supporting behaviours to reduce waste and how that waste is disposed.

Travel - This aspect oversees the monitoring and reporting of staff travel activity and developing site travel plans which promote low carbon options as appropriate.

Procurement

This component is tasked with reducing cost and carbon through the implementation of rationalisation projects and the adoption of sustainable development methodology and framework.

Community Engagement

This workstream is predominantly tasked with ensuring the Trust's services are resilient to the effects of climate.

Workforce

This part of the management plan focuses on the integration of sustainable development and carbon management into the Trust's recruitment process, training programme and policy development and wider engagement with staff.

Each workstream is delivered through a working group that completes annually the appropriate section of the Good Corporate Citizenship assessment. This assists the organisation in understanding current performance and areas of development and can be compared or shared with other organisations. The Trust aims to achieve 70% in each area by 2015 as targeted by the Sustainable Development Unit.

10.3 Good Corporate Citizenship

The Trust recognises the significant role it can play as a community leader and demonstrating good corporate citizenship. The Good Corporate Citizenship Assessment Tool (GCCA) produced by the Department of Health and the Sustainable Development Unit, enables the Trust to complete an annual self assessment test to measure sustainable, social, economic and environmental performance and reduce impacts in line with the measurements set by the Sustainable Development Unit.

In 2013, the SDU changed the assessment format of the Good Corporate Citizenship Assessments (GCCA). This has caused some problems in comparing

the 2013 scores with previous years. Three additional subject areas were also introduced; Overall, Adaptation, & Models of Care (which are excluded from the graph as no past data comparisons are available). As a whole, NCH&C are performing above the national averages within the East of England.

Fig. 2 below shows the Trusts highest scoring subject area, excluding the three new sections, is Community Engagement with a score of 66%. This has been on a steady rise since 2011 and the Trust is confident that it will meet the 70% Target of 2015.

The lowest scoring subject area, excluding the three new sections, is Workforce with a score of 39%. Workforce has reduced by 5% since 2012, in part due to changes in the assessment criteria for this element in 2013. Workforce committee meetings are underway and should help increase the score significantly over the next 2 years.

All subject areas, excluding Workforce and Facilities Management, are on a steady increase – emphasis placed during 2013 – 14 on the assessment committees is focused on ensuring appropriate action planning is concluded. The Trust Sustainability committee will continue to monitor these assessments to ensure progress is made.

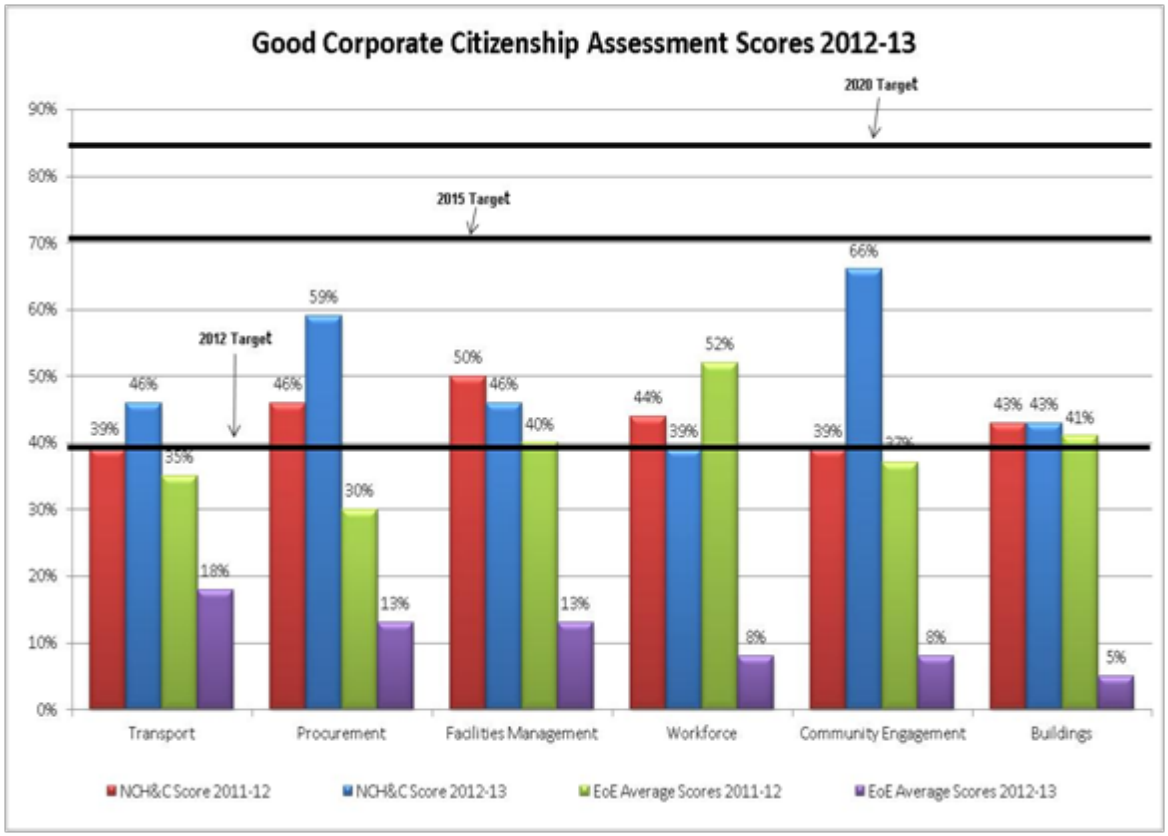


Figure 2. 2011/12 and 2012/13 GCCA performance

11. Serious incidents requiring investigation

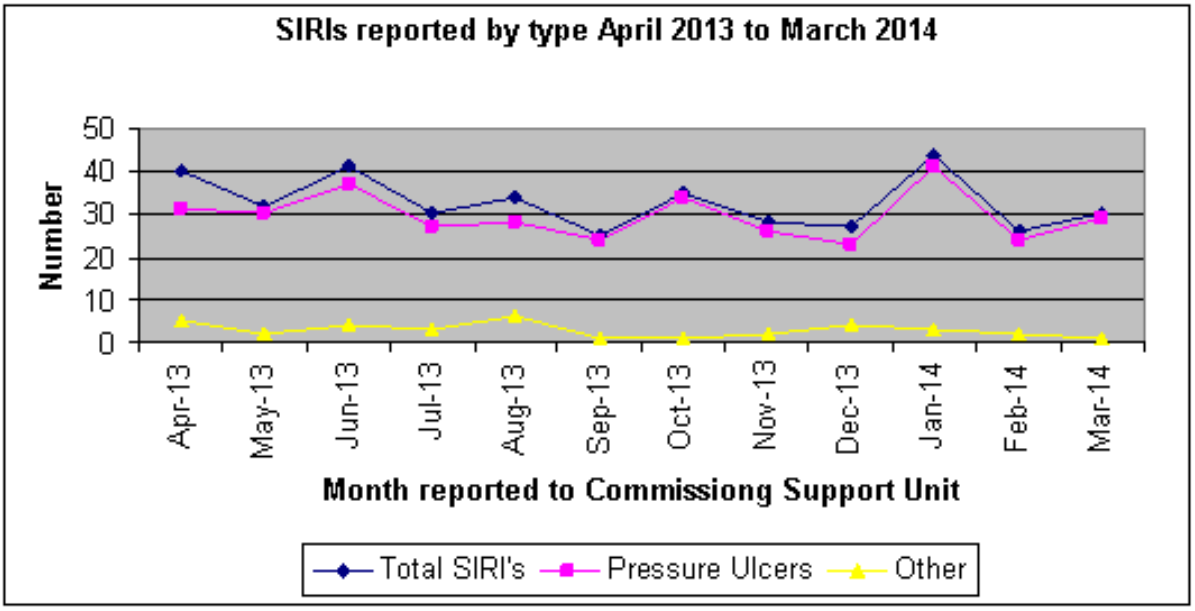
Management and learning from incidents

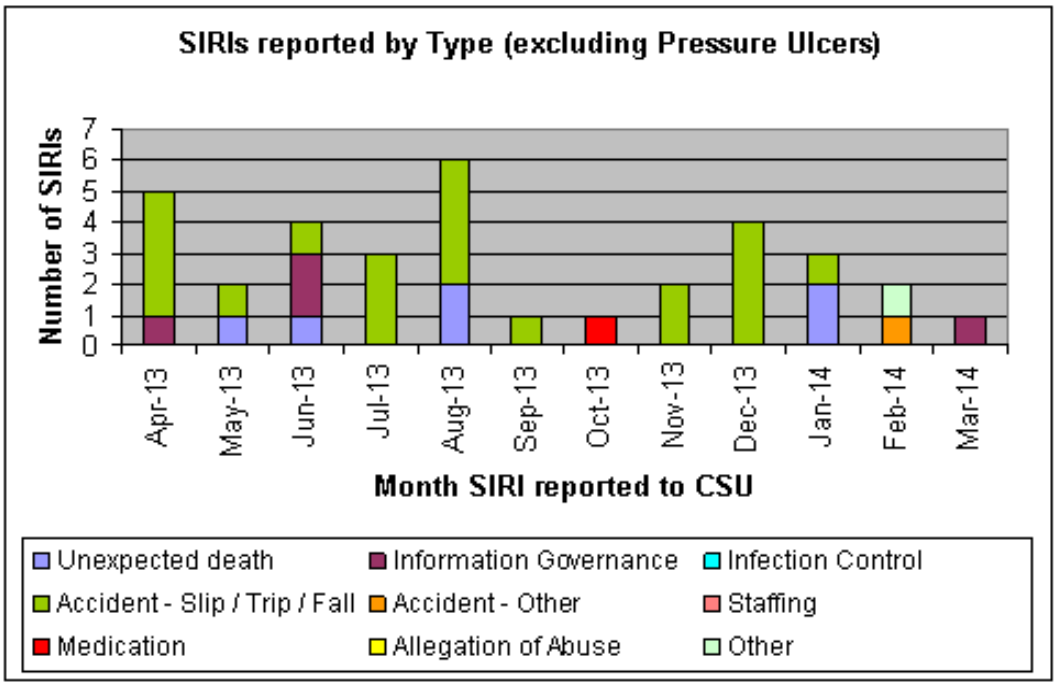
The Trust has an NHS Litigation Authority accredited, Board-approved Incident Reporting, Investigation and Management Policy in place which reflects the reporting requirements of the National Reporting & Learning System which is monitored by the Trust Development Authority and the Care Quality Commission.

The policy contains flow charts for incident and serious incidents requiring investigation (SIRI) reporting as defined by the former National Patient Safety Agency. This describes the process for escalation through the electronic reporting system, assignment of an investigator and level of investigation required through to the final approval of the incident. During 2013 the Trust introduced the new posts of Quality Assurance Managers to support clinical teams to improve the performance in incident and SIRI reporting. This action supports further integration of quality assurance into operational delivery.

The Trust reports monthly on all incidents and SIRIs, including any learning and actions taken to the Trust Board in public throughout 2013/14. Between April 2013 and March 2014, 388 SIRIs were reported, 354 were grade 3 and grade 4 pressure ulcers and there were 34 other causes.

The following graphs report the numbers and types of SIRIs (including and excluding pressure ulcers) for 2013/14.





All SIRIs have been investigated using root cause analysis methodology. The Trust aims to submit its 3 day and 45 day reports on time and currently have no 45 day reports overdue.

The Trust reported five unexpected deaths of patients in our inpatient units as Serious Incidents and these were investigated using root cause analysis. These incidents are further reviewed through the mortality review panels alongside all reported deaths.

Never Events

Never Events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. A core list of Never Events is published by the Department of Health. The Trust has not had any Never Events.

12. Data security

In accordance with disclosure requirements under Annex A of David Nicholson's letter to NHS Chief Executives and Finance Directors, 20 May 2008, *"Information Governance Assurance Programme"*, there have been five serious incidents requiring investigation involving data loss or confidentiality breaches, including incidents reported to the Information Commissioner's Office. These are described in the Annual Governance Statement below.

13. Charges for information

The Trust has complied with Treasury's guidance on setting charges for information. This guidance is available as *Appendix 6.3 to Treasury's MPM*.

14. Remuneration Report

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

Remuneration Policy

The remuneration of the Chairman and the Non Executive Directors is set in accordance with the levels provided by the Appointments Commission. The Chairman's remuneration is set in accordance with bandings relating to the relative size of the Trust's annual turnover.

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.

Remuneration and Nomination Committee Membership:
Vivienne Clifford-Jackson, Non Executive Director (Committee Chair)
Kenneth Applegate, Trust Chair
Lisa Gamble, Non Executive Director
Alex Robinson, Non Executive Director
Derek Allwood, Non Executive Director
James Ross, Non Executive Director (1st April 2013 to 30th September 2013)

Salaries and allowances

The salaries and other allowances of the senior managers who have held office for all or part of the 2013/14 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.

		2013/14					
		Salary (bands of £5,000)	Taxable Benefits (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)
Name	**Title**	£000s	£00s	£000s	£000s	£000s	£000s
Kenneth Applegate	Chair	20 - 25	0	0	0	0	20 - 25
Michael Scott	Chief Executive	135 - 140	0	0	0	17.5 - 20.0	155 - 160
Dr. Rosalyn Proops	Medical Director	95 - 100	0	0	0	0	95 - 100
Anna Morgan	Director of Nursing, Quality & Operations	105 - 110	0	0	0	12.5 - 15.0	120 - 125
Paul Cracknell	Director of Strategy and Transformation	105 - 110	0	0	0	12.5 - 15.0	120 - 125
Matthew Colmer	Director of Performance and Information	90 - 95	5.4	0	0	12.5 - 15.0	110 - 115
Roy Clarke	Director of Finance	105 - 110	0	0	0	12.5 - 15.0	120 - 125
Derek Allwood	Designate Non Executive Director (from 01.04.13 to 30.09.13) Non Executive Director (from 01.10.13 to 31.03.14)	5 - 10	0	0	0	0	5 - 10
Vivienne Clifford-Jackson	Non Executive Director	5 - 10	0	0	0	0	5 - 10
Lisa Gamble	Non Executive Director	5 - 10	0	0	0	0	5 - 10
Neil Harrison	Non Executive Director	5 - 10	0	0	0	0	5 - 10
Prof. Ian Harvey	Designate Non Executive Director	5 - 10	0	0	0	0	5 - 10
Alexander Robinson	Non Executive Director	5 - 10	0	0	0	0	5 - 10
James Ross	Non Executive Director (from 01.04.13 to 30.09.13)	0 - 5	0	0	0	0	0 - 5

		2012/13					
		Salary (bands of £5,000)	Taxable Benefits (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)
Name	**Title**	£000s	£00s	£000s	£000s	£000s	£000s
Kenneth Applegate	Chair	20 - 25	0	0	0	0	0
Michael Scott	Chief Executive	125 - 130	5.7	0	0	17.5 - 20.0	150 - 155
Dr. Rosalyn Proops	Medical Director	75 - 80	0	0	0	0	75 - 80
Anna Morgan	Director of Nursing, Quality & Operations	100 - 105	0	0	0	12.5 - 15.0	115 - 120
Paul Cracknell	Director of Strategy and Transformation	110 - 115	0	0	0	10.0 - 12.5	125 - 130
Matthew Colmer	Director of Performance and Information	95 - 100	0	0	0	12.5 - 15.0	110 - 115
Roy Clarke	Director of Finance	100 - 105	0	0	0	12.5 - 15.0	115 - 120
Derek Allwood	Designate Non Executive Director (from 01.04.13 to 30.09.13) Non Executive Director (from 01.10.13 to 31.03.14)	0 - 5	0	0	0	0	0 - 5
Vivienne Clifford-Jackson	Non Executive Director	5 - 10	0	0	0	0	5 - 10
Lisa Gamble	Non Executive Director	5 - 10	0	0	0	0	5 - 10
Neil Harrison	Non Executive Director	0 - 5	0	0	0	0	0 - 5
Prof. Ian Harvey	Designate Non Executive Director	0 - 5	0	0	0	0	0 - 5
Alexander Robinson	Non Executive Director	5 - 10	0	0	0	0	5 - 10
James Ross	Non Executive Director (from 01.04.13 to 30.09.13)	5 - 10	0	0	0	0	5 - 10

Pay Multiples

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 the Trust in the financial year 2013/14 was £135-£140k (£120-£125k in 2012/13). This was 5.2 times (4.6

in 2012/13) the median remuneration of the workforce, which was £26,822 (£26,556 in 2012/13).

In 2013/14, 1 part-time (3 part-time in 2012/13) employee received whole time equivalent remuneration in excess of the highest paid director, with a salary in the £170-175k band.

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.

Pension benefits

Past and present employees are covered by the provisions of the NHS Pensions Scheme or the National Employment Savings Trust. The accounting treatment in relation to pension liabilities is detailed in note 9.6 to the accounts.

Pension benefits for the senior managers 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.

Name	Title	Real increase in pension at age 60 (bands of £2,500) £000s	Real increase in pension lump sum at aged 60 (bands of £2,500) £000s	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) £000s	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000s	Cash Equivalent Transfer Value at 1 April 2013 (to nearest £1,000) £000s	Cash Equivalent Transfer Value at 31 March 2014 (to nearest £1,000) £000s	Real increase in Cash Equivalent Transfer Value £000s	Employer's contribution to stakeholder pension £000s
Michael Scott	Chief Executive	2.5 - 5.0	7.5 - 10.0	50 - 55	160 - 165	1043	1161	95	19
Anna Morgan	Director of Nursing, Quality & Operations	0 - 2.5	5.0 - 7.5	20 - 25	60 - 65	325	374	41	15
Paul Cracknell	Director of Strategy and Transformation	0 - 2.5	2.5 - 5.0	10 - 15	35 - 40	138	157	17	15
Matthew Colmer	Director of Performance and Information	(0 - 2.5)	(-2.5 - -5.0)	25 - 30	75 - 80	395	401	-2	13
Roy Clarke	Director of Finance	0 - 2.5	5.0 - 7.5	20 - 25	65 - 70	225	255	25	15

Cash Equivalent Transfer Values

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

Real Increase in CETV

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

Norfolk Community Health and Care NHS Trust

Norfolk Community Health and Care NHS Trust

Annual Accounts 2013/14

Annual Accounts

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Statement of Chief Executive's responsibilities as the 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.

Mark Easton
Interim Chief Executive
6th June 2014

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; and
- 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

Mark Easton
Interim Chief Executive
6th June 2014

Roy Clarke
Director of Finance
6th June 2014

Annual Governance Statement

1 Scope of 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. 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.*

2 The governance framework of the Trust

Board committee structure

The Board comprises the Chair and five Non-Executives drawn from a variety of backgrounds, five voting and one non-voting Executive Directors who lead the clinical and corporate services that deliver quality care to patients and service users. The Board has also appointed a non-voting Designate Non-Executive Directors to strengthen its independent challenge, expertise and succession planning. 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 appropriate committees monitor their areas in more detail, as described below.

The Board is supported in particular by Audit, Quality and Risk Assurance, and Finance and Performance Committees specialising in assuring the Board about the effective running of individual areas of the Trust. The Quality and Risk Assurance Committee provides the leadership, supervision and monitoring of all serious incidents, complaints, claims and Coroner's inquests. This Committee provides the overview, enquiry and challenge to ensure consistency; appropriate levels of investigation; root cause analysis and that key learning is delivered. 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.

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. A Chair's report and minutes following each meeting are provided to the Board.

The Quality and Risk Assurance Committee reviews the content of the Quality Account before it is presented to Board. The Audit Committee receives additional assurance from Executive Directors on the information and process underpinning the Quality Account.

In addition, the Remuneration and Nomination Committee provides a mechanism for succession planning and setting executive pay and conditions. The Charitable Funds Committee has delegated responsibility to make and monitor arrangements for the control and management of the charitable funds. The Finance and Performance Committee reviews the financial and performance strategies, financial and performance policies and reports and efficiency plans of the Trust.

In all cases, the Board receives the approved minutes of each committee 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. The Risk Management Strategy and the Board Assurance and Escalation Framework that are approved by the Board clearly outline the strategic intent and the committee structures that support the Board and provide the framework for risk control.

Assessment of Board effectiveness

The Board has undertaken a number of external reviews, observations and evaluations, internal whole Board and individual member self assessments and facilitated sessions. 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 committees have also produced annual assurance reports to the Board on how they have discharged their remit throughout the year. The attendance record of the Board and its committees is included in the Annual Report. All meetings have been quorate.

In reviewing their own performance the Board Committees have confirmed that:

The Quality and Risk Assurance Committee:

- The system of quality and risk assurance is adequate to identify risks and allows the Board to understand the appropriate management of those risks;
- The Board Assurance Framework and Corporate Risk Register are 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.

The Finance and Performance Committee:

- The systems for monitoring, advising on and recommending to the Board matters relating to the Trust's financial and performance management strategies and in-year reporting are adequate;
- The systems for advising the Board on the effective and efficient uses of resources are adequate;
- The systems for appraising annual budgets, CIPs and QIPP plans and recommending them to Board are adequate;
- 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.

The Audit Committee:

- 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.

The Charitable Funds Committee:

- Policies and procedures for charitable funds investments have been followed;
- The scheme of delegation for expenditure of charitable funds has been followed;
- The Committee has approved all individual expenditure in excess of £5,000 within the designated purpose of the fund;
- 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.

Delivering High Quality Care for Patients. The Accountability Framework for NHS Trust Boards

The Trust has assessed its performance against the national priorities set out in the Accountability Framework. The relevant national performance measures for the Trust, and the Trust's performance against these are described in the Annual Report. Most measures were achieved. The most significant areas of under-performance were in smoking cessation and delayed transfers of care.

The Smoking Cessation service agreed an annual target for 2013/14 of 2,000 quits with its commissioner, Norfolk County Council. It became apparent during the autumn that the Trust was deviating from its trajectory and a contract query notice was issued by the commissioner in November 2013. The Trust then developed a remedial action plan to address performance to improve referrals rates and the number of quits. However, the number of subsequent referrals generated was not sufficient to recover the level of quits required towards the end of the year, and, as such, the Trust failed this target, with an outturn of 1,525 quits. However, it is anticipated that a change in the structure of the service coupled with a number of actions will place the Trust is in a strong position to improve performance during 2014/15.

Throughout the year, the number of patients whose discharge was delayed for non-medical reasons occupied an average of 6.1% of the Trust's community hospital beds. However, during the year the overall trend has been decreasing, with a rate of just 5.0% compared to the upper ceiling of 5.4%. Whilst there are no contractual targets in place for this performance measure, analysis of the data has shown delays have been attributable to both health service related reasons (including patient and family choice), as well as social care delays.

The average level of community hospital beds occupied by patients whose discharge was delayed for non-medical reasons was 6.1% of beds, compared to 5.2% the previous year. Whilst there are no contractual targets in place for this measure, this is above the local target of 5.4%. Analysis indicates health system-wide pressures, including patient and relative choice, and the provision of social care packages and undertaking continuing healthcare assessments, as having contributed to the increase in delayed discharges. There have been improvements in the discharge process as a result of the implementation of the 'Productive Ward' across the Trust's community hospitals. The 'Productive Ward' is a management tool focusing on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency.

Compliance with the Corporate Governance Code

The Trust is compliant with those sections of the Corporate Governance Code that are relevant to an NHS Trust. The Trust has assessed its compliance against the relevant sections of the Financial Reporting Council's UK Corporate Governance Code and Monitor's Code of Governance for Foundation Trusts. The Trust is compliant in terms of the requirements in relation to the Board composition, Board

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. Requirements in relation to Governors are incorporated into the Trust's Foundation Trust plans and the Trust's draft Foundation Trust Constitution.

The Constitution was updated and approved by the Board during the year to comply with the new model Constitution issued by Monitor. The Constitution has been confirmed as being legally compliant, by the Trust's solicitors, with legislation relating to Foundation Trusts and the known requirements of Monitor. As part of the Trust's Foundation Trust application, Monitor undertook a legal review in January 2014 and made suggestions and recommendations for further changes, which have been further reviewed by the Trust's solicitors, and will be considered by the Board in May 2014.

In summary, the governance arrangements in place for the discharge of statutory functions have been checked for any irregularities, and can be confirmed as being legally compliant.

3 Risk assessment

The Risk Management Strategy for the Trust clearly outlines the leadership, responsibility and accountability arrangements. This document was reviewed and updated during the year to reflect improved arrangements following annual review. The updated document clearly differentiates between the Trust's risk management arrangements and the governance and assurance framework, and details the governance infrastructure, which has been both strengthened and standardised.

The Trust achieved level 1 against the NHS Litigation Authority (NHS LA) risk management standards in 2012/13, which confirmed that the process for managing risks has been described and documented. The NHS LA no longer assesses trusts against these standards. It replaced its system of assessments with the provision of information designed to help trusts reduce claims. Trusts are now provided with real time access to claims and information on the NHS LA's safety and learning service.

The Trust's Risk Management 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 continues to use the National Patient Safety Agency (NPSA) risk matrix in order to assess the likelihood and severity of identified risks. Externally facilitated Board assurance sessions on key issues in risk management, such as the Bribery Act and the NHS Provider Licence, have been provided to all members of the Board. Risk management awareness has also been cascaded throughout the Trust.

The Trust maintains a Corporate Risk Register which is the aggregation of the local team and corporate department risk registers where the residual risk is rated as 12

and above. It includes any additional sources of risk such as external or internal reviews. It is maintained centrally by the Trust's Risk Manager and recorded on the incident reporting system. As such it identifies the source, describes the risk, scores and grades it and provides a summary of the action taken to control it. It includes a review date and a residual risk rating. The Corporate Risk Register is reviewed on a monthly basis at operational and corporate meetings in conjunction with the Board Assurance Framework to ensure that there are appropriate checks and balances between the two risk registers and that appropriate escalation and/or de-escalation occurs.

The Trust also maintains a Board Assurance Framework which provides a record of the principal strategic risks to the Trust achieving its objectives. It identifies the controls in place, the methods of assurance and the control and assurance gaps. It is informed by the risks where the residual risk is graded at 15 and above on the Corporate Risk Register once these ratings have been confirmed and agreed by the local unit or departmental review and escalated for inclusion. They may include internal, external and strategic risks which may affect the Trust's business, those identified by the Executive Directors or any additional source where local controls are not sufficient to manage the risk e.g. infection control, finance or information risk. It includes key risks identified through aggregated analysis of incidents, complaints and claims which may not already appear on the Corporate Risk Register.

Each risk is linked to a Trust objective and has an executive lead, responsible for receiving assurance that the actions required to mitigate the risk are completed at either local, operational or strategic level. The Board Assurance Framework provides a vehicle for the Trust Board to be assured that the systems, policies and people in place are operating in a way that is effective and focused on the key risks which might prevent the Trust objectives being achieved. The Board has adopted best practice from HM Treasury guidance that includes "lines of defence". The first line is monitoring used by front-line clinicians or business units such as team risk registers and performance data collected and used by staff. The second line is management oversight by those not responsible for delivery such as corporate reporting and governance compliance assessments. The. third line is independent reviews undertaken by internal and external audit and third party inspectorates. Reliance on a range of 1, 2 and 3 would give a green assurance rating.

For 2013/14, the Board also adopted a Red, Amber Green traffic light rating (RAG) in the Board Assurance Framework for the level of confidence that can be placed on the assurances: Green: indicates a high level of assurance can be placed on the sources of assurance in proportion to the risks. This means that there are both internal and external sources of assurance, and that they are reasonably recent. Amber: indicates that there are some areas of concern over the quality or timeliness of assurances. This would include whether reliance is placed on only external or only internal sources of assurance, or that the assurances are not reasonably recent. Red: indicates that there is a lack of both internal and external assurance, or that the assurances are not recent. These statements refer to the confidence in the sources of assurance, and are not to be confused with whether controls are effective. For example, there may be a good range of sources of

assurance (green) that informs the Board that controls are not working, i.e. negative assurance.

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 is designed to capture and bring together 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. It was modified from a national tool developed by the National Patient Safety Agency and was tested in all business units prior to rollout.

The Board Assurance Framework together with other reporting mechanisms provided to the Board, provides the evidence that the effectiveness of controls that manage the risks to the Trust achieving its principal objectives, have been reviewed. Internal Audit has reviewed and rated the Assurance Framework confirming that the risk control measures that are in place are reasonable and that action plans have been developed to improve the controls and assurance processes where appropriate.

The Board Assurance Framework is reported monthly to the Board, having also undergone a detailed review at the Quality and Risk Assurance Committee. The Framework is continually updated in order to ensure that it covers all areas on which the Board should be seeking assurance. This information is supplemented and enhanced by the other performance management tools presented, including the Integrated Performance Report, Finance Report and Quality Assurance Report. These reports provide a comprehensive performance overview to the Board on adherence with regulatory targets, quality indicators, financial delivery and workforce metrics.

Risks identified in 2013/14

The Board has been monitoring a number of risks throughout the year. Despite mitigation, the following risks remained as high rated risks on the Board Assurance Framework throughout most of the year:

- Delivery of the cost improvement programme plans (CIP). If CIP is not delivered over the five year planning period then the Trust will be unable to achieve the required surplus and liquidity levels;
- Competition risks. If the Trust loses services to its competitors then the long term sustainability of the Trust could be at risk.;
- Economic risks. If cost pressures or income reductions (e.g. tariff inflation, pay awards, non-pay cost inflation, increasing backlog maintenance) exceed the levels built into the Trust's financial strategy and long term financial model, then there is a risk to the Trust's sustainability and aspirations for Foundation Trust status;
- Demographic funding risks. If demand for services increase over and above that which is funded then the quality of service (specifically patient experience including waiting times) may deteriorate, thereby also damaging the Trust's

reputation, and creating activity pressure over the 5 years of the financial model;
- Delivery of the Transformation programme. If the Trust does not have an appropriate vision, implementation plan and the necessary controls in place then the risks to quality will not be mitigated and the transformation plan will not deliver the intended cultural change and improvements to service delivery.

These have been incorporated into the following year's Board Assurance Framework to ensure that they continue to be effectively managed and mitigated.

The Trust highest rated clinical risks taken from the Corporate Risk Register are:

- Risks to patients acquiring avoidable pressure ulcers,
- Risks to breaching the waiting time targets for podiatric surgery,
- Risks to patients falling and causing themselves harm.

Trust's risk profile

At the start of the year, the Board identified 21 strategic risks covering: (1) ensuring patient safety, (2) clinical effective services, (3) good patient experience, (4) contractual performance, (5) relations with commissioners, (6) clinical leadership, (7) achieving foundation trust status, (8) workforce assurance – staff engagement, (9) staff deployment, (10) economic risks, (11) demographic funding, (12) cost improvement programme, (13) competition risks, (14) estates risks, (15) IM&T infrastructure, (16) information services, (17) implementing the transformation programme, (18) tender opportunities, (19) provision of appropriate alternatives to hospital admission, (20) locally responsive services, and (21) integration with social care. Residual risk ratings for most of these risks reduced significantly through active mitigation.

An analysis of the Trust's risk profile shows that throughout the year there has been an improvement in risk reporting and effective management of a number of risks to within acceptable levels, agreed by the Board. However, a review by Internal Audit identified areas of high, medium and low risk in the design and operation of the Trust's assurance framework and associated processes. The high risks are covered in more detail under the relevant section below. The recommendations made by Internal Audit are being fully implemented.

The governance framework of the Trust is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2014 and up to the date of approval of the Annual Report and accounts.

The Trust reviews its quality and risk profile produced by the Care Quality Commission. It presents the Trust's compliance risk against the outcomes which relate to services provided by the Trust. It also details the actions that the Trust is currently taking to ensure that the Trust improves these identified areas. The quality and risk profile is issued to Trusts on a monthly basis and reviewed through the Trust's quality and risk assurance processes. Any new areas of concern are reported to the Quality and Risk Assurance Committee. There were no areas of significant concern reported through the quality and risk profile.

Serious Incidents Requiring Investigation (SIRI)

The Trust has an NHS Litigation Authority accredited, Board-approved Incident Reporting, Investigation and Management Policy in place which reflects the reporting requirements of the National Reporting & Learning System which is monitored by the Trust Development Authority and the Care Quality Commission. The policy contains flow charts for incident and serious incidents requiring investigation (SIRI) reporting as defined by the former National Patient Safety Agency. This describes the process for escalation through the electronic reporting system, assignment of an investigator and level of investigation required through to the final approval of the incident. During 2013 the Trust introduced the new posts of Quality Assurance Managers to support clinical teams to improve the performance in incident and SIRI reporting. This action supports further integration of quality assurance into operational delivery. The Trust reports monthly on all incidents and SIRIs, including any learning and actions taken to the Trust Board in public throughout 2013/14. Between April 2013 and March 2014, 388 SIRIs were reported, 354 were grade three and grade four pressure ulcers and there were 34 other causes.

All SIRIs have been investigated using root cause analysis methodology. The Trust aims to submit its 3 day and 45 day reports on time and currently have no 45 day reports overdue. The Trust reported five unexpected deaths of patients in our inpatient units as SIRIs and these were investigated using root cause analysis. These incidents are further reviewed through the mortality review panels alongside all reported deaths.

Never Events

Never Events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. A core list of Never Events is published by the Department of Health. The Trust has not had any Never Events.

Data security

In accordance with disclosure requirements under Annex A of David Nicholson's letter to NHS Chief Executives and Finance Directors, 20 May 2008, *"Information Governance Assurance Programme"*, there have been five serious incidents requiring investigation involving data loss or confidentiality breaches, including information breaches reported to the Information Commissioner's Office (ICO). These are summarised below:

- Internal e-mail accounts, over an eleven month period, were set up without e-mail encryption. This was managed as an Information Governance Serious Incident Requiring Investigation and reported to Commissioners. An investigation commenced and immediate steps were taken to ensure all affected e mail accounts were enabled with encryption. A team were assigned to carry out a complete audit of the accounts. The results of the audit showed that although the data was insecure there was no actual loss of data or information, for this reason it was decided not to make a report to the Information Commissioner.

- Patient information was handed in to the Trust by a member of the public who reported finding it on decommissioned Trust property. The incident was reported to commissioners as an Information Governance Serious Incident Requiring Investigation. A site inspection was undertaken immediately and the site was found to be secure. The investigation was unable to determine how the information came to be in the possession of a member of the public. The incident was reported to the Information Commissioner who assessed the outcome of the investigation and subsequent actions. The Information Commissioner closed the incident in March 2014 with no further action.

- An appointment letter, sent to a patient, was found to contain the last page of a medical report which had been enclosed in error and belonged to another patient. This was reported to commissioners as an Information Governance Serious Incident Requiring Investigation and an investigation using root cause analysis methodology was undertaken. The Trust's Caldicott Guardian provided additional advice on the sensitivity and importance of the information that was disclosed in error. The Caldicott Guardian supported the recommendations from the responsible manager, and ensured that the Trust put the required changes into immediate effect. The incident was reported to the Information Commissioner who closed the incident in April 2014 with no further action being required.

- A team hand over sheet containing patient details was left, in error, at a patient's house. Once the information loss was recognised an incident was raised immediately and steps taken to successfully retrieve the information. This was reported to the commissioners and the information commissioner as an Information Governance Serious Incident Requiring Investigation. An investigation using the root cause analysis methodology was undertaken. The team have now stopped taking the team handover sheets out on community visits and have changed their processes. The incident remains open with the Information Commissioner.

- Information was disclosed in error during the ending of a contract. The outgoing service provider requested a copy of their data base which was

provided to them in a safe and secure manner however on downloading the information it became apparent that additional information had been included in error. This was reported to commissioners as an Information Governance Serious Incident Requiring Investigation and reported to the Information Commissioner. An investigation using the root cause analysis methodology has commenced. Immediate steps were taken within the department to ensure this mistake could not be repeated.

4 The risk and control framework

The overall responsibility for the management of risk lies with the Chief Executive as Accountable Officer. 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.

As part of the Board's continuing commitment to risk management, the Trust's management structure was reviewed during the year and the revised arrangements were further effected during the year. The Director of Nursing, Quality and Operations provides the leadership and management for the risk management function within the Trust. The Medical Director is the Caldicott Guardian. The Director of Finance is the Senior Information Risk Owner (SIRO).

The Board has sought assurance through monthly scrutiny of the Board Assurance Framework and the receipt of reports to the Board from the five Board committees. The Board has approved a Board Assurance and Escalation Framework, which provides a consistent, clear and integrated system for the assurance process and escalation of risks.

The Quality and Risk Assurance Committee receives minutes and exception reports from a number of sub-groups that monitor areas of quality and risk including: Quality and Clinical Effectiveness, Infection Prevention and Control, Multi-agency Safeguarding, Risk, Health and Safety and Information Governance. All these meetings have a role to provide regular monitoring for best practice as well as to identify themes and trends for learning and sustained improvements.

The annual review of the Organisational Development Programme has also been undertaken to ensure that the Trust's training programmes are aligned to statutory and mandatory requirements, and that training continues to support the embedding of risk management policies and procedures throughout the Trust.

Learning is promoted across the Trust through a series of training events commensurate with staff duties and responsibilities. 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 key to maintaining the risk management culture within the Trust. Learning is acquired from a variety of sources, including:

- Analysis of incidents, complaints and claims and acting on root cause analysis
- External inspections;
- Health and safety issues;
- CQC quality and risk profile data;
- Assurance from Internal and External Audit reports;
- Clinical Audit programme.
- Quality Account including Quality Goals.

The governance arrangements in place during the year have continued to develop and led to improvements in Trust-wide engagement with the risk agenda and controls assurance. These arrangements manage risk and provide assurance to the Board through five Board committees namely: Quality and Risk Assurance, Finance and Performance, Audit, Remuneration and Nominations, and Charitable Funds. The Board committee structures reporting through to Board have been clearly defined following a comprehensive review of the Governance Manual, including Standing Orders, the Scheme of Delegation and Reservation to the Board, Standing Financial Instructions and the terms of reference and reporting arrangements, for all Board committees, led by the committee chairs and Trust Secretary.

The risk management function, risk registers and the Board Assurance Framework have all been considerably developed during the year led by Executive Directors and the Board committees. These enhanced practices have all been audited in year by the Trust's Internal Audit team, the results of which have demonstrated both improvements and deficiencies in the Trust's controls assurance processes.

All risk registers for the Trust have been brought together into a centrally maintained electronic system. 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; the Risk Group comprising Trust-wide risk leads, reporting 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.
The Trust has implemented the NHS Information Risk Management Guidelines by establishing a register of key information assets, allocating each one to an information asset owner who reports to the Information Governance Group and Senior Information Risk Owner. Information risk management is reviewed and monitored by the Information Governance Group. The Trust has implemented and rigorously enforced the Information Risk and Information Security Policy to control where personal information is stored and to protect personal information that is stored on all portable data storage devices from unauthorised access, through the encryption of all portable devices and remote access personal computers.

The Board is provided with assurance on the use of resources through a monthly report and the Finance and Performance Committee undertakes a review on a regular basis. The Board has provided the Trust Development Authority with monthly self certification against mandated Board statements and relevant NHS Provider Licence Conditions. Supporting tables of evidence were reviewed by the Board in order to provide assurance on the accuracy of self certification and compliance with the NHS Provider Licence.

NHS Trusts do not need a licence. Licences are granted automatically to Foundation Trusts. However, Directions from the Secretary of State require the Trust Development Authority to ensure that NHS Trusts comply with equivalent conditions of the NHS provider licence as it deems appropriate. Furthermore, Monitor require aspirant Foundation Trusts to consider all likely future risks to compliance and be able to demonstrate that they have reviewed appropriate evidence regarding the level of, severity and likelihood of a breach of conditions occurring and the plans for mitigation of these risks to ensure continued compliance. The Board has considered all likely future risks to compliance with the NHS Provider Licence and has demonstrated that it has reviewed appropriate evidence regarding the level of, severity and likelihood of a breach of conditions occurring and the plans for mitigation of these risks to ensure continued compliance.

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. 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 also informed by the Head of Internal Audit Opinion and comments made by the external auditors in their management letter and other reports.

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 weaknesses and ensure continuous improvement of the system is in place.

The Board undertook a range of actions to support both ongoing assurance and scrutiny and specific actions to reduce risks; examples being:

- Refining the revised governance arrangements, including refreshing the Governance Manual, and evaluating the implementation and effectiveness of these changes;

- Annual Assurance Reports provided by each Board Committee setting out how they have discharged their delegated responsibilities in accordance with their terms of reference;
- Board Committees have undertaken annual self assessment on their performance and effectiveness, and identified areas for improvement, and their training needs;
- Reviewed the Board Assurance Framework (BAF) report at each Board meeting, alternating the full BAF with an exception report;
- Closely monitoring compliance with challenging national and local infection prevention and control targets;
- Assurance on the delivery of the corporate and strategic objectives;
- Monitoring performance through integrated performance, quality assurance and finance reports to ensure reduction in risk and adherence with the Trust's quality priorities;
- Ongoing review and testing of emergency preparedness and resilience planning;
- Information Governance Toolkit compliance at level two.
- Audit Committee reviewed annual reports from the Quality and Risk Assurance Committee, Charitable Funds Committee and the Finance and Performance Committee, focused on the process by which assurance was gained by these committees.

Work has been commissioned from the Internal Audit service as noted within this Governance Statement to review the adequacy of the controls and assurance processes in place and to develop improvements within the governance processes. The Trust is committed to the continuous improvement of its risk management and assurance systems and processes, to ensure improved effectiveness and efficiency. My review is also informed by:

- Opinion and reports by Internal Audit, who work to a risk-based annual plan with topics that cover governance and risk management, service delivery and performance, financial management and control, human resources, operational and other reviews;
- Opinion and reports from our external auditors;
- Monthly performance management reports to the Trust Development Authority;
- Department of Health performance requirements/indicators;
- Full compliance with the Care Quality Commission essential standards for quality and safety for all regulated activities across all locations;
- NHS Litigation Authority (NHSLA) assessments against risk managements standards;
- Information governance assurance framework including the Information Governance Toolkit compliance;
- Results of national patient and staff surveys;
- Investigation reports and action plans following serious incidents requiring investigation;
- Clinical audit reports.

The Trust retains the services of PricewaterhouseCoopers to act as its internal auditors. During the year they carried out the following reviews on our behalf offering the benefit of their experience of the wider health and social care sector and other sectors. Their overall assurance opinion is listed alongside. An overall risk rating is not provided where it is a critical friend review.

- Board Assurance Framework and Risk Management – medium risk.
- Information governance – low risk.
- Care Quality Commission standards – no assurance opinion given
- Business continuity – medium risk.
- Data quality – medium risk.
- Financial reporting and budgetary control – low risk.
- Key financial controls – low risk.
- Corporate governance – low risk.
- Clinical governance – medium risk.
- Business development – low risk
- Children's services – medium risk
- Sickness absence – high risk.
- Sickness absence follow up – medium risk

In addition, the following external reviews were undertaken to provide assurance:

- Quality Governance Framework by KPMG;
- Annual financial statements by Ernst and Young.

Internal Audit reviews of the following areas have identified that, in general, the control environment in those areas reviewed remains strong or significant improvement in the control environment were noted:

- Corporate Governance;
- Information Governance;
- Business Development;
- Financial Reporting & Budgetary Controls; and
- Key Financial Controls.

The Trust recognises the need for ongoing review and development of the robustness of its systems of control and assurance, and the monitoring of its risk registers and Assurance Framework to ensure they identify the changing impact and likelihood of risk and better support the delivery of business objectives.

These are presented in more detail in the Head of Internal Audit Opinion described below.

The work of internal audit and executive managers

In accordance with the Public Sector Internal Audit Standards, the Head of Internal Audit has provided an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control (i.e. the Trust's system of internal

control). This was achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which provides a reasonable level of assurance, subject to the inherent limitation of internal audit (covering both the control environment and the assurance over controls). The opinion does not imply that Internal Audit have reviewed all risks relating to the Trust. The findings are based upon and limited to the results of the internal audit work performed as set out in the 2013/14 Annual Internal Audit Risk Assessment and Plan approved by the Audit Committee on 7 May 2013 and agreed amendments.

The opinion is based on our assessment of whether the controls in place support the achievement of management's objectives as set out in the Individual Assignment Reports. Internal Audit completed the programme of internal audit work for the year ended 31 March 2014. The work identified low, moderate and high rated findings. Based on the work have completed, Internal Audit believe that there is some risk that management's objectives may not be fully achieved. Improvements are required in those areas to enhance the adequacy and / or effectiveness of governance, risk management and control.

Internal Audit High Risk Recommendations: 2013/14 Annual Report

Business Assurance Framework and Risk Management (overall classification: Medium Risk). The documentation of risks within Datix is of variable quality. Risks are not reviewed on timely basis - 24 out of 25 risks tested were overdue for review. The risk register on Datix is not complete (High Risk).

> Management action: The Trust has reviewed the detailed testing results (provided by the Internal Auditors) in order to improve training and support for risk handlers. The actions taken include: (1).Head of Risk Management to ceased formal risk training for 3 months (over 200 staff currently trained) this releases capacity of approx. 2 days per month. DATIX Administrator ceased formal incident training for 3 months (over 550 staff currently trained); this releases capacity of 2 days per month. This released sufficient time directly support the Localities / Directorates by providing follow-up training which addresses: Quality of incident reporting; Expectations around Incident Management; Risk Register management: Quality; Expectations regarding review; Action planning; Escalation. These training sessions were delivered out in the localities. The Quality Assurance Managers (QAM) continue to receive training around incident management and risk register management in order that they will be able to provide support to teams. The Head of Risk Management has worked with the QAMs and Health and Safety Manager to embed processes and to ensure a consistent message is communicated. A Quality & Risk Operational Group has been set up to provide support for integrated working between the QAMs, Risk Management and Health, Safety & Security.

Clinical Governance (overall classification: Medium Risk). The central clinical audit resource is currently in transition; there is an unfilled vacancy for Band 5 administrative staff and additional funding for resource has been requested but not yet approved. The clinical audit fieldwork is 10% behind plan (five out of 49 reviews) (High Risk).

Management action: A clinical audit facilitator post was recruited to and started in post on 10.02.14. They have re-focused job description to support clinical effectiveness and continued additional support from the Medical Directorate.

Business Continuity Follow-up (overall classification: Medium Risk). A formal programme of business continuity plans testing had yet to be devised at the time of our audit fieldwork. As a result, there is no formal lessons learned programme in place for capturing learning (High Risk).

Management action: An annual work plan for Emergency Preparedness, Resilience and Response (EPRR) has now been developed. The Business Continuity Plans have been developed at service and directorate level. This enabled the aggregated Trust level plan to be finalised at the end of March 2014 and approved by the Board. There are in place annual work plans with an 2014/15 assurance timeline, aggregated Business Impact Assessments and Aggregated Business Disruption Risk Assessments (which constitute Business Continuity plans).

There is a significant amount of the Trust's work on the implementation of the EPRR plans currently in progress (High Risk).

Management action: A review of the Norfolk community risk register has been completed and will inform a wider piece of work for the Local Health Resilience Partnership strategy. It will also inform emergency planning/Major Incident Plan. The new Major Incident Plan has been approved by the Board in April 2014. Training needs assessments and training courses are underway. Training is incorporated into the testing of new Major Incident Plan.

Sickness Absence (overall classification: High Risk). Line managers are not always completing absence forms in a timely manner. As a result, the electronic staff record (ESR) is not updated on a timely manner and therefore contains inaccurate information. Exceptions for timely completion of forms were noted for eight out of 17 (47%) start of absence forms and six out of 18 (33%) return from absence forms. The exceptions for timeliness of updating the ESR were noted for six out of 17 (33%) start of absence forms and four out of 18 (22%) return from absence forms (High Risk).

Management action: Time delays were investigated with individuals and the payroll supplier where appropriate. Time lines for completion of forms were re-iterated to line managers as part of the new training programme and policy. A Sickness Absence Follow Up review (see below) found that this issue was still ongoing and that compliance has improved slightly although the risk rating remained High. As a result the actions to address this review were followed up through management action plan within the Follow Up report.

Line Managers are not monitoring the sickness absence records of their teams and taking action where individuals have hit trigger points for repeated sickness absence. HR Advisors are not always updated on status of the sickness absences. Exceptions noted in 16 out of 26 (62%) from our sample testing (High Risk).

> Management action: This was addressed as part of the mandatory management essentials training as per the action plan. Meetings were held with line managers to discuss sickness absence. The Sickness Absence Follow Up review (see below) found that this issue was still ongoing and that compliance had improved slightly although the risk rating remained High. As a result it is proposed that the actions to address this review were followed up through management action plan within the Follow Up report.

Data Quality (overall classification: Medium Risk). Data quality issues were noted during testing of KPI data; exceptions were noted in 13 out of 15 cases (High Risk).

> Management action: The use of referrals through the Transformation Project has been simplified. Training now includes the requirement to add an explanatory note where changes to clinical data are made for data quality correction purposes. The number of referral options has been reduced from 14 to 6. The IT Training Team has investigated the possibilities of adding an explanatory note on SystmOne and has raised a development request with the supplier. The Mobile Working guidance is specific to the use of e-books only, so it was not suitable to include instructions about entering the data on SystmOne. It has been covered in SystemOne optimisation training.

Children's Services (overall classification: Medium Risk). The Supervision policy is out of date and does not reflect the developments in supervision practices at the Children's Services and across the Trust (High Risk).

> Management action: the Supervision Policy has been updated to reflect the developments in supervision practices at the Children's and across the Trust, and is being implemented.

Sickness Absence Follow up (overall classification: Medium Risk). Sickness absence forms are not always completed and updated onto the Electronic Service Record in a timely manner (High Risk).

> Management action: The actions in place have reduced the time taken for managers to arrange close down of sickness absence in ESR from an average of 16.1 calendar days to 10.6 calendar to days.

Line managers are not always monitoring the sickness absence records of their teams and taking action where individuals have hit trigger points for repeated sickness absence (High Risk).

> Management action: The Human Resources team are regularly meeting with line managers to review the Absence Managers packs to identify the required actions, such as formal meetings and referral to Occupational

Health. The 12-month sickness absence has decreased to 4.3%, which is the lowest absence rate since the Trust was established in 2010. Data presented to the Board evidences a consistently improving sickness absence rate when comparing the 12-month rolling total over the last 12-months compared to the previous year.

Controls assurance from shared service provider

In addition to the above Internal Audit reviews, deficiencies were identified relating to system change control procedures at the Trust's provider of financial administration and payroll administration services, Serco ASP. The deficiencies were highlighted by Serco ASPs independent ISAE 3402 audit report for 2013/14, which was provided by Pricewaterhouse Coopers. The Trust has reviewed the findings of this report and concluded that the identified deficiencies have not adversely impacted the Trust during 2013/14. The Trust will closely monitor the remedial actions that Serco ASP are taking in response to the findings.

6. Other significant issues to report

During the year, operational risks were identified within the Trust's Podiatric Surgery service, which were reviewed and resulted in the Trust changing the service delivery model.

7. Conclusion

As Accountable Officer and based on the review process outlined above, the Trust has identified and is taking action on the control issues arising in year which have been identified in detail in the body of the Annual Governance Statement.

Mark Easton
Interim Chief Executive
Norfolk Community Health and Care NHS Trust

6th June 2014

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 2014 under the Audit Commission Act 1998. The financial statements comprise the Trust and Group's Statement of Comprehensive Income, the Trust and Group Statement of Financial Position, the Trust and Group Statement of Changes in Taxpayers' Equity, the Trust and Group Statement of Cash Flows and the related notes 1 to 32. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

the table of salaries and allowances of senior managers on page 66;

the table of pension benefits of senior managers on page 67; and

the narrative disclosure of pay multiples on page 66-67.

This report is made solely to the Board of Directors of Norfolk Community Health and Care NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. 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 and auditors

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 72, 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.

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 and Group's circumstances and have been consistently applied and adequately disclosed;

- the reasonableness of significant accounting estimates made by the Trust and the Group; and

- the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report 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.

Opinion on 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 2014 and of its expenditure and income for the year then ended;

- give a true and fair view of the financial position of the Group as at 31 March 2014 and of its expenditure and income for the year then ended; and

- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and

- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Trust Development Authority's Guidance;

- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or

- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

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

Respective responsibilities of the Trust and auditors

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2013, as to whether the Trust has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those 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 2014.

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.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2013, we are satisfied that, in all significant respects, Norfolk Community Health and Care NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014.

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 Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Neil A Harris
Audit Director
For and on behalf of Ernst & Young LLP
London
June 2014

Norfolk Community Health and Care NHS Trust

Financial Statements & Notes to the Accounts

2013-14

Statement of Comprehensive Income
For the year ended 31st March 2014

	Note	Pre Consolidation Trust 2013/14 £000s	Pre Consolidation Trust 2012/13 £000s	Consolidated Group 2013/14 £000s	Consolidated Group (Restated)* 2012/13 £000s
Gross employee benefits	9.1	**(84,891)**	(84,443)	**(84,891)**	(84,443)
Other operating costs	7	**(35,246)**	(37,652)	**(35,337)**	(37,737)
Revenue from patient care activities	4	**118,371**	118,797	**118,371**	118,797
Other operating revenue	5	**4,895**	6,046	**5,019**	6,114
Operating surplus/(deficit)		**3,129**	2,748	**3,162**	2,731
Investment revenue	11	**0**	0	**30**	30
Other gains and (losses)	12	**85**	0	**85**	0
Surplus/(deficit) for the financial year		**3,214**	2,748	**3,277**	2,761
Public Dividend Capital dividends payable		**(107)**	(65)	**(107)**	(65)
Retained surplus/(deficit) for the year		**3,107**	2,683	**3,170**	2,696

Other Comprehensive Income

		2013/14 £000s	2012/13 £000s	2013/14 £000s	(Restated)* 2012/13 £000s
Impairments and reversals taken to the revaluation reserve		**(381)**	0	**(381)**	0
Gain on revaluation of property, plant & equipment		**3,794**	0	**3,794**	0
Net gain/(loss) on revaluation of available for sale financial assets	12	**0**	0	**(51)**	80
Total Comprehensive Income for the year		**6,520**	2,683	**6,532**	2,776

Financial performance for the year

	2013/14 £000s	(Restated)* 2012/13 £000s
Retained surplus for the year	**3,107**	2,683
Impairment added back**	**1,477**	0
Adjustments in respect of donated/government granted asset reserve elimination	**46**	0
Adjusted retained surplus/(deficit)	**4,630**	2,683

*Due to the consolidation of Norfolk Community Health & Care NHS Trust Charitable Fund into the Trust accounts taking place for the first time in 2013/14, prior year comparatives have been restated to include the Charitable Fund.

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

Notes 1 to 32 form part of these Financial Statements.

Statement of Financial Position
As at 31st March 2014

	Note	Pre Consolidation Trust 31st March 2014 £000s	Pre Consolidation Trust 31st March 2013 £000s	Consolidated Group 31st March 2014 £000s	Consolidated Group (Restated)* 31st March 2013 £000s	Consolidated Group (Restated)* 1st April 2012 £000s
Non-current assets:						
Property, plant and equipment	14	**67,687**	8,871	**67,687**	8,871	8,981
Intangible assets	15	**20**	53	**20**	53	87
Other investments - charitable	27.2	**0**	0	**1,059**	1,109	1,204
Trade and other receivables	20.1	**31**	40	**31**	40	0
Total non-current assets		**67,738**	8,964	**68,797**	**10,073**	**10,272**
Current assets:						
Inventories	19	**326**	375	**326**	375	404
Trade and other receivables	20.1	**7,013**	4,616	**6,987**	4,572	8,229
Cash and cash equivalents	21	**17,874**	16,587	**18,023**	16,708	14,636
Total current assets		**25,213**	21,578	**25,336**	**21,655**	**23,269**
Total assets		**92,951**	30,542	**94,133**	**31,728**	**33,541**
Current liabilities						
Trade and other payables	23	**(12,895)**	(11,058)	**(12,899)**	(11,078)	(15,779)
Provisions	25	**(651)**	(630)	**(651)**	(630)	(517)
Total current liabilities		**(13,546)**	(11,688)	**(13,550)**	**(11,708)**	**(16,296)**
Net current assets		**11,667**	9,890	**11,786**	**9,947**	**6,973**
Non-current assets plus net current assets		**79,405**	18,854	**80,583**	**20,020**	**17,245**
Non-current liabilities						
Trade and other payables	23	**(116)**	0	**(116)**	0	(11)
Provisions	25	**(170)**	(149)	**(170)**	(149)	(145)
Total non-current liabilities		**(286)**	(149)	**(286)**	**(149)**	**(156)**
Total Assets Employed:		**79,119**	18,705	**80,297**	**19,871**	**17,089**
FINANCED BY:						
TAXPAYERS' EQUITY						
Public Dividend Capital		**15,414**	14,943	**15,414**	14,943	14,943
Retained earnings		**48,738**	3,762	**48,738**	3,762	1,073
Revaluation reserve		**14,967**	0	**14,967**	0	0
Charitable funds reserve		**0**	0	**1,178**	1,166	1,073
Total Taxpayers' Equity:		**79,119**	18,705	**80,297**	**19,871**	**17,089**

*Due to the consolidation of Norfolk Community Health & Care NHS Trust Charitable Fund into the Trust accounts taking place for the first time in 2013/14, prior year comparatives have been restated to include the Charitable Fund. As required under IAS 1 Presentation of Financial Statements additional comparative figures have been provided for balances as at 1st April 2012.

Notes 1 to 32 form part of these Financial Statements.

The financial statements and notes to the accounts were approved by the Trust's Audit Committee with the Chief Executive in attendance, under delegated authority from the Trust Board, on 6th June 2014 and signed on its behalf by:

Mark Easton
Interim Chief Executive 6th June 2014

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2014

	Pre Consolidation Trust				Consolidated Group				
	Public Dividend Capital	Retained Earnings	Revaluation Reserve	Total Reserves	Public Dividend Capital	Retained Earnings	Revaluation Reserve	Charitable Funds Reserve	Total Reserves
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1st April 2013 (Restated)*	**14,943**	**3,762**	**0**	**18,705**	**14,943**	**3,762**	**0**	**1,166**	**19,871**
Changes in taxpayers' equity for the year ended 31st March 2014									
Retained surplus for the year	0	3,107	0	**3,107**	0	3,107	0	0	**3,107**
Gain on revaluation of property, plant, equipment	0	0	3,794	**3,794**	0	0	3,794	0	**3,794**
Impairments and reversals taken to the revaluation reserve	0	0	(381)	**(381)**			(381)		**(381)**
Transfers under Modified Absorption Accounting - PCTs	0	53,425	**0**	**53,425**	0	53,425	0	0	**53,425**
New PDC received - cash	469	0	0	**469**	469	0	0	0	**469**
New PDC received - PCT legacy items paid for by Department of Health	2	0	0	**2**	2	0	0	0	**2**
Other movements	0	(2)	0	**(2)**	0	(2)	0	0	**(2)**
Revaluation and impairment of charitable fund assets	0	0	0	0	0	0	0	(51)	**(51)**
Charitable funds adjustment	0	0	0	0	0	0	0	63	**63**
Net recognised revenue/(expense) for the year	**471**	**56,530**	**3,413**	**60,414**	**471**	**56,530**	**3,413**	**12**	**60,426**
Transfers between reserves in respect of Modified Absorption Accounting	0	(11,554)	11,554	**0**	0	(11,554)	11,554	0	**0**
Balance at 31st March 2014	**15,414**	**48,738**	**14,967**	**79,119**	**15,414**	**48,738**	**14,967**	**1,178**	**80,297**
Balance at 1st April 2012 (Restated)*	**14,943**	**1,079**	**0**	**16,022**	**14,943**	**1,079**	**0**	**1,073**	**17,095**
Changes in taxpayers' equity for the year ended 31st March 2013									
Retained surplus/(deficit) for the year	0	2,683	0	2,683	0	2,683	0	0	2,683
Revaluation and impairment of charitable fund assets	0	0	0	0	0	0	0	80	80
Charitable funds adjustment	0	0	0	0	0	0	0	13	13
Balance at 31st March 2013 (Restated)*	**14,943**	**3,762**	**0**	**18,705**	**14,943**	**3,762**	**0**	**1,166**	**19,871**

*Due to the consolidation of Norfolk Community Health & Care NHS Trust Charitable Fund into the Trust accounts taking place for the first time in 2013/14, prior year comparatives have been restated to include the Charitable Fund.

Statement of Cash Flows
For the year ended 31st March 2014

	Pre Consolidation Trust	Pre Consolidation Trust	Consolidated Group	Consolidated Group (Restated)*
	2013/14	2012/13	**2013/14**	2012/13
	£000s	£000s	**£000s**	£000s
Cash flows from operating activities				
Operating surplus	**3,129**	2,748	**3,129**	2,748
Depreciation and amortisation	**3,310**	2,809	**3,310**	2,809
Impairments and reversals	**1,477**	0	**1,477**	0
Dividend (paid)/refunded	**(28)**	(7)	**(28)**	(7)
(Increase)/decrease in Inventories	**49**	29	**49**	29
(Increase)/decrease in trade and other receivables	**(2,394)**	3,716	**(2,394)**	3,716
Increase/(decrease) in trade and other payables	**2,070**	(3,535)	**2,070**	(3,535)
(Increase)/Decrease in Other Current Liabilities	**(2)**	0	**(2)**	0
Provisions utilised	**(576)**	(610)	**(576)**	(610)
Increase/(decrease) in provisions	**618**	727	**618**	727
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	**0**	0	**(1)**	(225)
Net cash inflow/(outflow) from operating activities	**7,653**	5,877	**7,652**	5,652
CASH FLOWS FROM INVESTING ACTIVITIES				
(Payments) for property, plant and equipment	**(6,843)**	(3,774)	**(6,843)**	(3,774)
Proceeds of disposal of assets held for sale (property, plant and equipment)	**6**	0	**6**	0
NHS Charitable Funds - net cash flows relating to investing activities	**0**	0	**29**	194
Net cash inflow/(outflow) from investing activities	**(6,837)**	(3,774)	**(6,808)**	(3,580)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**816**	2,103	**844**	2,072
CASH FLOWS FROM FINANCING ACTIVITIES				
Public Dividend Capital received	**471**	0	**471**	0
NHS Charitable Funds - net cash flows relating to financing activities	**0**	0	**0**	0
Net cash inflow/(outflow) from financing activities	**471**	0	**471**	0
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**1,287**	2,103	**1,315**	2,072
Cash and cash equivalents at beginning of the period	**16,587**	14,484	**16,708**	14,636
Cash and cash equivalents at end of the period	**17,874**	16,587	**18,023**	16,708

*Due to the consolidation of Norfolk Community Health & Care NHS Trust Charitable Fund into the Trust accounts taking place for the first time in 2013/14, prior year comparatives have been restated to include the Charitable Fund.

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 NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2013-14 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 Manual for Accounts 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 property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation are accounted for by use of absorption accounting in line with the HM Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Income, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 Accounting for Government Grants and Disclosure of Government Assistance and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1st April 2013, including Primary Care Trusts, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Income.

1.4 Charitable Funds

For 2013/14, the divergence from the FReM that NHS Charitable Funds are not consolidated with NHS Trust's own returns is removed. Under the provisions of IAS 27 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 accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Trust has determined that consolidation of its related charitable fund is appropriate and Note 1.5.1 provides further detail.

1.5 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.

Notes to the Accounts - 1. Accounting policies (continued)

1.5.1 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 the most significant effect on the amounts recognised in the financial statements.

Inward transfer of property assets

Further to Note 1.3, as part of national structural changes within the NHS, the Trust received a number of freehold and leasehold land and building assets as well as items of plant and machinary with a net book value of £53.8m as a result of the closure of Norfolk PCT on 1st April 2013. In accounting for this transfer, the Trust has applied Modified Absorption Accounting as set out within the Department of Health Manual for Accounts 2013/14. This treatment reflects the transfer as an in-year transaction taking effect on 1st April 2013, at the value stated in the closing accounts of the PCT on 31st March 2013. At this point, the Trust shows an increase in non-current assets, and a corresponding increase directly in retained earnings. To preserve the revaluation reserve associated with the assets as included within the PCT closing accounts, an adjustment has been made between retained earnings to create an equivalent revaluation reserve on 1st April 2013. The Trust has subsequently undertaken a review of accounting treatment of transferred property interests to ensure appropriate classification in accordance with applicable accounting policies, particularly IAS 16 Property, Plant & Equipment and IAS 17 Leases.

Consolidation of Norfolk Community Health & Care NHS Trust Charitable Fund

Further to Note 1.4 regarding the consolidation of charities, the Trust has determined that the Norfolk Community Health & Care NHS Trust Charitable Fund requires consolidation into the Trust accounts. This is on the basis that the Trust exercises control of the charity through its role as sole corporate trustee, and that the value of the charity's net assets are material to the combined accounts.

1.5.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other, key sources of estimation uncertainty at the end of the reporting period that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

In line with the Trust's accounting policies, the Trust has used estimation in determining the recognition and valuation of provisions, non-current assets lives and valuations, accruals for current payables and receivables, and impairment of receivables. These are explained in further detail in the relevant note.

1.6 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 for healthcare services.

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

1.7 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. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Notes to the Accounts - 1. Accounting policies (continued)

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, as 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 Scheme are provided in Note 9.6 to the accounts.

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 the scheme. As a defined contribution scheme, the cost to the Trust of participating in the NEST scheme is taken as equal to the contributions payable to the scheme for the accounting period.

1.8 Other expenses

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

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

Notes to the Accounts - 1. Accounting policies (continued)

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 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 is 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.

1.10 Intangible assets

Recognition

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

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.

Notes to the Accounts - 1. Accounting policies (continued)

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.

1.11 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are 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 is 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 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 the 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.

1.12 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.

1.13 Government grants

The value of assets received by means of a government grant are credited directly 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)

1.14 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.15 Leases

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

The Trust as lessee

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 on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

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

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

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

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the 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.

1.16 Inventories

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

Notes to the Accounts - 1. Accounting policies (continued)

1.17 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 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.

1.18 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable 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 using HM Treasury's discount rate of between -1.90% and +2.20% in real terms depending on the timing of future cash flows, or +1.8% for employee early departure obligations.

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

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in 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.

1.19 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 25.

1.20 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to 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.

1.21 Carbon Reduction Commitment Scheme

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

1.22 Contingencies

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

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable. Where the time value of money is material, contingencies are disclosed at their present value.

Notes to the Accounts - 1. Accounting policies (continued)

1.23 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 de-recognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, or loans and receivables. The calssification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. A gain or loss on an available for sale financial asset is recognised in other comprehensive income, except for impairment losses and foreign exchange gains and losses, until the financial asset is de-recognised. At that time, the cumulative gain or loss previously recognised in other comprehensive income shall be re-classified from equity to profit or loss as a re-classification adjustment in accordance with IAS 39 Financial Instruments: Recognition and Measurement.

Loans and receivables

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

The 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, other than those held at 'fair value through profit and loss' 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.

For financial assets carried at amortised cost, 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.

1.24 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.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

The Trust does not hold any other financial liabilities.

Notes to the Accounts - 1. Accounting policies (continued)

1.25 Value Added Tax (VAT)

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

1.26 Foreign currencies

The Trust's functional currency and presentational currency is Pound Sterling. Transactions denominated in a foreign currency are translated into Pound Sterling at the exchange rate ruling on the dates of the transactions. The Trust does not hold any monetary items denominated in foreign currencies.

1.27 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 32 to the accounts.

1.28 Public Dividend Capital (PDC) and PDC dividend expense

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

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as Public Dividend Capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets, net assets transferred from NHS bodies dissolved on 1 April 2013 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.

1.29 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).

1.30 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses, gains and losses, assets and liabilities, reserves and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not co-terminus.

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

From 2013/14, the Trust consolidates the results of Norfolk Community Health & Care NHS Trust Charitable Fund (registered charity number 1051173) over which it has the power to exercise control as the sole corporate trustee.

Notes to the Accounts - 1. Accounting policies (continued)

1.31 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 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, on a quarterly basis.

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2013/14. The application of the Standards as revised would not have a material impact on the accounts for 2013/14, were they applied in this year:

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2. Operating segments

The Trust does not have separately identifiable operating segments. Almost all of the Trust's income generating activity is from community healthcare services.

Income from NHS commissioning organisations accounts for over 80% of total income.

3. Income generation activities

The Trust does not undertake income generation activities that could be considered material.

4. Revenue from patient care activities

	2013/14	2012/13
	£000s	£000s
NHS England	**23,080**	0
Clinical Commissioning Groups	**77,720**	0
Primary Care Trusts	**0**	101,618
Strategic Health Authorities	**0**	180
NHS Foundation Trusts	**4,212**	4,389
Non-NHS:		
Local Authorities	**12,359**	11,553
Private patients	**0**	2
Other	**1,000**	1,055
Total revenue from patient care activities	**118,371**	118,797

5. Other operating revenue

		(Restated)*
	2013/14	2012/13
	£000s	£000s
Education, training and research	**1,923**	1,386
Charitable and other contributions to revenue expenditure (non-NHS)	**124**	68
Non-patient care services to other bodies	**2,044**	3,588
Income generation	**120**	0
Rental revenue from operating leases	**808**	1,072
Total other operating revenue	**5,019**	6,114
Total operating revenue	**123,390**	124,911

*Due to the consolidation of Norfolk Community Health & Care NHS Trust Charitable Fund into the Trust accounts, taking place for the first time in 2013/14, prior year comparatives have been restated to include the Charitable Fund.

6. Revenue from sale of goods

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

7. Operating expenses

	2013/14 £000s	(Restated)* 2012/13 £000s
Services from other NHS Trusts	**47**	531
Services from CCGs/NHS England	**0**	0
Services from other NHS bodies	**83**	59
Services from NHS Foundation Trusts	**1,188**	1,129
Total Services from NHS bodies**	**1,318**	1,719
Purchase of healthcare from non-NHS bodies	**559**	805
Trust Chair and Non-executive Directors	**63**	56
Supplies and services - clinical	**6,736**	7,625
Supplies and services - general	**9,454**	8,764
Consultancy services	**889**	754
Establishment	**1,217**	1,729
Transport	**3,755**	3,468
Premises	**4,746**	8,640
Insurance	**8**	0
Legal fees	**133**	0
Impairments of receivables	**518**	147
Depreciation	**3,277**	2,775
Amortisation	**33**	34
Impairments and reversals of property, plant and equipment	**1,477**	0
Audit fees	**88**	116
Other auditor's remuneration	**71**	100
Clinical negligence	**266**	242
Education and training	**626**	678
Change in discount rate	**12**	0
Charitable expenditure	**91**	85
Total operating expenses (excluding employee benefits)	**35,337**	37,737
Employee benefits		
Employee benefits excluding Board members	**83,988**	83,332
Board members	**903**	1,111
Total employee benefits	**84,891**	84,443
Total operating expenses	**120,228**	122,180

*Due to the consolidation of Norfolk Community Health & Care NHS Trust Charitable Fund into the Trust accounts, taking place for the first time in 2013/14, prior year comparatives have been restated to include the Charitable Fund.

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

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 Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2013/14 Total £000s	2012/13 Total £000s
Payments recognised as an expense					
Minimum lease payments				**2,374**	5,967
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**2,374**	5,967
Payable:					
No later than one year	99	1,376	728	**2,203**	1,339
Between one and five years	74	1,350	520	**1,944**	1,474
After five years	0	1,273	0	**1,273**	15
Total	**173**	**3,999**	**1,248**	**5,420**	2,828
Total future sublease payments expected to be received:				18	1072

8.2 Trust as lessor

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

	2013/14 £000	2012/13 £000s
Recognised as revenue		
Rental revenue	**808**	1,072
Contingent rents	**0**	0
Total	**808**	1,072
Receivable:		
No later than one year	**645**	1,072
Between one and five years	**37**	0
After five years	**5**	0
Total	**687**	1,072

9. Employee benefits and staff numbers

9.1 Employee benefits

Employee benefits - gross expenditure 2013/14	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	**71,541**	65,945	5,596
Social security costs	**4,948**	4,783	165
Employer contributions to NHS pension scheme	**8,618**	8,289	329
Other pension costs	**3**	3	0
Termination benefits	**29**	29	0
Total employee benefits including capitalised costs	**85,139**	**79,049**	**6,090**
Employee costs capitalised	**248**	0	248
Total employee benefits excluding capitalised costs	**84,891**	**79,049**	**5,842**

Employee benefits - gross expenditure 2012/13	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	70,060	66,369	3,691
Social security costs	5,110	4,932	178
Employer contributions to NHS Pension Scheme	8,612	8,312	300
Other pension costs	0	0	0
Termination benefits	661	661	0
Total employee benefits including capitalised costs	84,443	80,274	4,169
Employee costs capitalised	0	0	0
Total employee benefits excluding capitalised costs	84,443	80,274	4,169

In 2012/13 there were rows for 'other post-employment benefits' and 'other employment benefits'. These are now included within 'the 'Salaries and wages' row.

9.2 Staff numbers

	2013/14			2012/13
	Total	Permanently employed	Other	Total
	Number	Number	Number	Number
Average staff numbers				
Medical and dental	**29**	29	0	33
Administration and estates	**467**	447	20	514
Healthcare assistants and other support staff	**626**	585	41	621
Nursing, midwifery and health visiting staff	**792**	763	29	802
Nursing, midwifery and health visiting learners	**39**	39	0	43
Scientific, therapeutic and technical staff	**355**	348	7	364
Social care staff	**1**	1	0	0
Other	**8**	8	0	7
TOTAL	**2,317**	**2,220**	**97**	2,384
Of the above - staff engaged on capital projects	**6**	0	6	0

9.3 Staff sickness absence and ill health retirements

	2013/14	2012/13
	Number	Number
Total Days Lost	22,552	25,584
Total Staff Years	2,219	2,261
Average working Days Lost	10.16	11.32

	2013/14	2012/13
	Number	Number
Number of persons retired early on ill health grounds	**6**	6
	£000s	£000s
Total additional pensions liabilities accrued in the year	**332**	441

9.4 Exit packages

Exit package cost band (including any special payment element)	2013/14 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	£s	Number	£s	Number	£s
Less than £10,000	0	0	1	8,256	**1**	**8,256**
£10,001-£25,000	1	10,166	1	16,512	**2**	**26,678**
£25,001-£50,000	1	37,201	2	51,796	**3**	**88,997**
£50,001-£100,000	1	86,769	0	0	**1**	**86,769**
£100,001 - £150,000	3	342,732	0	0	**3**	**342,732**
£150,001 - £200,000	0	0	0	0	**0**	**0**
>£200,000	0	0	0	0	**0**	**0**
Total number of exit packages by type (total cost)	**6**	**476,868**	**4**	**76,564**	**10**	**553,432**

Exit package cost band (including any special payment element)	2012/13 Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages by cost band	Total cost of exit packages
	Number	£s	Number	£s	Number	£s
Less than £10,000	3	15,263	0	0	3	15,263
£10,001-£25,000	4	69,828	0	0	4	69,828
£25,001-£50,000	3	90,141	0	0	3	90,141
£50,001-£100,000	2	117,285	0	0	2	117,285
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost)	12	292,517	0	0	12	292,517

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 note 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.

9.5 Exit packages - other departures analysis

	2013/14 Agreements	Total value of agreements	2012/13 Agreements	Total value of agreements
	Number	£000s	Number	£000s
Mutually agreed resignations (MARS) contractual costs	4	77	0	0
Non-contractual payments requiring HM Treasury	0	0	0	0
Total	4	77	0	0

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.

As a single exit package can be made up of several components, each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 9.4 which will be the number of individuals.

No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

9.6 Pension costs

NHS Pensions Scheme
Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP 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 NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

a) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19 Employee Benefits, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. 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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set 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 formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions
The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

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 the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

National Employment Savings Trust Scheme
Following the government's introduction of automatic 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 the 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.

10. Better Payment Practice Code

10.1 Measure of compliance

	2013/14 Number	2013/14 £000s	2012/13 Number	2012/13 £000s
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	**16,663**	**31,183**	16,066	29,023
Total non-NHS trade invoices paid within target	**13,939**	**24,024**	13,751	24,498
Percentage of NHS trade invoices paid within target	**83.7%**	**77.0%**	85.6%	84.4%
NHS Payables				
Total NHS trade invoices paid in the year	**643**	**6,296**	692	**18,366**
Total NHS trade invoices paid within target	**515**	**5,550**	547	**16,511**
Percentage of NHS trade invoices paid within target	**80.1%**	**88.2%**	79.0%	89.9%

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

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

There have been no costs incurred during 2013/14 or 2012/13 in relation to the late payment of commercial debts.

11. Investment Revenue

	2013/14 £000s	(Restated)* 2012/13 £000s
Interest revenue		
Charity investment assets	**30**	30
Total investment revenue	**30**	30

*Due to the consolidation of Norfolk Community Health & Care NHS Trust Charitable Fund into the Trust accounts, taking place for the first time in 2013/14, prior year comparatives have been restated to include the Charitable Fund.

12. Other Gains and Losses

	2013/14 £000s	(Restated)* 2012/13 £000s
Gain on disposal of assets other than by sale (property, plant and equipment)	**85**	0
Change in fair value of financial assets carried at fair value through the SoCI (Charitable Funds)	**(51)**	80
Total	**34**	80

Under Modified Absorption Accounting, the Trust is required to reflect any accounting policy alignment that results from assets transferred from NHS bodies that closed on 1st April 2013 as an in-year transaction with no prior period restatement. This has resulted in the Trust recognising a gain as a result of the reclassification of a finance lease to an operating lease, due to the liability transferred to the Trust exceeding the transferred value of the asset. This is reflected in Note 14 to the accounts as a 'disposal other than by sale'.

*Due to the consolidation of Norfolk Community Health & Care NHS Trust Charitable Fund into the Trust accounts, taking place for the first time in 2013/14, prior year comparatives have been restated to include the Charitable Fund.

13. Finance Costs

There have been no interest costs incurred during 2013/14 or 2012/13.

14. Tangible non-current assets

14.1 Property, plant and equipment

2013/14	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:								
At 1st April 2013	**355**	**5,143**	**1,241**	**4,844**	**76**	**3,661**	**3,052**	**18,372**
Transfers under Modified Absorption Accounting - PCTs	9,829	41,680	2,074	182	0	0	0	**53,765**
Additions of assets under construction	0	0	2,808	0	0	0	0	**2,808**
Additions purchased	0	3,180	0	161	0	499	0	**3,840**
Reclassifications	0	1,868	(3,302)	362	0	1,072	0	**0**
Disposals other than by sale	0	(256)	0	0	0	0	0	**(256)**
Upward revaluation	0	2,198	0	0	0	0	0	**2,198**
Impairments taken to the revaluation reserve	0	(381)	0	0	0	0	0	**(381)**
At 31st March 2014	**10,184**	**53,432**	**2,821**	**5,549**	**76**	**5,232**	**3,052**	**80,346**
Depreciation:								
At 1st April 2013	**0**	**131**	**0**	**3,951**	**76**	**2,331**	**3,012**	**9,501**
Upward revaluation	0	(1,596)		0	0	0	0	**(1,596)**
Impairments charged to Statement of Comprehensive Income	0	1,477	0	0	0	0	0	**1,477**
Charged during the year	0	2,001	0	395	0	846	35	**3,277**
At 31st March 2014	**0**	**2,013**	**0**	**4,346**	**76**	**3,177**	**3,047**	**12,659**
Net Book Value at 31st March 2014	**10,184**	**51,419**	**2,821**	**1,203**	**0**	**2,055**	**5**	**67,687**
Asset financing:								
Net Book Value at 31st March 2014 comprises:								
Owned - purchased	9,648	45,964	2,821	1,203	0	2,055	5	**61,696**
Owned - donated	136	697	0	0	0	0	0	**833**
Owned - government granted	0	282	0	0	0	0	0	**282**
Held on long term lease*	400	4,476	0	0	0	0	0	**4,876**
Total at 31st March 2014	**10,184**	**51,419**	**2,821**	**1,203**	**0**	**2,055**	**5**	**67,687**

*These assets are held under long term leases agreements, which range between 90 and 999 years, with no associated financial liabilities.

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
At 1st April 2013	0	0	0	0	0	0	0	**0**
Transfers under Modified Absorption Accounting - PCTs	1,110	10,444	0	0	0	0	0	**11,554**
Net in-year valuation movements	0	3,413	0	0	0	0	0	**3,413**
At 31st March 2014	**1,110**	**13,857**	**0**	**0**	**0**	**0**	**0**	**14,967**

Additions to Assets Under Construction in 2013/14

	£000s
Buildings excluding dwellings	11
Information Technology	2,797
Balance as at 31st March 2014	**2,808**

14.2 Property, plant and equipment prior-year

2012/13	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:								
At 1st April 2012	155	460	4,839	3,884	76	3,245	3,052	15,711
Additions of assets under construction	0	0	1,358	0	0	0	0	1,358
Additions purchased	0	0	0	916	0	397	0	1,313
Reclassifications	200	4,683	(4,956)	54	0	19	0	0
Reclassifications as held for sale and reversals	0	0	0	(10)	0	0	0	(10)
Disposals other than by sale	0	0	0	0	0	0	0	0
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0
At 31st March 2013	**355**	**5,143**	**1,241**	**4,844**	**76**	**3,661**	**3,052**	**18,372**
Depreciation:								
At 1st April 2012	0	28	0	2,281	76	1,734	2,611	6,730
Upward revaluation/positive indexation	0	0		0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0
Charged during the year	0	103	0	1,674	0	597	401	2,775
At 31st March 2013	**0**	**131**	**0**	**3,951**	**76**	**2,331**	**3,012**	**9,501**
Net book value at 31st March 2013	**355**	**5,012**	**1,241**	**893**	**0**	**1,330**	**40**	**8,871**
Asset financing:								
Net Book Value at 31st March 2013 comprises:								
Owned - purchased	355	5,012	1,241	893	0	1,330	40	8,871
Total at 31st March 2013	**355**	**5,012**	**1,241**	**893**	**0**	**1,330**	**40**	**8,871**

14.3 Property, plant and equipment

Property assets have been independently valued at fair value with the effective date of 31st March 2014. The valuation has been 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 terms are consistent with the requirements of HM Treasury. Fair value has been determined for non-specialised assets as market value for existing use, and for specialised assets as depreciated replacement cost. Where assets are valued at depreciated replacement cost, values are not believed to be materially different to market value.

The range of economic lives of non-current assets are set out in the table below:

Economic Lives of Non-Current Assets	Min Life Years	Max Life Years
Intangible Assets		
Software licences	2	5
Property, Plant and Equipment		
Buildings	10	80
Plant & machinery	3	15
Transport equipment	5	7
Information technology	3	5
Furniture and fittings	5	10

Remaining economic lives of buildings have been independently reviewed as at 31st March 2014, and where these differ from the useful lives applied up to that date, will be adopted prospectively from 1st April 2014.

15.1 Intangible non-current assets

2013/14	Computer licenses	Licenses and trademarks	Total
Cost or valuation:	**£000s**	**£000s**	**£000s**
At 1st April 2013	**54**	**81**	**135**
Reclassifications	81	(81)	**0**
At 31st March 2014	**135**	**0**	**135**
Amortisation:			
At 1st April 2013	**49**	**33**	**82**
Reclassifications	33	(33)	**0**
Charged during the year	33	0	**33**
At 31st March 2014	**115**	**0**	**115**
Net Book Value at 31st March 2014	**20**	**0**	**20**
Asset financing:			
Net Book Value at 31st March 2014 comprises:			
Owned - purchased	20	0	**20**
Total at 31st March 2014	**20**	**0**	**20**

15.2 Intangible non-current assets prior year

2012/13	Computer licenses	Licenses and trademarks	Total
	£000s	£000s	£000s
Cost or valuation:			
At 1st April 2012	54	81	135
Reclassifications	0	0	0
At 31st March 2013	54	81	135
Amortisation:			
At 1st April 2012	26	22	48
Reclassifications	0	0	0
Charged during the year	23	11	34
At 31st March 2013	49	33	82
Net Book Value at 31st March 2013	5	48	53
Net Book Value at 31st March 2013 comprises:			
Owned - purchased	5	48	53
Total at 31st March 2013	5	48	53

15.3 Intangible non-current assets valuation and useful lives

Intangible assets are valued at depreciated historical cost due to their short finite life and relatively low value. Intangibles are amortised over the shorter of the term of the license and their useful economic lives which is assessed at being between two and five years.

16. Analysis of impairments and reversals

	2013/14	2012/13
	Total	Total
	£000s	£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 (DEL)	**0**	0
Unforeseen obsolescence	0	0
Loss as a result of catastrophe	0	0
Other	1,477	0
Changes in market price	0	0
Total charged to Annually Managed Expenditure (AME)	**1,477**	0
Total Impairments of Property, plant and equipment changed to SoCI	**1,477**	0
Total Impairments charged to SoCI - DEL	**0**	0
Total Impairments charged to SoCI - AME	**1,477**	0
Overall Total Impairments	**1,477**	0

Property, plant and equipment impairments relate to property assets where the Trust has identified that the draft carrying value of the assets in question as at 31st March 2014 exceeded their recoverable amount which is determined as market value for existing use. This results from the level of recent investment to maintain compliant operational environments exceeding the additional value added by these works, based on an independent valuation as at 31st March 2014.

17. Capital commitments

Contracted capital commitments at 31 March 2014 not otherwise included in these financial statements:

	31st March 2014	31st March 2013
	£000s	£000s
Property, plant and equipment	**149**	0
Intangible assets	**0**	14
Total	**149**	14

18. Intra-Government and other balances

	Current receivables	**Non-current receivables**	**Current payables**	**Non-current payables**
	£000s	**£000s**	**£000s**	**£000s**
2013/14:				
Balances with other central government bodies	4,315	0	4,932	115
Balances with Local Authorities	1,220	0	244	0
Balances with NHS Trusts and Foundation Trusts	707	0	1,053	0
Balances with bodies external to government	745	31	6,670	1
At 31st March 2014	**6,987**	**31**	**12,899**	**116**
2012/13: (Restated)*				
Balances with other central government bodies	474	0	5,605	0
Balances with Local Authorities	2,110	0	119	0
Balances with NHS Trusts and Foundation Trusts	907	0	499	0
Balances with bodies external to government	1,119	40	4,835	0
At 31st March 2013	**4,610**	**40**	**11,058**	**0**

19. Inventories

	Consumables £000s	Energy £000s	Other £000s	Total £000s	Of which held at NRV £000s
Balance at 1st April 2013	**133**	**19**	**223**	**375**	0
Additions	3,006	48	1,582	**4,636**	0
Inventories recognised as an expense in the period	(3,043)	(48)	(1,594)	**(4,685)**	0
Write-down of inventories (including losses)	0	0	0	**0**	0
Balance at 31st March 2014	**96**	**19**	**211**	**326**	**0**

20. Receivables

20.1 Trade and other receivables

	Current		Non-current	
	31st March 2014 £000s	(Restated)* 31st March 2013 £000s	31st March 2014 £000s	(Restated)* 31st March 2013 £000s
NHS receivables - revenue	**4,770**	1,343	**0**	0
NHS prepayments and accrued income	**252**	30	**0**	0
Non-NHS receivables - revenue	**2,047**	3,547	**0**	0
Non-NHS receivables - capital	**0**	6	**0**	0
Non-NHS prepayments and accrued income	**969**	450	**31**	40
Provision for the impairment of receivables	**(1,524)**	(1,122)	**0**	0
VAT	**354**	8	**0**	0
Operating lease receivables	**119**	310	**0**	0
Total	**6,987**	4,572	**31**	40
Total current and non current	**7,018**	4,612		

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.

*Due to the consolidation of Norfolk Community Health & Care NHS Trust Charitable Fund into the Trust accounts, taking place for the first time in 2013/14, prior year comparatives have been restated to include the Charitable Fund.

20.2 Receivables past their due date but not impaired

	31st March 2014 £000s	31st March 2013 £000s
By up to three months	1,319	1,647
By three to six months	368	368
By more than six months	91	232
Total	1,778	2,247

20.3 Provision for impairment of receivables

	31st March 2014 £000s	31st March 2013 £000s
Balance at 1st April 2013	1,122	975
Amount written off during the year	(116)	0
Amount utilised during the year through issuing of credit notes	0	(122)
Amount recovered during the year	(513)	(493)
Increase/(decrease) in receivables impaired	1,031	762
Balance at 31st March 2014	**1,524**	**1,122**

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.

21. Cash and cash equivalents

	2013/14	(Restated)* 2012/13
	£000s	£000s
Opening balance 1st April	**16,708**	14,636
Net change in year	**1,315**	2,072
Closing balance 31st March	**18,023**	16,708
Comprising:		
Cash with Government Banking Service	**17,851**	16,564
Commercial banks	**160**	144
Cash in hand	**12**	0
Current investments	**0**	0
Cash and cash equivalents closing balance 31st March	**18,023**	16,708

*Due to the consolidation of Norfolk Community Health & Care NHS Trust Charitable Fund into the Trust accounts, taking place for the first time in 2013/14, prior year comparatives have been restated to include the Charitable Fund.

22. Non-current assets held for sale

	Plant and Machinery £000s	Total £000s
Balance at 1st April 2013	0	**0**
Plus assets classified as held for sale in the year	0	**0**
Less assets sold in the year	0	**0**
Balance at 31st March 2014	**0**	**0**
Balance at 1st April 2012	0	**0**
Plus assets classified as held for sale in the year	6	**6**
Less assets sold in the year	(6)	**(6)**
Balance at 31st March 2013	**0**	**0**

23. Trade and other payables

	Current		Non-current	
	31st March 2014 £000s	(Restated)* 31st March 2013 £000s	**31st March 2014 £000s**	(Restated)* 31st March 2013 £000s
NHS payables - revenue	**1,253**	1,703	**0**	0
NHS accruals and deferred income	**2,105**	1,623	**115**	0
Non-NHS payables - revenue	**2,955**	2,003	**0**	0
Non-NHS payables - capital	**244**	439	**0**	0
Non-NHS accruals and deferred income	**3,715**	2,669	**1**	0
Social security costs	**2,627**	2,641	**0**	**0**
Total	**12,899**	11,078	**116**	0
Total payables (current and non-current)	**13,015**	**11,078**		
Included above:				
Outstanding pension contributions at the year end	**1,176**	1,094		

*Due to the consolidation of Norfolk Community Health & Care NHS Trust Charitable Fund into the Trust accounts, taking place for the first time in 2013/14, prior year comparatives have been restated to include the Charitable Fund.

24. Deferred income

	Current		Non-current	
	2013/14 £000s	2012/13 £000s	**2013/14 £000s**	2012/13 £000s
Opening balance at 1st April	**1,009**	963	**0**	0
Deferred revenue addition	**142**	832	**116**	0
Transfer of deferred revenue	**(489)**	(786)	**0**	0
Total deferred Income at 31st March	**662**	1,009	**116**	0

25. Provisions

	Total	Pensions relating to other staff	Legal claims	Redundancy
	£000s	£000s	£000s	£000s
Balance at 1st April 2013	**779**	160	27	592
Arising during the year	**672**	18	38	616
Utilised during the year	**(576)**	(9)	(14)	(553)
Reversed unused	**(66)**	0	(10)	(56)
Change in discount rate	**12**	12	0	0
Balance at 31st March 2014	**821**	**181**	**41**	**599**
Expected Timing of Cash Flows:				
No later than one year	**651**	11	41	599
Later than one year and not later than five years	**34**	34	0	0
Later than five years	**136**	136	0	0

Amount included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities:

As at 31st March 2014	**239**
As at 31st March 2013	1,218

The provision for pensions relating to other staff 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 1.8%. There is no uncertainty in respect of timings of future payments.

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 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.

26. Contingencies

	31st March 2014	31st March 2013
	£000s	£000s
Contingent liabilities		
Third party liability (NHSLA)	**24**	13
Net value of contingent liabilities	**24**	13

The Trust has a contingent liability of £23,775 (£12,875 in 2012/13) in respect of employers and public liability claims under the NHS Litigation Authority Liabilities to Third Parties Scheme. A further amount of £40,625 (£27,000 in 2012/13) is included within provisions (see Note 25).

27. Financial Instruments

27.1 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 (excluding the Charitable Fund) has with NHS commissioners and the way those NHS commissioners are financed, the NHS 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. The Trust does not hold any financial assets other than those classified as Loans and Receivables under IAS 39.

Norfolk Community Health & Care NHS Trust Charitable Fund does hold a portfolio of investment assets that are classified under IAS 39 as Available for Sale Financial Assets. These include fixed and variable interest accounts and listed equity shares. A breakdown of these Available for Sale Financial Assets across the different categories is set out in Note 27.2.

Treasury management operations for both the Trust and Charitable Fund are conducted by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies as agreed by the board of directors. The Trust and Charitable Fund's treasury activity is subject to review by internal audit.

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 has not held any borrowings to date.

Credit risk
Because 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 31st March 2014 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are mainly incurred under contracts with NHS commissioners, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated funds. The Trust is not, therefore, exposed to significant liquidity risks.

Market risk
The Charitable Fund holds a portfolio of investment assets which includes listed equity shares and variable interest accounts. The equity shares are subject to a degree of market risk inherent to the nature of traded equities and the continual fluctations of their price on the open market. The variable interest accounts are subject to movements in the associated interest rates which would impact the return on investment.

27.2 Financial Assets

	Pre Consolidation Trust Available for sale financial assets £000s	Pre Consolidation Trust Loans and receivables £000s	Pre Consolidation Trust Total £000s	Consolidated Group Available for sale financial assets £000s	Consolidated Group Loans and receivables £000s	Consolidated Group Total £000s
NHS Receivables	0	4,740	**4,740**	0	4,740	**4,740**
Non-NHS Receivables	0	668	**668**	0	642	**642**
Cash at bank and in hand	0	17,874	**17,874**	0	18,023	**18,023**
Listed Equities (Charitable Funds)	0	0	**0**	423	0	**423**
Fixed Interest (Charitable Funds)	0	0	**0**	627	0	**627**
Variable Interst (Charitable Funds)	0	0	**0**	9	0	**9**
Total at 31st March 2014	**0**	**23,282**	**23,282**	**1,059**	**23,405**	**24,464**
NHS Receivables	0	1,234	1,234	0	1,234	1,234
Non-NHS Receivables	0	2,785	2,785	0	2,741	2,741
Cash at bank and in hand	0	16,587	16,587	0	16,708	16,708
Listed Equities (Charitable Funds)	0	0	0	407	0	407
Fixed Interest (Charitable Funds)	0	0	0	679	0	679
Variable Interst (Charitable Funds)	0	0	0	23	0	23
Total at 31st March 2013 (Restated)*	0	20,606	20,606	1,109	20,683	21,792
NHS Receivables	0	2,011	2,011	0	2,011	2,011
Non-NHS Receivables	0	5,583	5,583	0	5,394	5,394
Cash at bank and in hand	0	14,482	14,482	0	14,636	14,636
Listed Equities (Charitable Funds)	0	0	0	447	0	447
Fixed Interest (Charitable Funds)	0	0	0	748	0	748
Variable Interst (Charitable Funds)	0	0	0	9	0	9
Total at 1st April 2012 (Restated)*	0	22,076	22,076	1,204	22,041	23,245

*Due to the consolidation of Norfolk Community Health & Care NHS Trust Charitable Fund into the Trust accounts, taking place for the first time in 2013/14, prior year comparatives have been restated to include the Charitable Fund.

27.3 Financial Liabilities

	Other £000s	Total £000s
NHS payables	1,253	**1,253**
Non-NHS payables	3,199	**3,199**
Other borrowings	0	**0**
Total at 31st March 2014	**4,452**	**4,452**
NHS payables	1,703	1,703
Non-NHS payables	2,442	2,442
Other borrowings	0	0
Total at 31st March 2013 (Restated)*	4,145	4,145

*Due to the consolidation of Norfolk Community Health & Care NHS Trust Charitable Fund into the Trust accounts, taking place for the first time in 2013/14, prior year comparatives have been restated to include the Charitable Fund.

28. Events after the end of the reporting period

There are no events after the end of the reporting period to report.

29. Related party transactions

The Department of Health is regarded as a related party. During the year 2013/14 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:

Norwich Clinical Commissioning Group
South Norfolk Clinical Commissioning Group
West Norfolk Clinical Commissioning Group
North Norfolk 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
NHS Litigation Authority
James Paget University Hospitals NHS Foundation Trust
East of England Ambulance Service NHS Trust

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 Pension Scheme
HM Revenue and Customs
Norfolk County Council
Norwich City Council
North Norfolk District Council
Broadland District Council
Kings Lynn and West Norfolk Borough Council
Breckland District Council
South Norfolk District Council

30. Losses and special payments

The total number of losses cases in 2013/14 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	144,849	79
Special payments	1,515	8
Total losses and special payments 2013/14	146,364	87

The total number of losses cases in 2012/13 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	108	2
Special payments	1,136	8
Total losses and special payments 2012/13	1,244	10

31. Financial performance targets

The financial performance measures below are based on the Trust accounts pre-consolidation, as the Department of Health does not take the results of the Charitable Fund into account for the purposes of performance monitoring.

31.1 Breakeven performance	**2010/11 £000s**	**2011/12 £000s**	**2012/13 £000s**	**2013/14 £000s**
Turnover	130,709	127,725	124,843	**123,266**
Retained surplus/(deficit) for the year	528	545	2,683	**3,107**
Adjustment for non-cash impacting distortions:				
Impairments	24	92	0	**1,477**
Impact of policy change re donated/government granted assets	0	0	0	**46**
Break-even in-year position	**552**	**637**	**2,683**	**4,630**
Break-even cumulative position	**552**	**1,189**	**3,872**	**8,502**

	2010/11 %	**2011/12 %**	**2012/13 %**	**2013/14 %**
Materiality test (i.e. 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
Break-even cumulative position as a percentage of turnover	0.42	0.93	3.10	6.90

31.2 Capital cost absorption rate

The dividend payable on Public Dividend Capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

31.3 External Financing Limit

The Trust is given an External Financing Limit which it is permitted to undershoot.

	2013/14	2012/13
	£000s	£000s
External Financing Limit	**2,021**	5,287
Internally generated cash flow financing	**816**	2,103
Underspend against External Financing Limit	**2,837**	7,390

31.4 Capital Resource Limit

The Trust is given a Capital Resource Limit which it is not permitted to exceed.

	2013/14	2012/13
	£000s	£000s
Gross capital expenditure	**6,647**	2,671
Less book value of assets disposed of	**0**	(6)
Charge against the Capital Resource Limit	**6,647**	2,665
Capital Resource Limit	**6,969**	2,750
Underspend against Capital Resource Limit	**322**	85

32. Third party assets

Third party assets held by the Trust relate to immaterial amounts of cash or cash equivalents held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

Closing balances of third party assets were less than £1,000 as at 31st March 2014 and 31st March 2013.

The Trust does not hold any other third party assets.