NHS
Norfolk Community Health and Care
NHS Trust

Annual Report and Accounts 2020/2021

LOOKING AFTER YOU LOCALLY

The Annual Report and Accounts is set out as follows:

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   1.1 Chief Executive's statement

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Abbreviations used in this report:

Norfolk Community Health and Care NHS Trust - NCH&C

NHS England - NHSE

NHS Improvement - NHSI

Clinical Commissioning Groups - CCGs

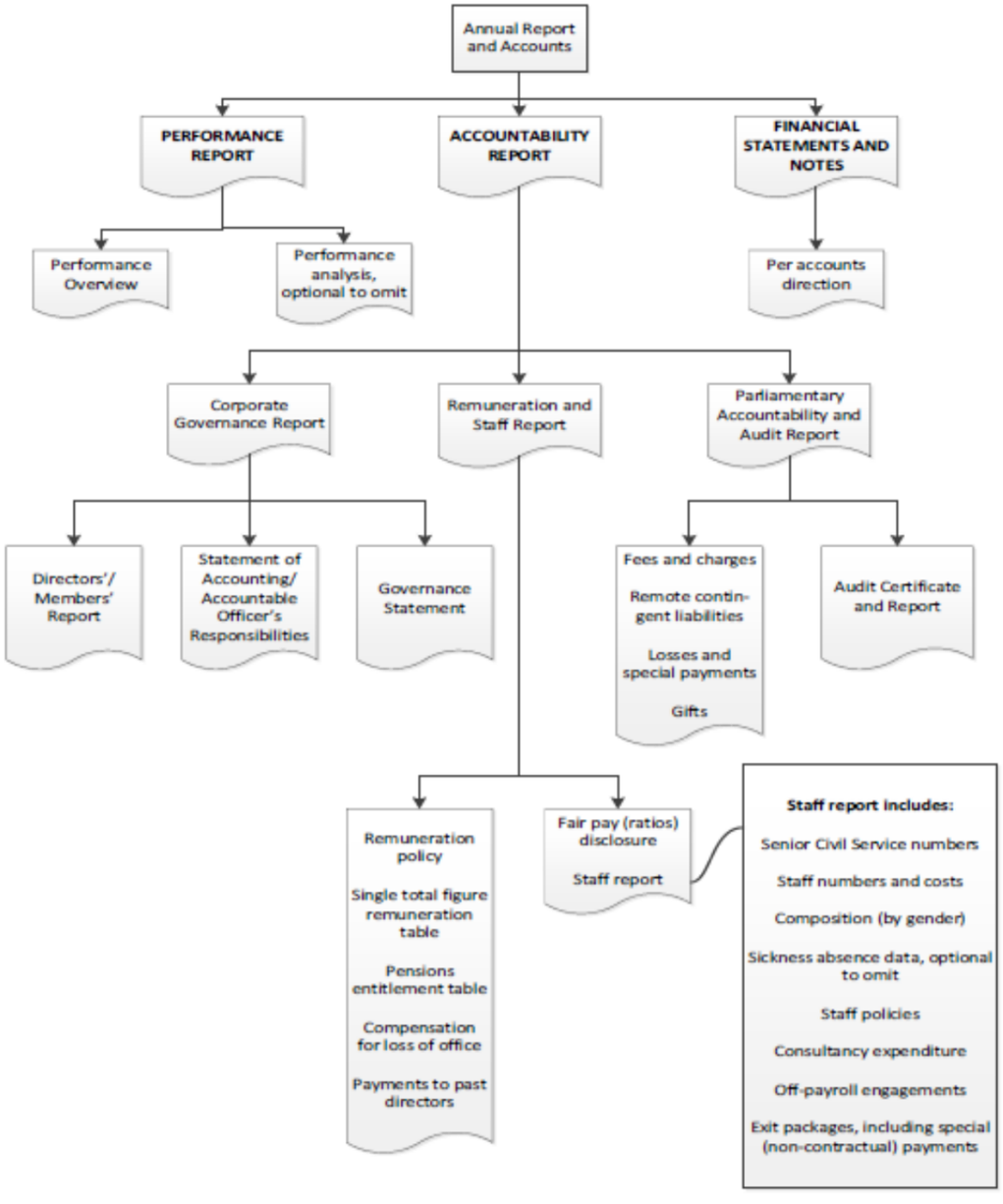
Norfolk County Council - NCC

Care Quality Commission - CQC

Non-Executive Director – NED

Primary Care Networks - PCN

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



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PERFORMANCE REPORT

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

1. Overview

This section of the Annual Report includes:

1.1 Chief Executive's statement

1.2 Statement of the purpose and activities of the Trust

1.3 Key risks and issues

1.4 Performance summary

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

The overview includes a statement from the Chief Executive providing her perspective on the performance of the organisation over the year, a statement of the purpose and activities of the organisation, the key issues and risks that could affect the organisation in delivering its objectives, and a performance summary. In response to the Covid-19 pandemic changes to annual reporting requirements have been made for NHS bodies. In particular, the detailed performance analysis section is not included this year.

1.1 Chief Executive's statement

NCH&C was rated as Outstanding by the CQC in June 2018, the first community trust in the country to receive the highest possible rating. In the categories of Caring and Well Led NCH&C received a rating of Outstanding, and for Safety, Effectiveness, and Responsiveness, a rating of Good was received.

Within these overall ratings two service areas were rated as Requires Improvement. These were in Safety within Community Health In-patient Services, and Responsiveness within Community Health Services for Children and Young People. An action plan is in place to drive up the standards across all of the categories across all of our services.

NHS Improvement's most recently published assessment of NCH&C through the NHS Oversight Framework (on 21 October 2016 under the previously known version of the Single Oversight Framework) is that the Trust is in segment 2, defined as: "support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or NHS Improvement considers formal action is not needed." This provides for: "Universal plus Targeted support as agreed with the provider to address issues identified and

help move the provider to Segment 1". The targeted support needs were identified in "finance and use of resources". However, the Trust's oversight framework rating in finance and use of resources was 1 (defined as maximum autonomy) at the year end. The current Oversight Framework is due to be replaced by a new NHS System Oversight Framework which is being consulted on until 14 May 2021.

The NHS Staff Survey 2020 is one way for staff to share their views about their job, the Trust and the NHS. Individual responses to the survey are strictly confidential and handled independently on behalf of the NHS. The aggregated results are detailed later in this report and continue to show both progress and areas for improvement.

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

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

NCH&C is working closely with primary care and other community colleagues to deliver the NHS Long Term Plan commitments. For example, the Long Term Plan confirms that general practices will join together to form primary care networks (groups of neighbouring practices typically covering 30–50,000 people). Practices have entered network contracts, alongside their existing contracts, which includes a single fund through which network resources will flow. Primary care networks are taking a proactive approach to managing population health and assessing the needs of their local population to identify people who would benefit from targeted, proactive support. NCH&C has successfully aligned its operational and clinical services with the PCNs

Performance measured across a range of metrics in quality and safety, operational performance, patient experience, productivity and value for money continues to be very good. However, challenges remain in improving performance in, for example, neuro-developmental services and wheelchair services to prevent further and prolonged deterioration in waiting times. NCH&C has submitted investment proposals to commissioners to expand the services. Resolving capacity issues is key to improving performance in the short-term and providing a longer-term sustainable resource level to maintain compliance.

NCH&C is working collaboratively with all partners within the context of the jointly agreed system priorities:

Primary and community care: As a system we know we must focus on prevention wherever possible, we cannot meet our clinical priorities without focusing on primary care and community care.

Mental health: We will focus on prevention and maintaining well-being for our people to stay happy and healthy. If people are in need we will provide high quality services.

Acute transformation: Transforming our acute hospital services in a way that improves the patient experience as well as making them more financially sustainable.

Urgent and emergency care services: To address pressures on urgent and emergency care services to enable good quality care for all.

Cancer: Commitment to improving the care, treatment and support all people who have been diagnosed with cancer and ensure that cancer is diagnosed early across our footprint.

Children and young people: Ensuring our children and young people have access to high quality physical and mental health services to give them the best possible start in life.

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

On 20 March 2020 NCH&C declared a major incident in response to the Covid-19 pandemic and all of the Trust's efforts were mobilised to focus on responding to this by ensuring patient safety and staff wellbeing. The Trust is currently in the recovery phase working to restore all services to normal activity levels.

Covid-19 Vaccination Plan

The Trust has rolled out vaccination clinics to its staff and supported the system in vaccinating other NHS and social care staff. The number of staff vaccinated at the year end exceeded 90%. Work is ongoing to support those staff that are hesitant of the vaccine, with supportive calls and accessible clinics. The Trust has agreed to support the National Vaccination Programme by taking on the Norwich Community Hospital centre. This process is overseen and assured by NHSI/E. The Trust is also lead provider for a learning disability vaccine clinic in the north of the county and a roving bus model to allow for supporting harder to reach groups.

1.2. Statement of the purpose and activities of the Trust

NCH&C was established on 1 November 2010 to provide community-based health and care services. NHS trusts were established under the National Health Service and Community Care Act 1990, with each NHS Trust individually being established by Statutory Instrument (NCH&C reference: 2010 no. 2466). Services are commissioned by clinical commissioning groups (CCGs), Norfolk County Council (NCC) and NHS England (NHSE).

This section includes NCH&C's:

1.2.1 Vision and Values.

1.2.2 Services provided by NCH&C.

Longer term plans:

1.2.3 Health and Care Partnership and Integrated Care System

1.2.4 Strategic and Annual Priorities

Graphic below showing NCH&C's values and strategic objectives

1.2.1 Vision and values

Our vision

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

Our values

Community

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

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

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

Compassion

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

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

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

Creativity

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

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

We continuously innovate and implement efficient delivery of care

1.2.2 Services provided by NCH&C

The graphic below shows the type and location of services provided by NCH&C.

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Our services include…

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

LOOKING AFTER YOU LOCALLY

The graphic below shows a typical day's activity at NCH&C

Longer term plans

This section includes:

1.2.3 Norfolk and Waveney Health and Care Partnership and Integrated Care System

1.2.4 Strategic and Annual Priorities

1.2.3 Health and Care Partnership and Integrated Care System

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

Norfolk and Waveney Health and Care Partnership will become an Integrated Care System (ICS), which is an even closer collaboration of NHS organisations, in partnership with local councils and others, taking collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. The NHS Long Term Plan sets out the aim that every part of England will be covered by an ICS by 2021, replacing STPs but building on their good work to date.

Norfolk and Waveney Health and Care Partnership has agreed the following priorities:

Preventing illness and promoting well-being – supporting people to live longer, healthier lives by targeting lifestyle risk factors. Aligning community services with local authorities and the third sector, supporting people to live independently.

Care closer to home – people living independently with better access to primary, and secondary care, as well as the third sector, thereby reducing demand on hospital and residential services.

Integrated working across physical, social and mental health, delivering holistic care, improved patient experience and better outcomes. Services focusing on social care and mental health parity of esteem.

Developing sustainable hospital services.

Delivering cost-effective, high quality services within the funds available.

Section 75 arrangement with Norfolk County Council

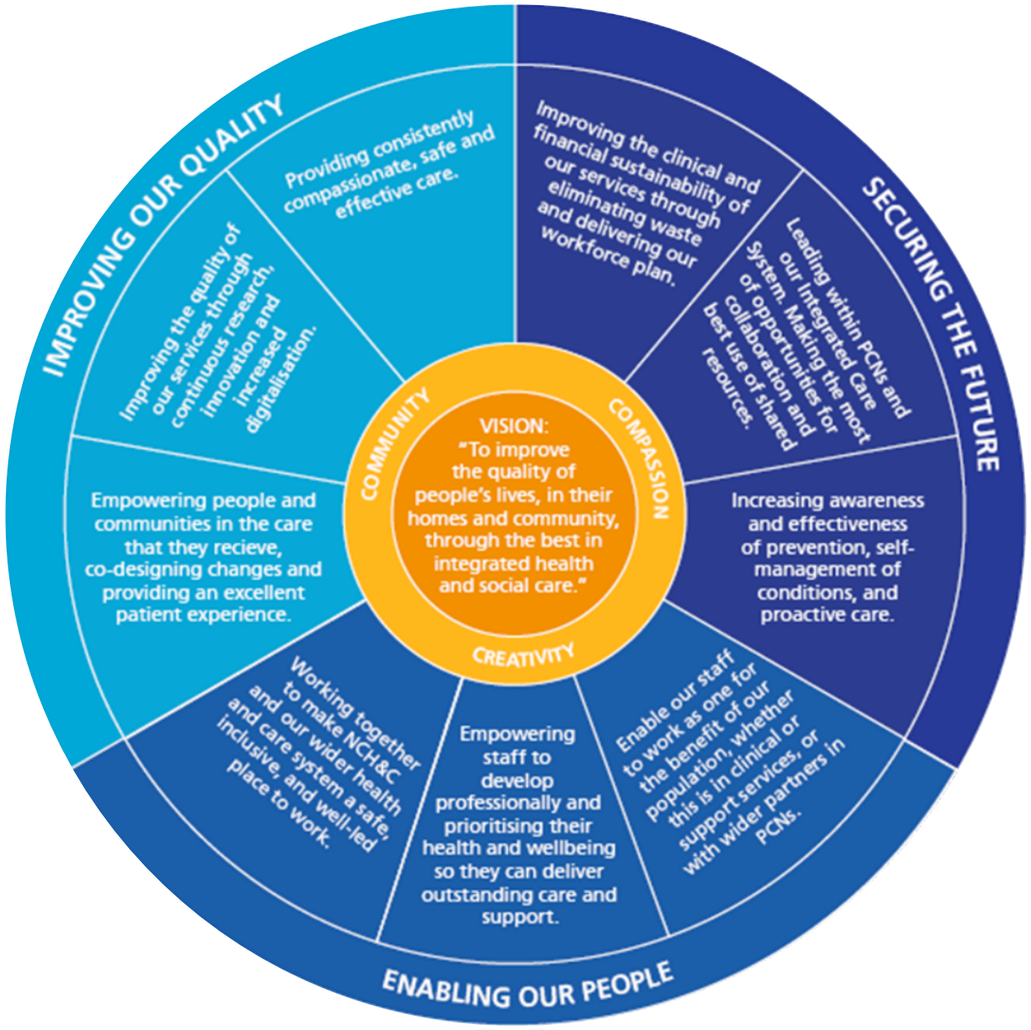
A Section 75 arrangement between NCH&C and Norfolk County Council has been in place since October 2014 for all of Norfolk other than the Great Yarmouth locality. It covers senior management posts for community health and social care:
A Director and Deputy Director, plus an Assistant Director and a Head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

The review included a staff survey, and in-depth interviews with the senior managers referred to above, other senior managers in both organisations and with a small number of service users. The responses from these four groups were consistent. Having an integrated management structure helped provide a more seamless service for patient/ service users. Staff were more aware of the availability of resources outside their service area, particularly where they are co-located.

1.2.4 Strategic and Annual Priorities

The graphics below describe the Trust's Strategic and Annual Priorities

Strategic priorities 2021 to



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

1.3 Key Risks and Issues

This section includes:

1.3.1 Strategic risks

1.3.2 Service changes

1.3.3 Policy drivers – NHS Long Term Plan

1.3.1 Strategic risks

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

Risks to improving our quality mitigated through delivering a continuous quality improvement approach.

Risks to enabling our people mitigated through staff engagement and empowerment.

Risks to securing the future mitigated through delivering the Financial Plan, ensuring the sustainability of services and developing good partner relations.

Risk in responding to the Covid-19 pandemic, and also the increased cyber security risks during this period.

An in-year risk to address the ongoing impact of the pandemic on services, such as waiting lists, as we move into the recovery phase.

1.3.2 Service changes

There are a number of opportunities and challenges that will arise from time to time. These have included both the tendering of NCH&C's existing services and those which are outside NCH&C's current portfolio. NCH&C's strategic focus going forward is on our contribution to the Health and Care Partnership, and on the key assumptions set out for the achievement of a surplus including the delivery of recurrent efficiency savings.

During the year, NCH&C continued to develop partnerships through:

Working with primary care colleagues and other partners to support the ongoing development of primary care networks.

Working with Norfolk and Suffolk NHS Foundation Trust (NSFT) on closer working around community physical and mental health services.

Working within an alliance of community-based providers.

Working within and leading on system workstreams.

Contributing to the system's response to the pandemic.

1.3.3 Policy drivers – NHS Long Term Plan

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

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

Key measures include:

A new NHS offer of urgent community response and recovery support: Within five years, all parts of the country will be expected to have improved the responsiveness of community health crisis response services to deliver services within two hours of referral, in line with NICE guidelines, including delivering re-ablement care within two days of referral. Norfolk and Waveney have been selected as one of seven NHS and local government teams to develop services based around community response teams, to deliver to the new access standards. A two-hour target will require health systems to deliver community health crisis services to older patients and those with complex health needs within two hours of referral. A separate two-day target requires health systems to deliver reablement care to patients in need within two days of referral. This is a key component of the long-term plan and the new NHS community services strategy, Ageing Well. The new pilot sites "will be the first to deliver the new standards for care", enabling NHSE to standardise the measurement and delivery of urgent community services across the country.

Primary care networks of local GP practices and community teams: Funding will cover expanded community multi-disciplinary teams aligned with new "primary care networks" covering 30-50,000 people. From 2019, NHS111 started booking patients directly into GP practices, as well as referring to pharmacies. A shared savings scheme will be offered to primary care networks so they can benefit from their improvements.

Guaranteed NHS support for people living in care homes: There will be an upgrade in NHS support for care home residents with care homes supported by a team of healthcare professionals, including named GP support. The new primary care networks will work with emergency services.

Care home staff will have access to NHS mail. This gives staff in care homes the ability to securely share residents' data and queries with doctors, nurses and GPs in the NHS, and get timely responses. It also connects them securely to pharmacists, dentists and anyone else in health and care with a secure email, such as an NHS mail account

Supporting people to age well: From 2020/21 the new primary care networks will assess local population risk and reduce hospital admissions through an increased use of preventative measures such as digital health records, population health management tools and new home-based or wearable monitoring equipment.

NHS Operational and Planning Guidance 2021/22 sets out the following priorities:

Supporting the health and wellbeing of staff and taking action on recruitment and retention.

Delivering the NHS Covid-19 vaccination programme and continuing to meet the needs of patients with Covid-19.

Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.

Expanding primary care capacity to improve access, local health outcomes and address health inequalities.

Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay.

Working collaboratively across systems to deliver on these priorities.

1.4 Performance Summary

This section includes information on:

1.4.1 CQC rating

1.4.2 NHS Oversight Framework segmentation

1.4.3 Financial performance

1.4.4 Operational performance

1.4.5 Workforce

1.4.6 Covid-19 pandemic response

1.4.7 Brexit planning

1.4.8 Sustainability performance

NCH&C has performed well against targets and standards set nationally and those agreed locally with commissioners. The Board reviews a detailed integrated performance report at each monthly meeting on operational performance, a monthly report on performance against quality of service measures, a bi-monthly workforce report, a monthly finance report, and a quarterly report on the management of strategic risks, known as the Board Assurance Framework. NCH&C has been assessed by CQC and NHSI.

1.4.1 CQC rating

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

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

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

Ratings for community health services

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

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

The Trust was due to be inspected again in 2019/20 and completed the CQC's routine provider information return as requested in preparation for the inspection. However, the Trust was notified that due to the Covid-19 pandemic the inspection would be delayed until further notice. As the risks from the pandemic have changed, the CQC evolved its approach to regulating. They adapted and developed their methods by using a transitional approach to monitoring services. This focused on safety, how effectively a service is led and how easily people can access the service. It included a strengthened approach to monitoring, based on specific existing key lines of enquiry, so they can continually monitor risk in a service using technology and their local relationships to have better direct contact with people who are using services, their families and staff in services targeting inspection activity where they have concerns. After reviewing information that they have about services, they contact the Trust directly. No regulatory action was taken by the CQC and there have no inspections this year. The Trust's rating has therefore remained as Outstanding.

1.4.2 NHS Oversight Framework segmentation

The NHS Oversight Framework sets out a regulatory oversight process which follows a cycle of:

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

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

Graphic below showing NHSI's five themes

Theme	Aim
Quality of care (safe, effective, caring, responsive)	To continuously improve care quality, helping to create the safest, highest quality health and care service. In close collaboration with the CQC.
Finance and use of resources	To balance finances and improve the productivity of the provider sector.
Operational performance	To maintain and improve performance against NHS constitutional standards.
Strategic change	To ensure providers are contributing through ICSs and/or STPs to the development and delivery of clinically, operationally and financially sustainable patterns of care.
Leadership and improvement capability (well-led)	To build provider leadership and improvement capability to deliver sustainable services. In 19/20 this also includes culture and organisational health.

NHSI has the following aims to:

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

There are four levels of segmentation or categorisation described below.

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

NHS Improvement's latest published (21 October 2016 under the previous version known as the Single Oversight Framework) assessment of NCH&C through the NHS Oversight Framework is that the Trust is in segment 2, defined as: "support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or NHS Improvement considers formal action is not needed." This provides for: "Universal plus Targeted support as agreed with the provider to address issues identified and help move the provider to Segment 1". The targeted support needs were identified in "finance and use of resources". However, the Trust's oversight framework rating in finance and use of resources was 1 (defined as maximum autonomy) at the year end.

A new System Oversight Framework will replace the existing framework in 2021/22.

1.4.3 Financial performance

2020/21 has been an unusual year for the Trust's financial performance. The Trust had initially planned to deliver the second year of its five-year financial strategy, with a balanced budget for 2020/21. The plan was balanced with a contribution from the financial recovery fund. However, to enable the Trust to devote its operational effort to responding to the pandemic, the financial regime was amended from April 2020. Funding was made available to cover the additional costs of responding to the pandemic and to ensure all NHS Trusts had enough cash reserves to pay suppliers promptly. All operating costs (including additional spend due to the Covid-19 pandemic) during April to September 2020 were reimbursed through this process. For the second half of the year funding was allocated including an allowance for Covid-19, and the Trust was expected to spend within this allowance.

The Trust agreed a revised plan in November 2020. The Trust delivered an accounting surplus of £0.9m in 2020/21, which was £0.7m better than the revised plan. This £0.7m favourable variance included a £0.2m increase in the value of the Trust's land and buildings, £0.2m of central funding provided to reimburse the Trust for expected costs relating to the 'Flowers' legal case brought against another NHS Trust, £0.2m financial benefit from the provision of personal protective equipment by the DHSC and £0.1m the net effect of all other variances.

Underlying this financial position is a significant increase in both income and expenditure in response to the pandemic. Staff costs increased by 9.5% to £91.1m during the financial year. This reflects the substantial effort of staff across the Trust in delivering patient care in the exceptional circumstances of the pandemic, with many staff working much longer hours than they usually would.

£1.3m was spent on agency workers, which is £0.5m below the Trust's agency ceiling of £1.8m. This spend was slightly higher than in the previous year as agency workers (as well as bank and substantive staff) were used to open additional beds in inpatient wards in response to the increased demands on services from the pandemic.

The main measure used by NHS England/ Improvement to monitor the Trust's financial performance is a control total based on an adjusted surplus/deficit delivery. The Trust's revised plan included a £0.5m 'control total' financial surplus. The Trust improved on this planned result,

delivering a £0.67m 'control total' financial surplus.

Total capital expenditure in 2020/21 was £5.1m, which was an increase of £0.4m on the prior year. The majority of the spend was for improving digital services (£1.9m on information technology), followed by £1.7m on backlog and routine maintenance on Trust estate, £1.2m on Covid-19 related spend and £0.2m on clinical equipment, with the balance on programme administration. The Trust is monitored against a Capital Resource Limit (CRL) set by NHSEI at £5.2m. The Trust's capital expenditure after the permitted adjustments of the value of disposals and donated / granted capital assets was £4.8m, which is £0.4m below the limit set by NHSEI.

The Trust's cash position continued to strengthen, with the cash balance increasing by £7.0m during the year to £33.0m at 31 March 2021. The increase in cash is primarily due to £2.2m of cash generated from operating activities and a £4.4m decrease in the value of contract receivables (debtors).

The better payment practice code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of the invoice. In recognition of the pressure many of our suppliers were facing, due to the pandemic, and reflecting national guidance on the importance of paying suppliers on time, the Trust strengthened its processes in this area. 91% of non-NHS invoices by volume and 85% of non-NHS invoices by value were paid within the code requirements. This is a significant improvement on the prior year, when 70% of invoices by volume and 59% of invoices by value were paid within the code.

In response to the pandemic, certain elements of the financial regime were suspended for 2020/21. This included delivery of the Trust's efficiency programme and the NHS Oversight Framework Financial Use of Resources rating. The financial regime for the first six months of 2021/22 will closely match that of the final six months of 2020/21, after which the NHS will return to a financial regime similar to that in operation pre-pandemic.

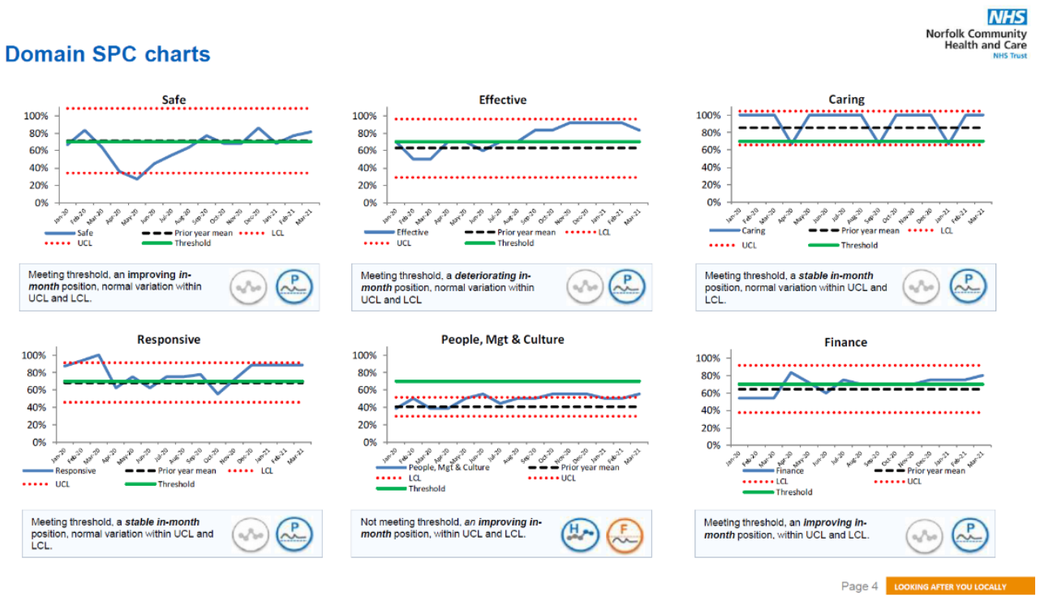
1.4.4 Operational performance

The Trust Board uses a performance dashboard for key areas of operation on a monthly basis. The chart below shows the latest available summary report at March 2021. Key Performance Indicators (KPIs) within the CQC domains, which drive the overall performance of the Trust, are tracked within an integrated performance report (IPR) assessed over the previous seven months. Each CQC domain has a KPI dashboard which highlights key areas of improvement or concern detailed within the IPR. For internal performance management purposes the CQC well domain is divided into two – people, management & culture and finance. Statistical process control analysis is used to indicate levels of variation and assurance.

	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend
Safe									
Effective									
Caring									
Responsive									
People, Management & Culture									
Finance									

Three services with long standing waiting list challenges are: the wheelchairs service, neurodevelopmental services and in learning disability services. Work is underway to address these issues with commissioners.

The following graphic shows the statistical process control analysis of each domain, indicating levels of variation and assurance throughout the year.



Operational performance and Covid-19

At the time of writing the Trust has no Covid-19 positive patients in its beds. Staff absence rates are now at or marginally above Trust average. The impact on services is being managed. The Trust is typically at Opel 2 (a 4 point scale of operational escalation). There is still service disruption hence a high target risk level, but the incident is being managed and impact broadly mitigated. Additional beds have now been closed and staff are being returned after redeployment to bolster against heightened pressure. There is a risk for patients of increased waiting times due to reduced services.

We are currently in the recovery phase within our schematic. We are returning services that had been deferred or delayed, and we are maintaining incident governance and identifying lessons learned and planning for the post-incident environment. The vaccination programme for staff has 90% of substantive staff vaccinated. Personal Protective Equipment supplies are stable and with good stock levels. The Trust operated a seven day, 12 hour Incident Control Centre throughout much of the pandemic.

The table below shows the number of long waiters by service with a three month comparison. Patients reaching 30 weeks in April 2021 would have been referred in July 2020, when referral rates were experiencing a modest rise post Covid-19 Wave 1. More significant rises in demand above historic patterns occurring during September to October 2020 are likely to appear in the Long Waiters figures during June to July 2021 unless mitigated.

Services	Appointments		30week waiters		
	With	Without	06/04/2021	28/02/2021	31/01/2021
Neurodevelopmental Services	68	43	111	96	89
Wheelchairs	27	48	75	60	50
Foot Health	0	1	1	3	6
Specialist and Enhanced Palliative Ca	0	1	1	1	1
Children's Epilepsy	0	1	1	1	0
Integrated Palliative Care Service We	0	1	1	1	0
Children's Community Nursing Team	0	1	1	0	0
Discharge to Assess (D2A)	0	1	1	0	0
Children's Consultant Outpatients	0	1	1	0	0
Grand Total current report	95	98	193	162	146
Movement from previous mo			+31	+16	-74

Earned autonomy

In July 2020 NCH&C implemented an Earned Autonomy Framework, which is a new approach to governance, oversight assurance and accountability that sets out how NCH&C reviews performance, promotes freedom within a framework, and identifies support needs across Local Teams (ie Places and Specialist Services Operations and Children's Services). NCH&C supports Local Teams to take on greater collaborative responsibility for the use of resources, quality of care and population health. In line with the move to maximum autonomy for better performing local systems, the level of earned autonomy arrangements will reflect both the performance and relative maturity of PCNs. The level of autonomy that best meets assurance needs will develop over time and we will be testing new ways of working by adopting a continuous Quality Improvement approach, including the PDSA cycle. The framework was co-designed between the Executive Team, Operations Directors and Clinical Quality Directors. Local Teams are categorised into support zones with bespoke support being made available depending on a number of factors faced by each team.

1.4.5 Workforce

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

National Staff Survey

Overall, the 2020 NHS Staff Survey results present no statistically significant changes in any of the 10 themes. Therefore, these results will lead us to focus on looking at areas where we have plateaued this year. Staff recommending NCH&C as a place to work and being happy with the standard of care provided continue to show improvement. Safety Culture has shown continual improvement since 2016. The trust is at or above average in three areas – treating staff involved in an incident fairly, providing feedback about changes made in response to reported incidents and staff having confidence in the organisation to address their concerns. This result correlates with the introduction of new Freedom to Speak Up Guardian, who despite the challenges of the pandemic has worked hard to raise the profile of this support mechanism locally and improve the processes.

We are pleased to see an improvement in response to 'the organisation takes positive action on health and wellbeing' (32.3% increased to 46%). This has been a top priority for NCH&C during the pandemic and we will continue to promote resources on our dedicated health and wellbeing website. We do, however, recognise the need to focus on flexible working opportunities and musculoskeletal health, and so will be prioritising these areas over the coming year.

There has been considerable improvement in staff reporting they never or rarely have unrealistic time pressures, improving from average (23.9%) to 28.4%. There was a deterioration in staff being involved in

changes that affect their work. Whilst this is not unexpected, due to the trust's approach during the pandemic response, it is an area we would like to see improvement on as restrictions ease.

New for last year, staff were also asked to share their experience of working through the pandemic. Overall, the response from colleagues working in Covid-19 areas and those who were redeployed reflected below average satisfaction. It is positive that those working from home, given the significant change for this group of staff, have had a positive experience.

Workforce and Covid-19

During the pandemic the Trust temporarily closed clinics and reduced the number of community visits allowing for the redeployment of staff to inpatient units, which enabled the Trust to be sufficiently staffed, despite the fact that there continued to be registered nurse vacancies. In response to the Covid-19 pandemic the ratio of registered nurses to patients was decreased from 1:8 to 1:12 as a minimum. This was in line with other Trusts and an approach adopted to consider other staffing resources. This supported the Trust's response to the system's requirement for extra beds. This was made possible by increasing the number of health care assistants, reviewing the role of therapists in contributing to safer staffing and the tasks undertaken by registered nurses.

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

1.4.6 Covid-19 pandemic response

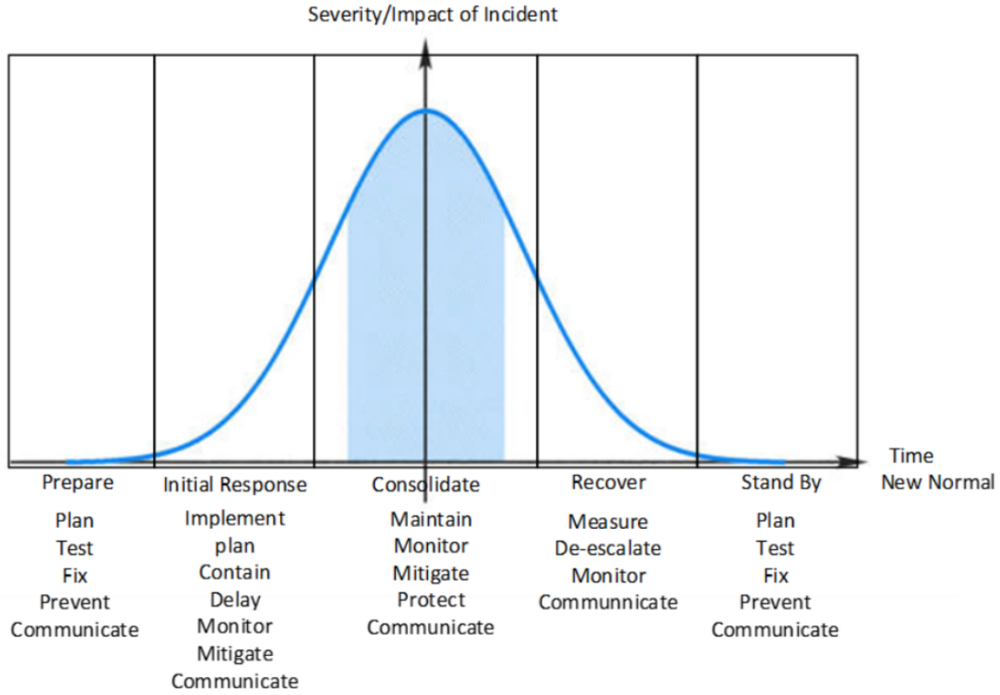
On 17 March 2020 NCH&C enacted the operational plan in response to the Covid-19 pandemic. On 20 March a major incident was declared. Three main risks were managed by the Trust:

- Loss of corporate and clinical capacity – NCH&C planning assumptions have been for the loss of up to 20% of staff due to either absence due to potential or confirmed infection or to perform carer duties during Covid-19 surges. However, a risk to corporate and clinical capacity remains during lulls in Covid-19 transmission due to staff catching up on other reasons for absence such as annual leave, training and sickness related to other seasonal illnesses which will return follow releasing of lockdown.
- Increase in demand due to widespread community illness (Covid-19 disproportionally affects older people); loss of service provision on which people rely such as social care, volunteers, etc. In addition, a proportion of Covid-19 cases have required hospitalisation; therefore, Acute providers will require community services to support discharge. Between Covid-19 surges the Trust can expect rebound demand and the consequence of delayed treatment to contribute to increased demand (in terms of referrals and time required to deliver care). In addition, the Trust can expect increased variation and volatility in demand as a result of service changes in referring organisation.
- Variation in supply chain, caused by reduced productivity and potential restrictions on travel as well as increased demand on the supply chain as service provision reacts to a Covid-19 surge or restoring service provision.

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

At the time of writing, NCH&C remains within its major incident and incident governance remains in place. Plans are in place to progressively and proportionately reduce incident governance throughout the current recovery phase. The plan includes the transfer of residual incident reporting to business as usual service provision, returning the Trust to its pre pandemic readiness state in terms of EPRR compliance and conducting a review of the impact on the incident on the Trust, including lessons learnt. Once the Trust has entered the "New Normal" phase of the rising tide incident all relevant documentation and records will be secured in preparation for any future legal requirements.

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



NCH&C has worked with its system resilience partners on preparation for an increase in

population during the summer months as people visit Norfolk on their vacation as well as

planning for a 4th wave of Covid-19. As activity within the Trust Incident Control Centre reduces its team will provide support to the Service Improvement Partnership to support the organisation in its recovery but they will remain prepared to return to ICC duties if the situation changes. The Trust has beds ringfenced for Covid-19 cases and has been identified as the Norfolk and Waveney Designated Space for Covid-19 discharges. The Trust continues to support the rollout of the vaccination programme to the general public including the implementation of a vaccination bus to help bring vaccines to more people in the community. Most staff have been vaccinated.

1.4.7 UK Withdrawal from the European Union (Brexit)

NCH&C's Brexit planning took full account of Government advice in its risk assessment and preparations in relation to: (1) medicines and medical devices; (2) accessing public sector contracts; (3) data protection; (4) merger review and anti-competitive activity; (5) exhaustion of intellectual property rights; and, (6) recognition of professional qualifications, and other workforce issues. The Deputy Chief Executive is the nominated lead executive for Brexit planning and has reported to the Audit Committee and Board. Assurance to the Board on Brexit preparations was provided in the following areas:

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

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

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

Workforce: NCH&C had a low-number of EU national members of staff and there was been no indication of staff leaving due to Brexit and this was monitored by the HR department. NCH&C has participated in system wide workforce forums.

Clinical trials: NCH&C does not sponsor clinical trials and has limited involvement in them.

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

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

Health demand: No significant increase in demand experienced or access issues identified. NCH&C has participated in a multi-agency scenario testing.

Withdrawal from the European Union has to date had no material impact on NCH&C.

1.4.8 Sustainability performance

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

NCH&C has always been proactive in striving for a sustainable organisation and, in response to the Sustainable Development Strategy for the Health, Public Health and Social Care System 2014-2020, created a sustainable development management plan (SDMP). We have since evolved to develop our 'Green Plan', the vision of which requires us to enable sustainable development across all areas of our activity that meets needs of the present without compromising the ability of future generations to meet their own needs.

The advent of the Covid-19 pandemic in late March 2020, and the efforts to control this, have delayed the further development of our Green Plan, and, as a result, an Interim Plan was issued. Work has recommenced in bringing the multi-disciplinary team together to facilitate the delivery programme with a target for the full Green Plan by Autumn 2021. The work will also include full staff engagement to both highlight the sustainability agenda and collect ideas and options for environmentally sustainable improvements in Trust activity.

As the reporting for the year 2020-21 was not conducted, again due to the pandemic, we will include in our full report the reviewed and analysed data for a two-year period (19-20 and 20-21). We will use this data, along with the assessed and prioritised ideas for environmentally sustainable improvements, to identify

ambitious targets across all areas of sustainable development within the Trust and the wider health economy.

2015 to 2019, the Trust reduced:

- CO2 output by almost 1000 tonnes on our energy (gas, electric and oil) consumption alone, achieved by a combination of disposal of underused estate and upgrades to LED lighting and removal of all oil fired heating with boiler replacement programmes.
- waste output by over 200 tonnes, including reducing our landfill waste from 232 tonnes a year to 0.
- vehicle mileage by almost 1.4 million miles a year.
- water consumption by 7,800 m3 and waste water production by 4,200 m3.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features. One of the ways in which an organisation can embed sustainability is through the use of our aforementioned Green Plan. Our interim Green Plan was approved in August 2020 and our final one is due to be presented in Autumn 2021.

We engage with suppliers to understand, record and track the sustainability of products and services and adherence to any related relevant contract requirements, through the tendering process when commissioning services, then through the contract management process, via tools such as the contract meetings and KPI monitoring. Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc, with the largest impact, by far, being the Covid-19 pandemic, which affected every part of our organisation.

We continue to measure our impact as an organisation on corporate social responsibility through the use of the Sustainable Development Assessment Tool (SDAT) tool. The factors identified within this tool are being embedded within our work in relation to accommodation and ways of working in the post-pandemic era.

2. Performance analysis

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

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

Accountable Officer's signature

Signed:……..…….

Josephine Spencer
Chief Executive
Norfolk Community Health and Care NHS Trust

Date:……

B

ACCOUNTABILITY REPORT

Scope of the Accountability Report.

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

The Accountability Report includes:

3. Corporate Governance Report

4. Remuneration and Staff Report

5. Parliamentary and Audit Report

3. Corporate Governance Report

This section of the report includes:

3.1 Directors' report

3.2 Statement of Accountable Officer's responsibilities

3.3 Governance statement

3.1 Directors' Report

This section includes:

3.1.1 Board composition and declaration of interests

3.1.2 Audit Committee

3.1.3 Disclosure of personal data related incidents

3.1.4 Directors' statement

3.1.5 Modern Slavery Act 2015 – Transparency in Supply Chains

3.1.1 Board composition and declaration of interests

Below is the Register of Directors and their declared interests which shows all individuals who served on the Board of Directors at any point during the year. All Board members were in post for the whole of the year from 1 April 2020 to 31 March 2021 except where indicated.

Board member	Designation	Declared Interest
Lorna Bailey (Deputy Trust Chair)	Non Executive	Self employed Speech and Language Therapist, Director of Bailey Booth & Massingham Ltd, Director of Independent Speech & Language Therapy Services Ltd, Director and 100% shareholder of Marlingford Consulting Ltd

Board member	Designation	Declared Interest
Geraldine Broderick Trust Chair	Non Executive	None
Laura Clear Director of Community Health and Social care Operations	Executive	None
Paul Cracknell Deputy Chief Executive and Director of Strategy and Transformation until 31.03.21	Executive Non-voting	None
John Webster Deputy Chief Executive and Director of Strategy and Transformation from 01.04.21	Executive Non-voting	Seconded from Norfolk and Waveney CCG
Steve Crowe	Non Executive	Director, Angling Direct PLC
Carolyn Fowler Director of Nursing and Quality	Executive	None
Venu Harilal Medical Director	Executive	Clinical input to Oak Court, 321 Fakenham Road, Taverham, Norwich NR8 6L, and Environmental Control Service, Suffolk Community Healthcare
Andrew Hopkins Director of Finance and Performance	Executive	None
Graham Nice	Non Executive	Specialist Advisor to the CQC, Managing Director, Graham Nice Associates Ltd
Geoff Rivers until 30.04.20	Non Executive	Director, Geoff Rivers Associates – local government work, Governor, Arch Bishop Sancroft High School, Harleston , Norfolk, Vice Cahir of the Independent Monitoring Board, HM Prison Hollesley Bay, Woodbridge, Suffolk, Treasurer, WEA (Worker Education Associations), Pulham Branch, Norfolk, Director, All Saints Multi Academy Trust
Josephine Spencer Chief Executive	Executive	None
Andrew Williams	Non Executive	Volunteer at Headway
Njoki Yaxley	Non Executive	None

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

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

NCH&C Committee Structure

- Quality Committee
- Finance and Performance Committee
- Charitable Funds Committee
- Remuneration and Nominations Committee
- Audit Committee
- People Committee (established in January 2021)

The Board also established a temporary Business Continuity Assurance Committee during the Covid-19 pandemic response, which met monthly between April and September 2020.

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

3.1.2 Audit Committee

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

Table showing members of the Audit Committee

Name	Designation
Lorna Bailey	Committee Chair, Non Executive Director
Njoki Yaxley	Committee member, Non Executive Director
Steve Crowe	Committee member, Non Executive Director

3.1.3 Disclosure of personal data related incidents

There were no personal data related incidents that required reporting to the Information Commissioners Office.

3.1.4 Directors' statement

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

3.1.5 Modern Slavery Act 2015 – Transparency in Supply Chains

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

The Trust also works with suppliers to ensure that they treat their obligations towards modern slavery with the same importance that we do.

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

Consequently, whilst the Trust does not have a specific anti-slavery policy (as it is not required to have one), it acts in accordance with the intentions of the Act with regard to its own operations and that of any sub-contractors and, therefore, the Trust's ability to deliver the contract is in no way compromised.

Statement of Directors' responsibilities in respect of the accounts

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

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

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

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

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

By order of the Board

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

.....Date.....Finance Director

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

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

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

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

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

Signed.....Chief Executive

Date.....

3.3 Governance Statement

This section includes:

3.3.1 Scope of the Accountable Officer's responsibility

3.3.2 The purpose of the system of internal control

3.3.3 Capacity to handle risk

3.3.4 Risk and control framework

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

3.3.6 Information governance

3.3.7 Review of effectiveness

3.3.8 Conclusion

3.3.1 Scope of Accountable Officer's responsibility

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

3.3.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Norfolk Community Health and Care NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Norfolk Community Health and Care NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

3.3.3 Capacity to handle risk

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

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

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

3.3.4 The risk and control framework

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

The Board Assurance Framework identified the following strategic risks:

Q1 Providing outstanding care: The risk finished 2020/21 worse than target and was rolled over with a target date of September 2021. Actions to mitigate gaps in assurance and control will reduce the risk rating once there is stronger assurance to evidence that these improvements are embedded.

Lead committee: Quality Committee

Q2 Covid response: The risk finished 2020/21 at target and has been at the target level since February 2021. This risk was therefore de-escalated from the BAF in May 2021.

Lead committee: Quality Committee

Q2.1 Covid ongoing impact: The risk finished 2020/21 worse than target and was rolled over. Plans are in place to mitigate the ongoing impact of the pandemic on services.

Lead committee: Quality Committee

W3 Enabling our staff: The risk finished 2020/21 worse than target and was rolled over. Mitigation plans include implementation of the Board approved Workforce Strategy and continuing to implement the actions arising from the National Staff Survey.

Lead committee: People Committee

S4 Partner relations: The risk finished 2020/21 at target. The risk has been updated and refreshed for the coming year.

Lead committee: Finance and Performance Committee

S5 Delivering the financial plan: The risk finished 2020/21 at target. The risk has been updated and refreshed for the coming year.

Lead committee: Finance and Performance Committee

S6 Sustainability of services: The risk finished 2020/21 worse than target and remained red and is the Trust's most significant strategic risk. It has been rolled over with a target date of April 2024. Uncertainty remains for all organisations in the system over funding and the impact of Covid-19 on future financial flows. The detailed Financial Plan was approved by the Board on 2 June 2021. We are continuing to work with the ICS to identify opportunities for corporate and support service savings and closer working.

Lead committee: Finance and Performance Committee

S7 Cyber security: The risk finished 2020/21 worse than target but within the amber rating and was rolled over. Two actions remained overdue for completion. These will be completed by the end of June, which is a delay of two months from the original plan. Once these two remaining actions are completed then the risk will reduce to target. These are: (1) implementation of the Office 365 Cloud backup solution, and (2) migration of Windows 7 Virtual Desktop Platform to Windows 10.

Lead committee: Finance and Performance Committee

The Board continued to implement an action plan following a self-assessment undertaken the previous year against the Well Led Framework, which identified four priority areas for further action and development, summarised as:

- Quality Improvement (QI): updated approach to innovation and improvement that codifies the QI approach, and assesses our effectiveness against it.

- Governance and Accountability: independent review of the Board Assurance Framework, the operation of the Board's committees, and the Governance Framework, receiving significant assurance with some low risk or advisory recommendations, that were implemented. A new earned autonomy framework and performance management process was also established.
- Stakeholder appraisal of the Trust: a 360 independent external review was completed during the year.
- Range of internal actions have been incorporated into a quality improvement action plan.

NHS Provider Licence

As an NHS Trust, NCH&C is exempt from the requirement to apply for and hold a NHS Provider Licence for the provision of NHS services under Statutory Instrument 2013 No. 2677 "The National Health Service (Licence Exemptions, etc.) Regulations 2013". However, while NHS Trusts are exempt, directions from the Secretary of State require NHSI to ensure that NHS Trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS Trust where necessary to ensure compliance. NHSI base their oversight, using the Single Oversight Framework, of all NHS Trusts and NHS Foundation Trusts on the conditions of the NHS Provider Licence. The Board has self-certified compliance with the NHS Provider Licence after assessing the principal risks to compliance, particularly in relation to:

- The effectiveness of governance structures.
- The responsibilities of Directors and committees.
- The reporting lines and accountabilities between the Board, its committees and the Executive Team.
- The submission of timely and accurate information to assess risks to compliance with the conditions of the licence, and
- The degree and rigour of oversight the Board has over the Trust's performance.

The Board assessed the risks to non-compliance and concluded that NCH&C is compliant with the NHS Provider Licence.

- Risk management is embedded in the activity of the organisation through a number of ways including:
- Staff training and development in risk
- Risk Group monthly meeting of all risks leads from across the Trust.
- Local risk registers kept at service level and a Trust-wide corporate risk register.
- Risks are regularly reviewed in Board committees and by the Executive.
- Equality impact assessments (EIA) are integrated into core Trust business through them being required for every policy and strategy.
- Incident reporting is openly encouraged. For example, all serious incidents, including actions and learning, are reported to Board monthly. All serious incidents are investigated using root cause analysis methodology. Initial investigation reports to commissioners are submitted within three days of reporting and full investigation reports are submitted together with any resulting action plan to commissioners within 40 days of it being reported. Lessons learned are disseminated to staff through the Quality and Safety Newsletter.

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

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

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

Audit Committee

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

Quality Committee

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

Finance and Performance Committee

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

Business Continuity Assurance Committee (Covid-19)

For the duration of the Covid-19 pandemic response the Board approved changes to the Governance Manual. This included temporarily standing down the Quality Committee and the Finance and Performance Committee between April and September 2020, and instead establishing a Business Continuity Assurance Committee (BCAC) which took over their key functions. The BCAC was chaired by the Chair of the Quality Committee and also comprised the Chair of the Finance and Performance Committee (as deputy chair) and Chair of the Audit Committee. The Medical Director, the Director of Nursing and Quality and the Director of Finance and Performance were also members of the BCAC. Governance support was provided by the Trust Secretary.

Remuneration Committee

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

Charitable Funds Committee

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

People Committee

This committee was established in January 2021 and usually meets bi-monthly with responsibility for overseeing the development and implementation of the Workforce Strategy and People Plan, Health and Wellbeing Strategy, Staff Engagement Strategy and the Organisational Development Strategy.

Executive Team

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

Other leadership forums in the Trust include the Trust Management Team comprising Executives and the next tier below. A Trust-wide forum was established during the pandemic to which all staff are invited called "Our Community Live". This is a virtual event and replaced the former Trust Leadership Forum, which met physically until the pandemic.

Assessment of Board effectiveness

The Board undertakes an annual self-assessment of its effectiveness using the good practice questions from the NHS Providers "Compendium of Best Practice", and then agrees an action plan to drive through continuous improvements. For the coming year the Board has prioritised two areas for improvement: (1) ensure sufficient time is spent on each agenda item, and (2) increase stakeholder engagement with the Board.

Developing Workforce Safeguards

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

- Sufficient suitably qualified, competent, skilled and experienced staff are deployed to meet care and treatment needs safely and effectively.
- There is a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times.
- Our approach reflects current legislation and guidance.
- Meeting the National Quality Board's (NQB) requirements has helped NCH&C comply with the CQC's fundamental standards on staffing, for example, in the well-led framework and related legislation.

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

- NCH&C has formally embedded NQB's 2016 guidance in its safe staffing governance.
- NCH&C has ensured the three components of (1) evidence-based tools, (2) professional judgement, and (3) outcomes, are used in its safe staffing processes.
- NCH&C confirms that its staffing governance processes are safe and sustainable.
- NCH&C is fully compliant with the registration requirements of the Care Quality Commission.
- NCH&C has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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

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

Incident reporting and learning

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

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

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

Clinical audit

Clinical audit is a way to find out if healthcare being provided by the Trust is in line with standards and enables us as a provider, and our patients to know where their service is doing well, and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients. Clinical audits can look at care nationwide (national clinical audits) and local clinical audits can also be performed locally in Trusts wherever healthcare is provided. NCH&C has participated in both national and local clinical audits, and implemented the learning from these. The clinical audit programme was constrained by the impact of the pandemic and any risks arising from this were mitigated in other ways, as agreed by the Quality and Audit Committees.

Freedom to Speak Up

NCH&C Freedom to Speak Up guardians have a key role in helping to raise the profile of raising concerns in the Trust and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled. Nijck Bowman, learning disability nurse, was appointed as the Trust's Freedom to Speak Up Guardian. Guardians do not get involved in investigations or complaints, but help to facilitate the raising concerns process where needed, ensuring policies are followed correctly.

Freedom to Speak Up has:

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

Emergency Preparedness

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet in relation to EPRR. These are monitored via an annual assurance process, the results of which are submitted to NHS England.

Counter Fraud

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

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

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

Statement on the discharge of statutory functions

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

- Standing Orders.
- Standing Financial Instructions.

Scheme of Delegation and Reservation of Powers to the Board.

- Codes of Conduct.
- Board Committees' terms of reference.

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

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

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

The Board has exercised effective financial stewardship by assuring itself that the Trust is operating effectively, efficiently, economically and with probity in the use of resources. It has also ensured that financial reporting and internal control principles are applied, and appropriate relationships with the Trust's internal and external auditors are maintained. The Board sees financial stewardship as underpinning and facilitating the delivery of quality care. This includes a careful assessment and understanding of the quality and patient care consequences of financial decisions. The challenge of balancing effective financial stewardship and effective quality governance is a significant one for the Board operating in a financially constrained health and care system. The Board works with staff, patients and stakeholders to identify opportunities for reshaping services and improving quality of care which also delivers value for money.

Audit Committee

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

Audit

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

The following Internal Audits were planned for 2020/21:

- Mandatory Training
- Freedom to speak up
- Board Assurance Framework
- Performance Management Arrangements
- Complaints Handling
- Data Quality
- Estates Strategy & Capital Planning
- IT Strategy
- Staff Rostering & Rotas
- Research & Development
- Financial systems and processes
- Bank, Agency, & Locum Staffing
- Caldicott Guardians
- Responding to Opportunities & Partnership Working
- Data Security & Protection Toolkit
- Non-healthcare contracting

The tables below show the outcome of Internal Audits completed and notes audits that have been delayed.

		Number of risk rated recommendations			
Project	Overall assurance provided	High	Medium	Low	Improvement
Mandatory Training	Significant assurance with some improvement required	-	1	3	1
Freedom to Speak Up	Partial assurance with improvement required	-	3	3	2
Board Assurance Framework	Significant Assurance	-	-	-	-
Performance Management Arrangements	Significant assurance with some improvement required	-	2	5	2
Complaints Handling	Significant assurance with some improvement required	-	1	1	1
Data Quality	Significant assurance with some improvement required	-	-	3	3
Estates Strategy and Capital Planning	DELAYED UNTIL 2021/22	-	-	-	-
IT Strategy	Significant assurance with improvement required	-	-	8	-
Staff Rostering and Rotas	*TBC*	-	-	-	-

		Number of risk rated recommendations			
Project	Overall assurance provided	High	Medium	Low	Improvement
Research and Development	**TBC**	-	-	-	-
Financial Systems and Processes	Significant assurance with some improvement required	-	3	3	-
Bank, Agency and Locum Staffing	**TBC**	-	-	-	-
Caldicott Guardians	Significant assurance with some improvement required	-	1	1	-
Responding to Opportunities and Partnership Working	DELAYED UNTIL 2021/22				
Data Security and Protection Toolkit	**TBC**	-	-	-	-
Non Healthcare Contracting	**TBC**	-	-	-	-
Total		-	11	27	9

The Head of Internal Audit concluded that:

"Our overall opinion for the period 1 April 2020 to 31 March 2021 is that based on the scope of reviews undertaken and the sample tests completed during the period, Significant assurance with some improvement required can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The level of non-compliance in certain areas puts some system objectives at risk. We identified weaknesses which put system objectives at risk in relation to the Freedom to Speak Up Audit. Otherwise, there are only minor weaknesses in the risk management activities and controls designed to achieve the risk management objectives required by management. Those activities and controls that we examined were operating with sufficient effectiveness to provide reasonable assurance that the related risk management objectives were achieved during the period under review."

3.3.6 Information governance

There were no personal data related incidents that required reporting to the Information Commissioners Office/DHSC in the Data Security Incident Reporting Tool.

Data quality and governance

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

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

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

3.3.7 Review of effectiveness

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

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

- The Board reviewed the Board Assurance Framework quarterly, following monthly review by management and Board committees.
- The Board reviewed Trust performance against national and local clinical quality targets, as well as delivery against corporate and strategic objectives, at each Board meeting.
- The Board regularly reviewed Trust delivery against its annual priorities.
- The Audit Committee reviewed annual reports from the other Board committees, focusing on the process by which assurance was gained by these committees.
- Each Board Committee provided Annual Assurance Reports, setting out how they have discharged their delegated responsibilities in accordance with their terms of reference.
- Each Board Committee undertook their annual self-assessment of their performance and effectiveness, and identified areas for improvement, and their training needs.
- There is an effective clinical audit programme in place.

- The Accountable Officer has taken into account the views of the Caldicott Guardian and Senior Information Risk Owner.
- The Accountable Officer has taken into account the findings from the Internal Audit programme and the Head of Internal Audit Opinion.

Performance assessed by NHS regulators. As described in the Performance Summary section above, the CQC has rated the Trust as "Outstanding" following an inspection in June 2018 and NHSI has placed the Trust into segment two of the NHS Oversight Framework in October 2016. Neither the CQC nor NHSI have updated the ratings since these assessments.

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

Covid-19 pandemic response

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

- Emergency addendum to the Governance Manual agreed by the Board.
- Board adopted amended terms of reference to allow remote decision making and committee meetings through video conferencing by Board and committees.
- Business Continuity Assurance Committee established under NED chairmanship to temporarily replace the key functions of the Quality Committee and Finance and Performance Committee, between April and September 2020.

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

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

3.3.8 Conclusion

No significant internal control issues have been identified.

Governance Statement signature

Signed……

Chief Executive Date:

Norfolk Community Health and Care NHS Trust

4. Remuneration and Staff Report

This section includes:

4.1 Remuneration Report

4.2 Staff Report

4.1 Remuneration Report

This section includes:

4.1.1 Remuneration policy

4.1.2 Salaries and allowances

4.1.3 Fair pay disclosure

4.1.4 Pension benefits

4.1.5 Cash Equivalent Transfer Values

4.2 Staff Report

4.2.1 An analysis of staff numbers and costs

4.2.2 Staff composition

4.2.3 Expenditure on consultancy

4.2.4 Off-payroll engagements

4.2.5 Exit packages

4.2.6 Staff engagement

4.2.7 Quality improvement

4.2.8 Trade Union reporting requirements

4.2.9 Equal opportunities

4.2.10 Social, community and human rights

4.2.11 Employee consultation

4.2.12 Health and Safety

4.2.13 Sickness absence

4.1.1 Remuneration Policy

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

Remuneration for Executive Board members is determined by the Remuneration Committee. In the case of the Chief Executive, a spot salary applies which is calculated on the basis of the weighted population of the county through the Very Senior Managers national framework.

For the other Executive Directors' remuneration, the Trust applies the mandatory guidance given by NHS Employers through the Agenda for Change framework for directors holding employment contracts.

4.1.2 Salaries and allowances

The salaries and other allowances of the senior managers who have held office for all or part of the 2020/21 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.

Table 4.1 – Salaries and allowances of Board members in 2020/21.

		2020/21					
Name	Title	Salary (Bands of £5,000)	Expense Payments - Taxable (to nearest £100)	Performance Pay & Bonuses (Bands of £5,000)	Long-term Performance Pay & Bonuses (Bands of £5,000)	All Pension-Related Benefits (Bands of £2,500)	TOTAL (Bands of £5,000)
Lorna Bailey	Non-Executive Director	10-15	-	-	-	-	10-15
Geraldine Broderick	Chair	30-35	2	-	-	-	30-35
Laura Clear	Director of Community Health and Social Care Operations	115-120	-	-	-	37.5-40	155-160
Paul Cracknell*	Deputy Chief Executive (until 31st March 2021)	115-120	51	-	-	35-37.5	155-160
Steven Crowe	Non-Executive Director	10-15	-	-	-	-	10-15
Carolyn Fowler	Director of Nursing and Quality	110-115	-	-	-	87.5-90	180-185
Venu Harilal**	Medical Director / Consultant	130-135	1	0-5***	-	25-27.5	155-160
Andrew Hopkins	Director of Finance and Performance	120-125	-	-	-	37.5-40	160-165
Graham Nice	Non-Executive Director	10-15	-	-	-	-	10-15
Geoffrey Rivers	Non-Executive Director (until 30th April 2020)	0-5	-	-	-	-	0-5
Josephine Spencer	Chief Executive	155-160	1	-	-	0-2.5	155-160
John Webster	Deputy Chief Executive and Director of Strategy and Transformation (from 22nd March 2021)	0-5	-	-	-	45-47.5	45-50
Andrew Williams	Non-Executive Director	10-15	-	-	-	-	10-15
Njoki Yaxley	Non-Executive Director	10-15	-	-	-	-	10-15

Factors determining the variation in the values recorded between individuals include but is not limited to a change in role with a resulting change in pay and impact on pension benefits.

*Paul Cracknell's taxable benefit is in relation to a salary sacrifice car provided by the Trust.

**Dr Harilal's remuneration includes both a Clinical and Medical Director role; the salary is split 40% for the Clinical role and 60% for the Medical Director role.

***Dr Harilal's performance and pay bonuses relate to a Clinical Excellence Award as part of his clinical role.

A '-' indicates nil.

Table 4.2 – Salaries and allowances of Board members in 2019/20.

Name	Title	2019/20					
		Salary (Bands of £5,000)	Expense Payments - Taxable (to nearest £100)	Performance Pay & Bonuses (Bands of £5,000)	Long-term Performance Pay & Bonuses (Bands of £5,000)	All Pension-Related Benefits (Bands of £2,500)	TOTAL (Bands of £5,000)
Lorna Bailey	Non-Executive Director	5-10	-	-	-	-	5-10
Geraldine Broderick	Chair	30-35	3	-	-	-	30-35
Laura Clear****	Director of Community Health and Social Care Operations	110-115	1	-	-	100-102.5	210-215
Paul Cracknell	Deputy Chief Executive	110-115	57	-	-	32.5-35	150-155
Steven Crowe	Non-Executive Director	0-5	-	-	-	-	0-5
Carolyn Fowler***	Director of Nursing and Quality (from 02/09/2019)	60-65	-	-	-	157.5-160	220-225
Venu Harilal*	Medical Director / Consultant	125-130	-	0-5**	-	30-32.5	155-160
Andrew Hopkins	Director of Finance and Performance	120-125	-	-	-	15-17.5	135-140
John Kennedy	Non-Executive Director	0-5	-	-	-	-	0-5
Anna Morgan	Director of Nursing and Quality (until 31/07/2019)	35-40	-	-	-	30-32.5	65-70
Graham Nice	Non-Executive Director	5-10	1	-	-	-	5-10
Heather Peck	Non-Executive Director	5-10	1	-	-	-	5-10
Geoffrey Rivers	Non-Executive Director	5-10	-	-	-	-	5-10
Josephine Spencer	Chief Executive	150-155	3	-	-	27.5-30	180-185
Andrew Williams	Non-Executive Director	5-10	1	-	-	-	5-10
Njoki Yaxley	Non-Executive Director	0-5	-	-	-	-	0-5

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

**Dr Harilal's performance and pay bonuses relate to a Clinical Excellence Award as part of his clinical role.

*** The increase in pension related benefits for Carolyn Fowler is due to a recalculation of her historically accumulated final salary pension benefits following her appointment as Director of Nursing and Quality.

**** The increase in pension related benefits for Laura Clear is due to a recalculation of her historically accumulated final salary pension benefits following her appointment as Director of Community Health and Social Care Operations.

A '-' indicates nil.

4.1.3 Fair pay disclosure

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

The banded remuneration of the highest paid director in the organisation in the financial year 2020/21 was £155k-£160k (2019/20, £150k-£155k). This was 5.7 times (2019/20, 5.6) the median remuneration of the workforce, which was £27,416 (£27,260 in 2019/20).

In 2020/21, no employees (no employees in 2019/20) received whole time equivalent remuneration in excess of the highest paid director. Remuneration ranged from £8,115 to £156,597 (2019/20 £7,626 to £151,929).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

4.1.4 Pension benefits

Past and present employees are covered by the provisions of the two NHS Pension Schemes, the 1995/2008 Scheme and the 2015 Scheme. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the Government Financial Reporting Manual 2020/21 (the FReM) requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability at 31 March 2021 is based on valuation data at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme

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

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

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

Table 4.3 - Pension benefits of executive members of the Board in 2020/21.

2020/21		Real increase during the reporting year in pension at pension age (bands of £2,500)	Real increase during the reporting year in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2020 (to nearest £1,000)	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021 (to nearest £1,000)
Name	Title	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Laura Clear	Director of Community Health & Social Care Operations	0-2.5	5-7.5	45-50	135-140	963	62	1,059
Paul Cracknell*	Deputy Chief Executive	2.5-5	0-2.5	25-30	40-45	356	22	400
Carolyn Fowler	Director of Nursing and Quality	2.5-5	10-12.5	40-45	130-135	902	95	1,029
Venu Harilal	Medical Director	0-2.5	0-2.5	40-45	35-40	571	26	625
Andrew Hopkins	Director of Finance and Performance	2.5-5	0-2.5	50-55	120-125	982	45	1,067
John Webster**	Deputy Chief Executive and Director of Strategy and Transformation	0-2.5	0-2.5	30-35	65-70	591	1	635
Josie Spencer***	Chief Executive	0-2.5	0-2.5	70-75	190-195	1,524	-	1,550

Paul Cracknell left the trust on 31st March 2021

**John Webster joined the trust on 22nd March 2021 on a twelve-month secondment from the Norfolk & Waveney Clinical Commissioning Group.

***Josie Spencer left the NHS Pension Scheme wef 17.09.19 and as such there is no real increase in Cash Equivalent Transfer Value.

A '-' indicates nil.

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement. (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design.). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed.

Table 4.4 - Pension benefits of executive members of the Board in 2019/20

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

* The increase in pension related benefits for Carolyn Fowler is due to a recalculation of her historically accumulated final salary pension benefits following her appointment as Director of Nursing and Quality.

**The period between Anna Morgan's departure and Carolyn Fowler's arrival was covered by the Deputy Director of Quality.

A '-' indicates nil.

4.1.5 Cash Equivalent Transfer Values

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

Real Increase in CETV

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

4.2.1 Analysis of staff numbers and costs

The following tables and narrative below are subject to audit.

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

Table 4.5 - Number of senior management by pay band at 31 March 2021

Band	Headcount
Band 8A	66
Band 8B	38
Band 8C	12
Band 8D	7
Band 9	3
VSM	2

Table 4.6 - Number of senior management by pay band at 31 March 2021

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

Table 4.7 - Staff (whole time equivalent) numbers

Staff Numbers	2020-21			2019-20		
	Total	Permanent	Other	Total	Permanent	Other
Medical and dental	20	17	2	24	24	0
Ambulance staff	0	0	0	0	0	0
Administration and estates	446	408	38	437	426	11
Healthcare assistant and other support staff	641	538	103	688	639	49
Nursing, midwifery and health visiting staff	613	600	13	618	586	32
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	333	324	9	316	310	6
Healthcare science staff	6	6	0	4	4	0
Social care staff	0	0	0	1	1	0
Agency and contract staff	0	0	0	0	0	0
Bank staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
Total	2,058	1,893	165	2,088	1,990	98

Table 4.8 - Employee benefits in 2020/21

2020-21	Total £000	Permanently Employed total £000	Other total £000
Salaries and wages	69,633	66,082	3,551
Social security costs	6,471	6,149	321
Apprenticeship levy	334	334	0
Pension cost - employer contributions to NHS pension scheme	9,160	8,705	455
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	4,003	3,756	247
Pension cost - other	35	35	0
Other post employment benefits	0	0	0
Other employment benefits	84	84	0
Termination benefits	461	461	0
Temporary staff - external bank	0	0	0
Temporary staff - agency/contract staff	1,327	0	1,327
TOTAL STAFF COSTS	**91,508**	**85,607**	**5,901**
Included within:			
Employee Costs Capitalised	373	373	0
Operating expenditure analysed as:			
Gross Employee Benefits excluding Capitalised costs	**91,135**	**85,607**	**5,901**

Table 4.9 - Employee benefits in 2019/20

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

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

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

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

4.2.2 Staff composition

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

Table 4.10 - Staff numbers by gender as at 31 March 2021.

Category	Female	Male	Total
Directors (Voting)	5	5	10
Non-voting directors and other VSMs	0	1	1
Other Staff	1,999	348	2,347
Total	2,004	354	2,358

The staff turnover figures for NCH&C are available through NHS Digital's NHS Workforce Statistics, available on their website:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

4.2.3 Expenditure on consultancy

Expenditure on consultancy services is shown in the accounts Note 4.1 Operating Expenses. The expenditure in 2020/21 was £146k (£110k in 2019/20).

4.2.4 Off-payroll engagements

Table 4.11 - Existing off-payroll payments as of 31 March 2021, for more than £245 per day and that last longer than six months.

Engagements	Number
Number of existing engagements as of 31 March 2021	-
Of which, the number that have existed:	
for less than one year at the time of reporting	-
for between one and two years at the time of reporting	-
for between two and three years at the time of reporting	-
for between three and four years at the time of reporting	-
for four years or more at the time of reporting	-

There was one new off-payroll engagement during the year as demonstrated in table 4.12 below. Any new off-payroll engagements are subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of staff, and where necessary that assurance is sought, with the process being overseen by the Remuneration Committee.

Table 4.12 - All off-payroll engagements between 1 April 2020 and 31 March 2021, for more than £245 per day.

Engagements	Number
No. of temporary off-payroll workers engaged between 1 April 2020 and 31 March 2021	1
Of which...	
No. not subject to off-payroll legislation	-
No. subject to off-payroll legislation and determined as in-scope of IR35	-
No. subject to off-payroll legislation and determined as out of scope of IR35	1
No. of engagements reassessed for consistency / assurance	-
purposes during the year	-
No. of engagements that saw a change to IR35 status	
following review	

Table 4.13 - Any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021.

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

4.2.5 Exit packages

The following tables and narrative below are subject to audit.

Table 4.14 - Exit packages agreed in 2020/21.

Exit package cost band (including any special payment element)	Number of compulsory redundancies Accounts 31 Mar 2021 2020/21	Cost of compulsory redundancies Accounts 31 Mar 2021 2020/21	Number of other departures agreed Accounts 31 Mar 2021 2020/21	Cost of other departures agreed Accounts 31 Mar 2021 2020/21	Total number of exit packages Accounts 31 Mar 2021 2020/21	Total cost of exit packages Accounts 31 Mar 2021 2020/21	Number of departures where special payments have been made Accounts 31 Mar 2021 2020/21	Cost of special payment element included in exit packages Accounts 31 Mar 2021 2020/21
<£10,000	1	3,198			1	3,198		
£10,000 - £25,000								
£25,001 - £50,000	1	38,509			1	38,509		
£50,001 - £100,000	3	218,371			3	218,371		
£100,001 - £150,000	1	118,835			1	118,835		
£150,001 - £200,000								
>£200,000								
Total	6	378,913	-	-	6	378,913	-	-

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

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

4.2.6 Staff Engagement

A new Staff Engagement Strategy was agreed at Board which sets out the following framework.

The Staff Engagement Framework has been devised to guide our leaders, setting out:

- what each staff engagement theme entails,
- tools and resources which can be utilised and
- the desired outcomes and those measures to be monitored.

It is expected that local teams will use this framework when developing their local staff engagement plans. This framework seeks to establish clear guidance, yet give our leaders autonomy, 'freedom within a framework' to implement evidence-based practice to improve staff engagement and through that improve patient care. The Organisational Development Strategy for 2019/22 continued to be implemented.

Direction

The PCN structure is now established within the organisation and a series of workshops with the executive team, senior leaders and key stakeholders have been undertaken to design, agree and communicate future direction and establish organisational culture going forwards.

Digitalisation

The effective adoption of technology to improve patient care and the working lives of staff, has seen a step change improvement as a result of the pandemic, where there has been a rapid investment in, and roll out of, technology to support remote working and remote patient treatment and monitoring. As a result, many of the initial plans within the strategy, such as Increasing the capability and capacity of staff to utilise the benefits of new technology, have already been achieved. Work is commencing with digital services to evaluate the success and learning from this rapid roll out, to ensure that the benefits are captured and maintained, providing further patient and staff choice in the future. This will also link into future engagement activity where we will evaluate the impact of digital communications such as "Ask the CEO" and "Our Community Live" as effective means of wider organisational engagement tools across a disparate geography. To date these have been positive and successful, and we would want to build on this experience further.

Development

Ensuring staff and leaders have the skills required to thrive in the future, that new roles support our workforce plan and that services themselves adapt to the changing environment and needs of patients has been a challenging prospect at times, during the pandemic. During the peak of the pandemic, work has focussed on providing support, guidance and reassurance to managers as part of the wider H&WB work, particularly in the provision of focussed "bitesize" videos for line managers. Some developmental activity needed to be put on hold to ensure that clinical staff were able to focus 100% on supporting patients and ensuring that operational services were always appropriately staffed.

An area of new development has been the Trust's involvement in supporting 'KickStart'. This is a government scheme which provides funding to employers to create job placements for 16 to 24-year olds on Universal Credit. It became apparent during the pandemic that there are tasks in operational areas that do not need to be done by a clinician, but that are vital for the smooth running of clinical services. Working with clinicians the Trust designed a job role that met the criteria for the scheme and have gained approval from the Department of Work and Pensions to recruit. In return the Trust can provide these young people with excellent work experience, support with job applications and interview training and future career opportunities through the Trust's apprenticeship programmes. The aim is to commence with a small number to pilot in one area and to then grow the scheme if it is successful.

Diversity

The pandemic has brought into sharp focus, issues around health inequality and patient and employee experience, particularly around issues of race. Work is happening at an organisational level, Integrated Care System level and at a regional and national level to support this and the challenge then becomes to ensure that we remained focused on the issues that relate to our local community.

The Trust has established a BAME network and will look to agree a programme of work with them to help us address some of the issues identified in our WRES data, as well as to meet our 'model employer' goals. The Trust is well represented on ICS and regional workstreams to help shape work going forwards as part of restoration.

Delegation

As previously described, the focus of the work to date has been with senior Trust managers to ensure that the steps, processes and understanding is in place to support the Trust's earned autonomy approach. The issue of autonomy comes further into focus as the Trust looks towards restoration and recovery, with reference to the work Michael West has been undertaking nationally around the 'ABC of core work needs' (Autonomy, Belonging, Contribution).

4.2.7 Quality Improvement

The Trust's Quality Account describes in detail how NCH&C has continually improved quality throughout the year. In summary, staff are trained in a range of models including lean and six sigma, agile management, process reengineering, and theory of constraints. Where appropriate NCH&C seek process accreditation and recognition of its Quality Management Systems and Industry Best Standards eg our IT service Desk has Service Desk Institute accreditation.

The model most commonly used within NCH&C is PDSA: Plan, Do, Study, Act cycles and our approach to innovation is supported by skills programmes e.g. our Quality Champions Programme (QCP) and by skilled individuals e.g. lean methodology facilitators, various project management methods and approaches to encourage new ways of thinking.

The Trust continues to progress the Quality Champions Programme (QCP) and over the past year we have continued where possible to complete the programme ensuring we continue to increase the organisational skills and knowledge associated to quality improvement activities.

QI objectives for the coming year include:

- Learn from the major incident and sustain and implement improved ways of working including the use of technology e.g. self care or focus on 'Home first'.
- Develop our safety culture to ensure it is everybody's business and for Places/ SSOCs to implement safety initiatives such as our Safer Staffing Review and local accreditation (ward and community).
- Explore additional methods as well as continue our approach to quality improvement and innovation.
- Increase patient and carer involvement in service redesign and develop shared decision making.

Learning from Covid-19

One of the biggest opportunities to improve quality this last year has come from reflecting on the positives of how we have had to adapt to different ways of working due to social distancing. As part of the restructure towards the local teams (Places and SSOCs) workshops were conducted to learn from the positive behaviours of Covid-19. Popular behaviours were flexibility, innovation and resilience and a number of good examples given. The use of MS Teams for the workshops aided good attendance for all, a patient story at Board showed how a Speech and Language Therapist aided a patient to swallow and learn to eat again over a video call, working now with Clinical leads has reduced unallocated daily visits.

Due to Covid-19 a number of the initiatives mentioned in last year's report have been delayed yet are still a priority as services open up such as the Quality Champions Programme, formal Leadership Development courses, and Talent Management which were stalled twice. A great deal of this has now moved online which has helped attendance and an evaluation of this regarding leadership development states that staff like the blended approach to learning as it aids different learning styles. Whilst formal leadership development was stalled, other forms of leadership development continued such as 90 minutes leadership coaching sessions for groups of leaders, weekly bitesize learning lasting from 10 -20 minutes explaining processes to help leaders in a timely manner and relating directly to the skill, knowledge or behaviour to help at that stage of the incident and including some excellent leaders interviews giving insights into leadership during the pandemic. To help potential and current leaders there has now been a Leadership Road Map developed relating to self-learn as well as formal courses.

Specific short programmes were given to support leaders from external suppliers virtually and helped with both reaction to Covid-19 and the move to the new PCN structures. Courses were also accessed from Norfolk and Waveney Health Care Partnership to support leaders in managing the psychological states of individuals and teams.

Coaching has continued to grow as a way to support our leaders at all levels through these volatile and ambiguous times and prepare them for the uncertainty. In short learning, leadership and coaching has not stopped completely it has just had to happen quite differently much of which has been adapted quickly in order not to impact on learners' needs.

Mandatory Training has moved online from the previous Mandy Tori and staff are to be asked regarding their views on this process to help plan for the future. Induction moved from 4 days to 1 day and then to virtual, initial evaluations still show good feedback from the receivers of this training, the managers are to be evaluated too as we move out of restrictions and plan the way forward.

4.2.8 Trade Union Reporting Requirements

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

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

The data is captured using an interactive database managed through the HR Operations function. At the end of the financial year HR Operations collate the final position and upload the information into the government portal each July. The information is then also published on the Trust's internet page. At the time of authoring this report the final extraction of data from the database has yet to be completed due to the last inputs from trade union colleagues.

4.2.9 Equal opportunities

NCH&C's approach to equal opportunities is set out in the Equality, Diversity and Inclusion Policy and the trust's Equality and Diversity objectives. As an NHS trust we have legal duties with which we must comply. These relate to individuals who receive care from us or work for us. Very simply this means that people cannot be treated less favourably because of, for example, their race, age, gender, disability, religion or sexual orientation. We use a process used across the NHS called the Equality Delivery Scheme 2 to help us fulfil our duties. The work is led for the Equality, Diversity & Inclusion Steering Group and overseen by the Board of Directors. The Board is committed to improving equal opportunities and equality performance by NCH&C, making it embedded in mainstream business and for all staff to meet the evidential requirements of the Equality Act, especially the public sector equality duty, and the statutory duty to consult and involve patients and communities and other local interests (Health and Social Care Act 2012 and Equality Act 2010). NCH&C has published five Equality Objectives:

- Ensure we provide a positive patient experience for all patients, regardless of their identity and protected characteristics
- Ensure that NHS is a fair and inclusive employer of choice
- Improve the awareness and understanding of our staff of the different identities of staff and patients, and the protected characteristics
- Provide support to our services to actively engage in the quality and diversity workstream to recognise and meet our patient's diverse needs
- Ensure NCH&C is working towards meeting the requirements of the anticipatory duty to make reasonable adjustments on public function in the Equality Act

The Board reaffirmed its commitment to Equality, Diversity and Inclusion, and approved a revised statement during the year. This action plan is available on NCH&C's website. The Trust also met its obligations to report on the gender pay gap, and compliance with the workforce disability equality standard and the workforce race equality standard during the pandemic to meet the revised reporting schedules.

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

NCH&C monitors its workforce and where employees identify as having a disability or long-term condition as set out in the Equality Act 2010, are supported to determine and implement reasonable adjustments to support the individual at work. NCH&C also carries out fair and equitable access to recruitment. This means that where an applicant indicates they have a disability or long-term condition as set out in the Equality Act 2010 reasonable adjustments are put in place to support the applicant. Equality and Diversity training forms part of NCH&C's induction programme and it's mandatory training programme.

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

BME Category	NCH&C (%)	2011 Census Norfolk (%)
Non-BME	84.9%	96.3%
BME	4.5%	4.0%
Not Stated/ Undefined	10.6%	0.0%

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

Status	Headcount
No	81.7%
Yes	5.7%
Not Declared	12.6%

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

Religious Belief	NCH&C (%)	2011 Census Norfolk (%)
Atheism	19.2%	29.6%
Buddhism	0.3%	0.3%
Christianity	40.6%	61.0%
Hinduism	0.4%	0.3%
Islam	0.1%	0.6%
Jainism	0.0%	-
Judaism	0.0%	0.1%
Sikhism	0.0%	0.1%
Other	8.8%	0.5%
I do not wish to disclose my religion/ belief	29.8%	7.6%
Undefined	0.8%	

The table below provide data on the age profile of staff

Age Profile	16 - 20	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 - 50	51 - 55	56 - 60	61 - 65	66 - 70	71+
NCH&C Staff Profile	1.7%	7.1%	10.3%	12.0%	10.5%	10.1%	13.1%	15.6%	12.8%	5.4%	1.1%	0.3%
2011 Census Norfolk (%)	7.1%	7.3%	6.9%	6.4%	7.0%	8.2%	8.5%	7.6%	7.4%	8.4%	7.4%	17.6%

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

Sexual Orientation	Total	NCH&C %
Heterosexual or Straight	1688	71.6%
Gay or Lesbian	42	1.8%
Bisexual	33	1.4%
Undecided	2	0.1%
Not stated (person asked but declined to provide a response)	566	24.0%
Undefined	23	1.0%
Other sexual orientation not listed	4	0.2%

4.2.10 Social, community and human rights issues

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

Positive obligations - The Human Rights Act means that all health organisations have an obligation to ensure that people's rights are respected in all that they do. Our approach is based on the principles of Quality, Proportionality and Involvement.

Quality - A human rights-based approach can improve the quality of health services and prevent service failure.

Proportionality - Any restriction of a person's human rights should be kept to a minimum.

Involvement - The involvement of service users is an essential part of a human rights-based approach based on Fairness, Respect, Equality, Dignity and Autonomy.

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

NCH&C has carried out a range of equality analysis and human rights screening when carrying out their duties to ensure NCH&C is paying 'due regard' to the three aims of the Public Sector Equality Duty and the Human Rights Act. NCH&C is an advocate of the Equality Diversity System 2 self-assessment tool. The EDS2 self-assessment was completed with the involvement of representatives from the local public sector, NHS Employers, and voluntary sector organisations. The Board approved the self-assessment and implemented an action plan in response this assessment which is available on our website.

4.2.11 Employee consultation

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

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

- Early Supported Discharge (ESD) Suffolk Consultation of Staff Transfer
- Priscilla Bacon Lodge Rowan Day Unit: A proposal to change the days of operation in line with service transformation
- Support Services – PCN Phase 3
- Review of Priscilla Bacon Lodge Staff Working Patterns Consultation
- Relocation of Staff working in Benjamin Court Unit to alternative bases within the North Locality
- Central Sterilisation Service Department (CSSD) Consultation of Staff Transfer
- Pathways Service Consultation of Staff Transfer
- City Reach Health Service Consultation of Staff Transfer
- Children's Nursing Consultation
- PCN Operational & Clinical Management Structure Consultation
- Review of Alder Ward Staff Working Patterns Consultation
- Special Care Dentistry Service Consultation of Staff Transfer.
- The Future of the Communication Development Worker Post Service Review Consultation
- Weekly "Ask the CEO" online events.

4.2.12 Health and safety

NCH&C recognises the importance of clear and comprehensive health and safety documentation to guide and support staff. The Trust's Health and Safety policy sets out: how health and safety is managed, identifies those with specific health and safety responsibilities, and identifies the policies and procedures which must be followed. Health and Safety training forms part of NCH&C's induction programme and its mandatory training programme which for this year has been through e-learning. Mandatory training is for every 3 years. Health and Safety mandatory training compliance was achieved for the year.

4.2.13 Sickness absence

The 12-month sickness absence rate for the year is 4.75%, compared to 4.91% for the previous year. This sickness figure is based on NCH&C's internal reporting systems and cover the period 1st April 2020 to 31st March 2021. The sickness figures provided in the table below are based on information published by the Department of Health, which NCH&C is required to publish. This information is based on NCH&C's data, but is subject to Department of Health analysis, and covers the period 1st January 2020 to 31st December 2021.

During 2020/21, the impact of the Covid-19 pandemic has had a direct impact on the Trust workforce in terms of absence. As well as direct sickness absence attributed to the virus itself, staff absence has also come in the forms of staff having to follow the national shielding guidance, being forced to self-isolate due to their own or other household member symptoms and there has also been carer/dependant absences through other enforced changes coming from national lockdowns (e.g. school closures).

When the Trust analyses sickness absence specifically, and does so by looking at this year under the impact of a pandemic, compared to the previous year, there have been some key observations. The 12-month rate of sickness absence dropped across the last year, dropping from 4.96% in Mar'20 to 4.75% in Mar'21. This has been directly impacted by then national decision that removed some people who were on a long-term period of sickness absence, and were, where eligibility dictated, instead re-categorised as 'shielding'. The sickness absence reason of 'Cold/Cough/Flu' replaced 'Gastrointestinal Problems' as the reason for the highest number of sickness absence instances in the previous 12-month period, rising from 370 instances in Mar'20 to 809 in Mar'21, an increase of 118%. Meanwhile, the 'number of days lost' to sickness absence saw 'Cold/Cough/Flu' decrease on the previous year from 3,369 days (12 months to Mar'20) to 1,297 days in Mar'21, although 'Chest/Respiratory Problems' saw significant increase from 2,194 days to 8,172 days in the same period increase of 272%, again, a direct impact of the Covid-19 virus. It is expected that 2021/22 will see the potential impacts of Long Covid on the Trust workforce.

The sickness rates to March 2021 have yet to be published on the NHS Digital website therefore unavailable for this report. It is anticipated these won't be published for a few more months.

5. Parliamentary Accountability and Audit Report

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

Accountability Report signature

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

Accountable Officer's signature

Signed:…….. Date……

Josephine Spencer
Chief Executive
Norfolk Community Health and Care NHS Trust

Independent Auditor's Report to the Board of Directors of Norfolk Community Health and Care NHS Trust

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FINANCIAL STATEMENTS

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