Norfolk and Suffolk NHS
NHS Foundation Trust

Annual report and accounts

April 2012 to March 2013

your wellbeing in mind

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Presented to Parliament pursuant
to Schedule 7, paragraph 25(4) of
the National Health Service Act 2006

Contents

From the Chair

This will be my last annual report as I finish my term as Chair of the Trust at the end of the financial year. During my ten years here, we have grown in size, from covering most of Norfolk and a bit of Suffolk, to all of Suffolk and Norfolk. We have changed our name twice and worked under two very different governments, a variety of financial and governance regimes, and an assortment of commissioners.

These are extraordinary times, and it's easy to adopt a position of doom and gloom. However I do believe this Trust is as well placed as any to survive and thrive. The merger makes us stronger and safer, and our success and reputation in gaining contracts supports us in remaining sustainable as an organisation.

The Trust service strategy has been controversial, and I would never pretend it will be easy to implement or that everyone will agree with all aspects of it. But we are not doing anything different from other trusts. What we have done is make sure our plans were led by clinicians, that we tested them robustly with service users, carers, and our community stakeholders, and above all that we have been open and honest about what we are planning. I think we have a way forward that will keep our services safe, and protect as many jobs as we possibly can.

One of the features has been the role of the clinical leads in the development of the plans, and particularly the emergence of new clinical leadership in Suffolk.

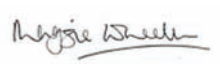
Our external relationships this year have been tested, and we have worked hard with our emerging Clinical Commissioning Groups, and strengthened our partnerships with the voluntary and community sector.

Our Board of Governors has benefitted from our new Suffolk colleagues, and both experienced and new Governors have embraced the new roles given to them by the Health Act to hold Non-Executive Directors to account. The requirement to hold meetings in public has not presented any problems to us as we have always – unusually for a Foundation Trust – held some of ours publicly.

The Board of Directors has been stable this year, and it has been great to have Debbie White working as Director of Operations in Suffolk. We were pleased to welcome Jane Marshall-Robb as a non-voting Director of Workforce and Occupational Development having joined the Trust originally to oversee the workforce during the merger.

Gary Page joined the Board as a Non-Executive Director in 2012 and I am delighted he is succeeding me as Chair. Gary shares my values, and brings a fresh perspective which will serve the Trust well as we move into an ever more competitive environment.

It has been a privilege to Chair the Trust for the last 10 years, and I am confident it will go from strength to strength.



Maggie Wheeler
Chair

Chief Executive's report

The past year has been very challenging for everyone working in and with the Trust. It has also been one of the most significant and important we have had. The concentration of the Trust and its partners on developing and consulting on our new service strategy has at times seemed all-consuming. This is not surprising given the need for us to ensure the Trust and its service are fit to face the challenges ahead, and to take proper account of the potential impact on staff and public interest in the plans.

It is a huge tribute to staff and our partners that all the evidence shows we have maintained our service quality. In fact, services have improved in many areas for the benefit of our service users and their families and carers despite the organisational changes we have dealt with.

During the year the Trust continued to evolve following the merger of Norfolk and Waveney Mental Health NHS Foundation Trust with Suffolk Mental Health Partnership NHS Trust to become Norfolk and Suffolk NHS Foundation Trust. This, in itself, would be enough for most organisations to deal with, and it led to significant change to staff in the corporate functions of the Trust. But even more importantly perhaps we have also seen some major developments and improvements in patient care that we hoped to achieve through the merger.

Our state of the art dementia unit at Hammerton Court is now operating successfully alongside the dementia intensive support teams, which have had a demonstrable impact on admissions, enabling more people to remain at home safely in familiar surroundings.

The opening of new inpatient facilities for children with mental health problems was also achieved in year so that for the first time these children and their families can receive services locally.

We launched new wellbeing and psychological therapy services in Suffolk working with key partners to provide a very exciting new accessible and more comprehensive service, after a successful contract bid.

The Trust also learnt that it had been successful in winning the contract for substance misuse services in Norfolk which again involved the Trust working closely with key partners to improve access and with a new service philosophy. This new contract commenced in April 2013, but all the preparation and the successful bid took place in 2012-13.

A number of teams in the Trust received recognition for their quality of care from external bodies, including the crisis resolution team in Central Norfolk which was the first community service to achieve AIMS accreditation from the Royal College of Psychiatrists. Lark ward at Woodlands in Ipswich has won the team of the year award from the National Association of Psychiatric Intensive Care and low secure units.

During the year the Trust's reputation for research was also enhanced as we moved into the top 12 Trusts in the Country for research studies.

We must also recognise the many hundreds of smaller but often important improvements introduced by staff in individual teams in individual services, including therapeutic groups, end of life care workshops, Hearing Voices conferences, a children and adolescent's website, and Releasing Time to Care initiatives. We are also extremely fortunate within our Trust to be so well supported by service user and carer representatives, and volunteers who do so much unsung work in communities and in wards.

All of this took place while many clinical staff, managers, service user and carer representatives were working on the planning and public consultation around our service strategy. Whilst we must recognise the degree of anxiety and concern raised as a result of the

consultation I also think it is very important to realise that the strategy has already generated a huge degree of excitement around the introduction of a Recovery model and culture across the Trust from service users, partners and staff. In February, following endorsement of the service strategy by commissioners and other stakeholders, the Trust launched its new Access and Assessment Services as one of the first elements of our new strategy.

In many ways 2012-13 has been a phenomenally successful year while at the same time a very challenging one for many of us. We look forward to 2013-14 with the hope of continuing this degree of success and making positive improvements for patients and carers, and concentrating on how we support staff to cope with the planned changes and develop new services.

I cannot end without paying tribute to Maggie Wheeler who is retiring as Trust Chair after many years - including an extension to assist with the transition period of the merger. Maggie has been a great example to me and, I know, to many others in the Trust. She deserves a rest but I know she has no intention of taking one, and I am very pleased that amongst other things Maggie will be taking over the Chair of the Norfolk and Suffolk Dementia Alliance of which the Trust is a partner.

Thank you to everyone who has played a part this year - whether that included improving and developing new services, maintaining the quality of existing services, or contributing to the planning and debate over the new service strategy.

We continue to look forward to the year ahead.

Aidan Thomas
Chief Executive

About the Trust

Norfolk and Suffolk NHS Foundation Trust provides mental health, substance misuse and learning disability services across Norfolk and Suffolk. The Trust believes in recovery and wellbeing, and understands the importance of good physical health, maintaining relationships and achieving a balance between treatment and continuing an active life.

Service users and carers are at the centre of all aspects of the Trust's work, and are vital in helping shape and support our service strategy. Our strategy supports and enables people with mental health problems, or who need to improve their wellbeing, to live a fulfilling life, and to help their personal recovery journeys.

Through the provision and co-ordination of high quality, excellent and cost-effective services, with a commitment to research and innovation, the Trust will be recognised as a national leader. Known by the local community to provide excellent advice, care and treatment in a friendly, flexible and timely manner the Trust will be an expert in mental health whole life care and wellbeing.

Our services

The Trust has inpatient facilities across both counties with smaller bases in rural locations. Many of the Trust's services are offered in the community, enabling service users to receive the support they need in an environment familiar to them.

The Trust provides a wide range of health and social care services specialising in mental health care, including:

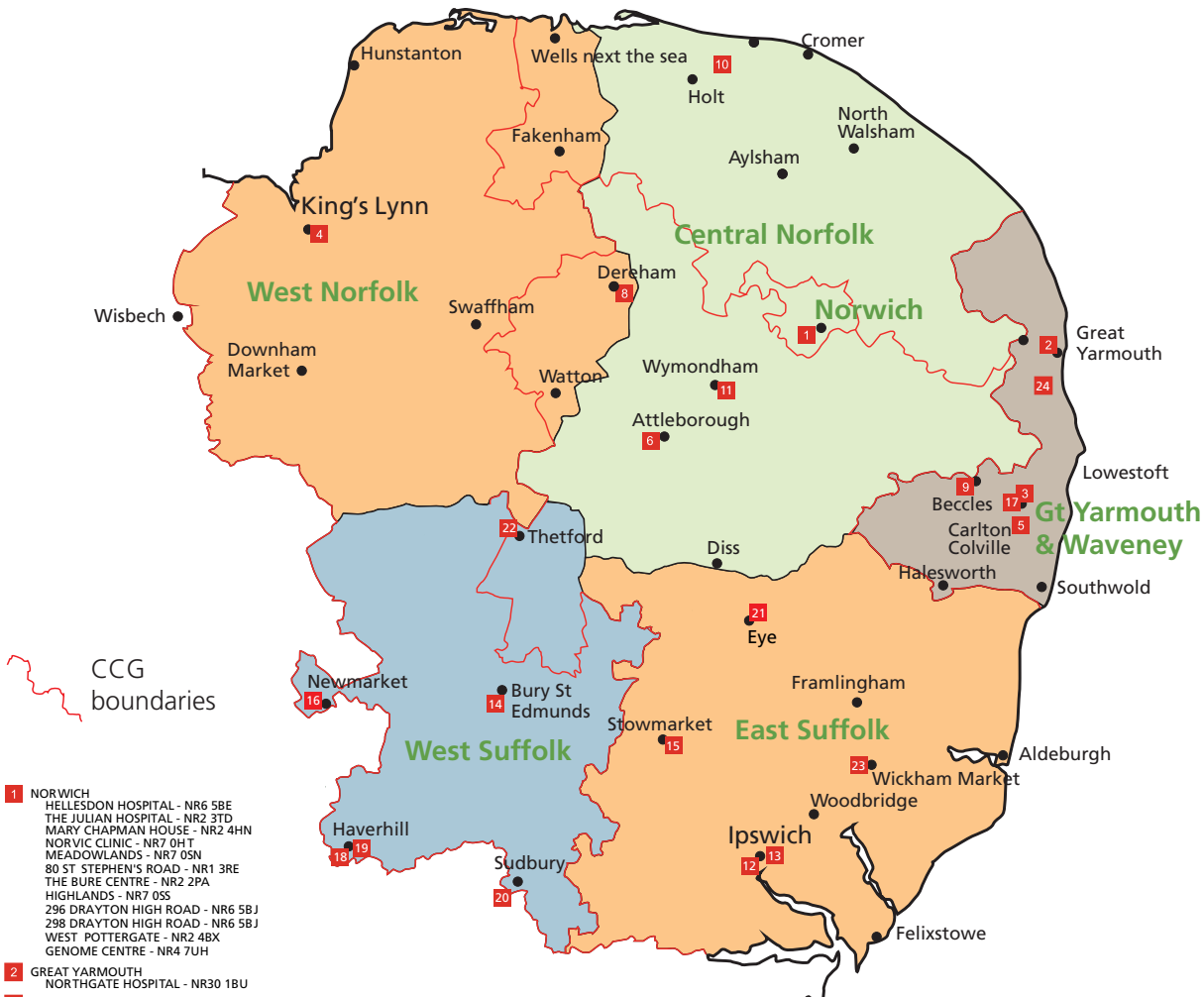
- Child and adolescent mental health service
- Early intervention in psychosis
- Community mental health service
- Working age adult services, including crisis resolution, recovery teams and assertive outreach
- Inpatient services
- Older people's services
- Trust drugs and alcohol service
- Learning disability services
- Community eating disorder service
- Wellbeing services and improving access to psychological therapies

For more information on these services, where they are based and how to access them, please visit our website www.nsft.nhs.uk

Our history

Norfolk and Waveney Mental Health NHS Foundation Trust and the Suffolk Mental Health Partnership NHS Trust came together on 1 January 2012 to become Norfolk and Suffolk NHS Foundation Trust. The merger has brought together the best aspects of services in Norfolk, Suffolk, Great Yarmouth and Waveney.

As a combined organisation the quality, number and accessibility of services can increase, creating a more efficient and effective organisation.



1 NORWICH
HELLESDON HOSPITAL - NR6 5BE
THE JULIAN HOSPITAL - NR2 3TD
MARY CHAPMAN HOUSE - NR2 4HN
NORVIC CLINIC - NR7 0HT
MEADOWLANDS - NR7 0SN
80 ST STEPHEN'S ROAD - NR1 3RE
THE BURE CENTRE - NR2 2PA
HIGHLANDS - NR7 0SS
296 DRAYTON HIGH ROAD - NR6 5BJ
298 DRAYTON HIGH ROAD - NR6 5BJ
WEST POTTERGATE - NR2 4BX
GENOME CENTRE - NR4 7UH

2 GREAT YARMOUTH
NORTHGATE HOSPITAL - NR30 1BU

3 LOWESTOFT
VICTORIA HOUSE - NR32 1PL
MERIDIAN HOUSE - NR32 1PL
TENNYSON CENTRE - NR32 1PT
NORTH WING - NR32 1PT
BARLEY WAY - NR33 7NH
KIRKLEY CLIFF - NR33 0DF

4 KING'S LYNN
CHATTERTON HOUSE - PE30 5PD
FERMOY UNIT - PE30 0WF

5 CARLTON COLVILLE
CARLTON COURT - NR33 8AG

6 ATTLEBOROUGH
BICKLEY DAY HOSPITAL - NR17 2QE

8 DEREHAM
SPRINGWELL - NR19 1DL
SIGNPOST HOUSE - NR20 3TL

9 BECCLES
DENCORA HOUSE - NR33 0BY

10 KELLING
SIMPSON CENTRE - NR25 6QA

11 WYMONDHAM
GATEWAY HOUSE - NR18 0WF

12 IPSWICH
ST CLEMENTS HOSPITAL - IP3 8LS
MARINER HOUSE - IP1 2DG
IVRY LODGE - IP1 3QW
IVRY HOUSE - IP1 3TF
TROTMAN COURT - IP4 1BN
WOODLANDS - IP4 5PD
WALKER CLOSE - IP3 8LY
ECCLES ROAD - IP2 2RF
CHILTON LODGE - IP3 8LT
CHILTON RISE - IP3 8LT
564 FOXHALL ROAD IP3 8LT
566 FOXHALL ROAD IP3 8LT

13 KESGRAVE
GRANGE LODGE - IP5 1JF

14 BURY ST EDMUNDS
BLOMFIELD HOUSE - IP33 1HE
CHILD DEVELOPMENT CENTRE - IP33 3ND
CHILD HEALTH CENTRE - IP33 3ND
WEDGWOOD UNIT - IP33 2QZ
50 BARONS ROAD - IP33 2JW
HOSPITAL ROAD SITE - IP33 3NR

15 STOWMARKET
VIOLET HILL DAY HOSPITAL - IP14 1JS
IPSWICH STREET - IP14 1BB
OLD FOX YARD IP14 1AB

16 NEWMARKET
SAGE CENTRE - CB8 7JG

17 LOTHINGLAND
AIREY CLOSE - NR32 3AX
ALLINGTON SMITH CLOSE - NR32 3AX

18 HAVERHILL
HAVERHILL HEALTH CLINIC - CB9 8HF
KEEBLES YARD - CB9 9DZ

19 KEDINGTON
ST OURMEAD CLOSE - CB9 7PA
MILL ROAD - CB9 7NW

20 SUDBURY
ST LEONARDS HOSPITAL - CO10 2RQ

21 EYE
HARTISMERE HOSPITAL - IP23 7BH

22 THETFORD
THETFORD HEALTHY LIVING CENTRE - IP24 1JD

23 WICKHAM MARKET
RIVERSIDE - IP13 0TA

24 GORLESTON
STEPPING OUT - NR31 7QB

Financial review

This part of the Directors' Report provides a review of the financial performance for the year ending 31 March 2013. The Trust has experienced a significant year of change with the bedding down of the corporate and support restructuring whilst developing the Trust's Service Strategy, that provides a blueprint for the future style and approach of mental health and learning disability services and forms the largest part of the Trust's savings plans. This is in response to the increasing pressures on finances from the austerity measures being applied across public services and the need to generate 20% savings by 2016.

This year has been the first full year of operation for the merged Norfolk and Suffolk NHS Foundation Trust, although the 2011-12 accounts were treated as if the two organisations had always been a single organisation.

The Trust has experienced a turbulent year as regards financial performance. The Trust has maintained its financial risk rating (FRR) of '3' throughout the year, but has been closer to falling below this threshold than at any time in its history. The Trust's original financial plan aimed for a financial risk rating of '4', but the delays in agreeing and implementing the Trust's Service Strategy (TSS) has meant savings plans were only 68% achieved in the year, hence the actual FRR of '3'. The Trust agreed a revised financial plan with Monitor (the independent regulator for Foundation Trusts) for the final six months of the year and has met this plan.

The Trust has reported a deficit of £3.1m in the Statement of Comprehensive Income (previously known as the Income and Expenditure Account). This is after allowing for exceptional items including creation of a provision for future TSS redundancy costs (£4.8m), the costs of change and restructuring associated with the merger (£3.1m) and impairment of property valuations (£1.5m). These are included in the operating expenses, but are "one-off" in nature and therefore tend to mask the underlying performance. The Trust received an "Investment Adjustment" from Monitor of £2.9m in recognition of the exceptional nature of the merger costs. This is not a cash figure, but allows the Trust to adjust its FRR to take account of such costs.

This section includes information relating to cash management, efficiency savings, capital programme, income generation and the financial outlook for the Trust. More information on 2012-13 can be found in the full set of annual accounts that are included in the second half of this report.

The Trust's accounts have been prepared in accordance with directions given by Monitor, the independent regulator for Foundation Trusts. They are also prepared to comply with International Financial Reporting Standards (IFRS) and are designed to present a true and fair view of the Trust's financial activities.

Going concern

The Foundation Trust's accounts have been prepared on a 'going concern' basis. This means that the Trust expects to operate into the future and that the balance sheet (assets and liabilities) reflects the on-going nature of the Trust's activities.

After making enquiries, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Comparison with 2011/12

The Annual Report and Accounts show comparative information with the combined accounts of the two organisations' 2011-12 financial year. This should help give readers an understanding of the financial performance and impact of any significant issues on the merged Trust's financial position.

Summary of financial performance

As at 31 March 2013, the Trust had delivered the following performance:

- Surplus of £1.3m before exceptional items (this adjusts the deficit of £3.1m identified above by the Investment Adjustment and the impairments).
- Financial risk rating of '3' which maintains the merged Trust's performance at a satisfactory level.
- A cash balance of £19.4m at 31 March 2013, which is a reduction on the previous year's performance (£20.1m), and reflects the outlay on the merger costs of change and underperformance on the delivery of the cost improvement programme.

This performance leaves the Trust well placed to achieve its corporate objectives for 2013-14, and demonstrates substantial progress against its longer-term business plan.

The Trust's total income fell by £1.6m between 2011-12 and 2012-13 resulting in a total turnover for the year of £219.4m. This movement on income is explained in the following table:

The NHS financial settlement for 2012-13 resulted in a 1.8% reduction (the deflation adjustment) on health care services contracts. In 2013-14 the reduction will be 1.3%.

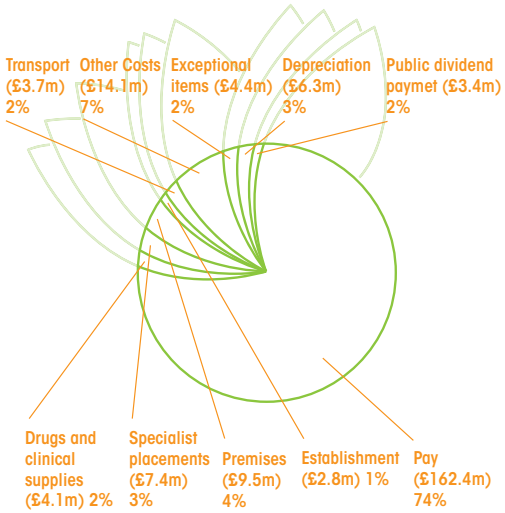
The Trust commenced the delivery of the new Wellbeing Service in Suffolk in July 2012, which was won via a competitive tendering process. The Trust has also been successful in its bid to provide substance misuse services (known as the Norfolk Recovery Partnership or NRP) across Norfolk and commenced this new service in April 2013.

The Trust with the support of NHS Norfolk and Waveney has introduced a Children's Intensive Support Team to support the CAMHS inpatient development and to enable children to be looked after at home and prevent excessive admissions to a hospital bed. NHS Suffolk has invested £0.3m in Dementia Intensive Support Teams with more to follow in 2013-14 building on NHS Norfolk and Waveney development the year before. The Trust also secured transformation funding to support the development and implementation of the TSS.

The Trust's Corporate and Support Services, particularly estates and facilities and Information Communications and Technology (ICT) provide services to a number of other organisations, including NHS Suffolk, Suffolk Community Services and East Coast Community Services.

Analysis of Changes in Turnover	**£m**
2011-12 Turnover	221.0
Income reductions (national requirement) of 1.8%	-3.1
Suffolk Wellbeing Service development	1.7
Suffolk Dementia Intensive Support Team development	0.3
Norfolk and Waveney Children's Intensive Support Team development	0.4
Waveney specialist placements transfer	0.4
Additional drug and alcohol misuse service funding	0.5
Transformation Funding supporting costs of change	1.5
Reduction in Support Services provision to external bodies	-3.9
R&D	-0.5
Other income changes	1.1
2012-13 Turnover	**219.4**

Total income £219.4m



Total costs £218.1m

This income was significantly reduced during the year as new arrangements were put in place, some as part of the internal restructuring of the Trust following the merger and others due to changes in these contracting organisations' requirements.

Research and Development funding fell by £0.5m in the year, but the Trust is taking part in more research than ever before and has carried forward income to the next year, where studies have been later starting than planned, or where there are on-going commitments in the new financial year.

The Trust's principal sources of income are from contracts for the provision of mental healthcare services to NHS Norfolk and Waveney and NHS Suffolk Primary Care Trusts, and secure services (both medium and low secure) for all primary care trusts in Norfolk, Suffolk and Cambridgeshire. These commissioners provided £188m (£189m in 2011-12) or 86% of turnover in 2012-13 (86% in 2011-12). In addition a further £11m was earned from the provision of social care services across Norfolk and Suffolk and for substance misuse services in Norfolk and alcohol services in Suffolk.

The most significant costs faced by the Trust during the year were those affecting pay. Whilst the pay award in 2012-13 only applied to staff earning less than £21,000 per year, a significant cost pressure continues to exist from the annual incremental progression through pay scales (circa 2% increase) that forms part of the national terms and conditions of the Agenda for Change pay system. There was no pay award for Directors or medical staff in 2012-13. The chart below demonstrates that pay accounts for 74% of total costs (excluding the exceptional charges would increase this percentage to 76%), which shows that mental health is very much a people based service. Staff, wherever they work will always represent the most significant, important and valuable resource that the Trust has.

The Trust has seen a large increase in temporary pay costs, including medical locums and bank and agency staff (both qualified and unqualified). A total of £14.7m was spent on temporary staff. This is mainly because the Trust was maintaining vacancies in advance of the TSS implementation in order to redeploy as many staff as possible and reduce the numbers of redundancies. There are also certain areas of the Trust where it is harder to recruit and temporary staffing is necessary to maintain safe staffing levels.

The significant areas of non-pay spend other than those relating to capital charges (depreciation and dividends), include drugs, specialist mental health placements and support service costs, such as catering and domestic services. In the chart exceptional items are shown as £4.4m which includes merger related costs of change and impairment of property valuation costs. The Trust has also included provisions for redundancies in respect of both the implementation of the TSS in 2013-14 and the implementation of the Norfolk Recovery Partnership service (alcohol and drugs misuse service following the award of this contract during 2012-13. The total provision across these services is £5.3m and these are included in other costs.

The Trust has implemented a single corporate structure across the merged organisation which was agreed by Directors following a consultation with affected staff in both predecessor organisations. This new structure has seen over 100 whole time

equivalent (WTE) staff leave the organisation since 1 January 2012. The Trust has spent £3.1m on the costs of change of the merger which relates to a combination of redundancy payments for staff, programme management and "double running" costs pending moves to one system/process. The merger programme is now complete

The Trust had a £13.7m Cost Improvement Plan (CIP) requirement in 2012-13, which was only 68% achieved and this explains the reduced financial performance from plan and compared to previous years. Within these figures the Trust over-delivered on the savings it planned from the merger and corporate restructuring (£4.3m actual compared to £3.6m plan), but delays in the Trust Service Strategy meant that this programme was £5m behind plan, with implementation only getting underway in mid-February 2013. This shortfall in CIP will need to be found in 2013-14 and plans are already in place to achieve this.

Financial risk rating

The financial risk rating represents a combined rating against some of the key financial performance measures (or metrics) contained within the financial statements. The metrics achieved by the Trust in its year-end reporting to Monitor are as follows:

- An Earnings before Interest, Taxation, Depreciation and Amortisation (EBITDA) margin of 5.4%.
- Proportion of budget achieved of 70%
- An income and expenditure surplus of 0.6%.
- A return on assets of 0.9%.
- A liquidity ratio of 10.54 days.

The overall rating is 3. These metrics are calculated after Monitor applied the Investment Adjustment to recognise the one off costs of change. Whilst this has been a robust performance, the reduction in liquidity means that the Trust has less resources for capital expenditure over the next year. The reduction in liquidity is a consequence of incurring the costs of change on the merger.

Private patient income

All foundation trusts are set a private patient cap that limits the level of private patient income that may be generated within a particular financial year. The Trust is able to generate up to 1.5% of its income from private patients. The Trust has not undertaken any private patient work during 2012-13.

Capital structure, expenditure and investments

The Trust's capital structure largely reflects the structure of the previous two pre-merger organisations. The Treasury has historically provided capital finance in the form of public dividend capital. As a result, the Trust is required to pay the Treasury dividends relating to that capital in September and March each year. These dividends amounted to £3.425m in 2012-13. The dividends are based on 3.5% of the average value of net relevant assets during the financial year and are essentially agreed with the Treasury at the start of the financial year and then adjusted later in the year based on the final Statement of Position, and as such a creditor or debtor may exist at year end between the Treasury and the Foundation Trust.

The Trust also has reserves relating to income and expenditure surpluses and asset revaluations resulting from the impact of valuations undertaken by professionally qualified valuers. The total of the Trust's public dividend capital and reserves is equivalent to the taxpayer's equity in the Trust.

The Foundation Trust has limited access to new public dividend capital as it is expected to finance capital expenditure from internally generated sources (i.e. from surplus and depreciation charges) or to agree an interest-bearing loan with either the Foundation Trust Financing Facility (FTFF) or a commercial lender. Foundation trusts have a prudential borrowing limit set by Monitor, the independent regulator for foundation trusts. This limit is designed to ensure that the Trust is able to operate with a degree of independence, while at the same time not putting services at risk.

The Trust's prudential borrowing limit is set as follows:

- Maximum cumulative long term borrowing £28.0m; and
- Approved working capital facility of up to (but not to exceed) £16.4m.

The Trust agreed a £4.72m loan from the FTFF loan to help fund the construction of Justin Gardner House, Hellesdon Hospital. This loan is repayable by instalments by September 2028, and interest is charged at a fixed rate of 3.87%.

A further facility of £5.2m was obtained from the FTFF to help fund Hammerton Court, Julian Hospital (the Dementia Intensive Care Unit) in Norfolk, of which the final £4.0m was drawn down in 2011-12. This loan is repayable by instalments by June 2030, and interest is charged at a fixed rate of 3.18%.

In Suffolk an £8m loan was agreed with the Department of Health in September 2010 to help finance the development of the Heath Road site in Ipswich, Foxhall House low secure unit and the adult wards at the Wedgewood Unit in Bury St Edmunds. This loan is repayable by instalments by September 2025, and interest is charged at a fixed rate of 2.74%.

The outstanding balance on the loans was £15.3m as at 31 March 2013.

The table below summarises the Trust's capital expenditure in the period:

The £7.56m represents just over 75% of the planned capital expenditure for the year. The most significant projects undertaken during the year concerned the refurbishment and redevelopment of the Wedgewood Unit in Bury St Edmunds. This included work to improve both adult and older people's ward accommodation and treatment areas as well as improving office accommodation.

The programme also saw the final completion of Hammerton Court Dementia Intensive Care Unit, which opened in March 2012.

The Trust's Information, Communications and Technology strategy has been further developed to support the integration of the two Trusts and improve the quality of service provision. The ultimate aim is to provide clinicians and other staff with a range of tools and services that will enable greater flexible working, easier access to information and greater productivity of service delivery leading to enhanced patient experience. The spend included the development of software to support the Trust's new Access and Treatment Service in Norfolk that will be rolled out across the Trust in 2013-14.

The capital programme for 2013-14 will be very much focussed around supporting the implementation of the Trust's Service Strategy, including the development of new bases, disposal of surplus assets and the continuing development of the Information, Communications and Technology strategy. Further work will also be undertaken to address any safety and risk management concerns such as ligature points or security improvements.

Capital Schemes for the Year ended 31 March 2013	**£m**
	0.201
Hammerton Court completion, Julian Hospital, Norwich	2.632
Wedgwood Unit Refurbishment, Bury St Edmunds	2.576
Information, Communication and Technology (ICT)	0.701
Statutory compliance including health and safety, fire safety, disability discrimination	0.441
Development of new CAMHS Tier 4 Unit, Lothingland	0.273
Minsmere House car park (Ipswich Hospital)	0.736
Other projects (£0.15 million or less)	
Total	**7.56**

Included in the above is £0.2m in for patient safety and quality improvements across the Trust.

Private Finance Initiative (PFI)

The Trust currently provides services from one location – the Wedgewood Unit on the West Suffolk Hospital site in Bury St Edmunds – that was originally developed as a Private Finance Initiative. This unit was opened in May 2002 and provides mental health inpatient services.

Liquidity and cash management

An NHS Foundation Trust has to ensure robust arrangements for managing cash. The Trust experienced a significant pressure on liquidity this year from a combination of reduced CIP performance, merger costs of change and delays in the sale of surplus assets all of which reduced the cash available to the Trust for capital investment. This led to tight management of the capital programme and a reduced spend in year in order to maintain a reasonable liquidity level.

The Trust negotiated an increase in its working capital facility (i.e. overdraft arrangement) with Barclays Bank (with approval from Monitor) from £14.9 to £16.4m to reflect 30-day operating expenditure of the merged Trust. The Trust has not needed to use this facility to date. As part of this arrangement the Trust has access to a higher interest account with Barclays which helps offset the fee for maintaining the working capital facility.

The Trust has traditionally earned interest on overnight balances on its bank account, but from November 2008 changed its practice so that any surplus operating cash is invested in financial instruments, which ensure adequate safety (the risk to invested capital is minimised), liquidity (investments can be released quickly) and generate a competitive return.

The Trust has been extremely mindful of the crisis affecting the financial and banking sectors over the past few years and has an agreement with Royal London Cash Management Ltd (RLCM) to manage its surplus cash. RLCM is a subsidiary of the Royal London Mutual Insurance Society Limited and manages £4bn of cash for clients including UK universities, charities, associations and other foundation trusts. Funds placed with RLCM are invested in certificates of deposit issued by major UK and International clearing banks with an adequate risk rating. The level of risk rating agreed with RLCM is better than that recommended by Monitor. Further information can be found at Note 30 to the accounts.

A committee of the Board of Directors, the Investment Committee, monitors the amount and performance of the cash managed by RLCM. In total the Trust earned £0.140m during the year, which is less than that earned in 2011-12, due to diminishing returns in financial markets as well as the pressures on the Trust's cash flow. However, interest earned through these arrangements was more than double that which would have been earned if cash were simply held in the main bank account.

The Foundation Trust is also able to make financial investments through a variety of other means, including joint ventures and subsidiary companies. However, the Trust has so far not made any investments in this respect.

Auditor's Renumeration

The Trust's external auditor for the period covered by this Annual Report was KPMG. KPMG has undertaken non audit work in 2012/13 in relation to VAT and pensions advice with fees totalling £73k. The Audit Committee is satisfied that the independence and objectivity of the work of the Trust's external auditor is safeguarded.

Post balance sheet events

The Board of Directors confirm that there are no post balance sheet events applicable to the 2012-13 financial year.

Charitable funds

The Foundation Trust also administers the Norfolk and Waveney Mental Health NHS Foundation Trust Charitable Fund (Charity Number: 1050441) and the Suffolk Mental Health Partnership NHS Trust Charitable Fund (Charity Number – 1103563). These funds have resulted from fundraising activities and donations received over many years. These funds are used for the benefit of both patients

and staff in accordance with the purpose for which the funds were either raised or donated. Such uses include equipment for wards, training for staff and Christmas entertainment. The funds are administered by the Trust's Finance Department. The funds are overseen by the Charitable Funds Committee, which is chaired by a Non-Executive Director of the Trust, and includes representatives from the Board of Governors and the Board of Directors.

The financial activities of the charitable funds for 2012-13 are contained within the 2012-13 Annual Report and Accounts for the Funds Held on Trust, and a copy of these documents may be requested for free from the Director of Finance from January 2014 following submission to the Charities Commission.

Political and charitable donations

The Trust did not make any political or charitable donations from its exchequer funds in 2012-13.

Financial outlook

The financial outlook remains very turbulent. Norfolk and Suffolk NHS Foundation Trust (NSFT) faces a major challenge over the next few years and more. A combination of the reducing funding settlements in the NHS, tariff deflation and growing demand mean that it will not be possible to maintain the current range and types of service in the near future. It is quite simply the most financially challenging environment that the Trust has witnessed.

The Trust is experiencing additional pressures on its services as financial hardship impacts on people's wellbeing and ability to keep good mental health and they turn to help from public services. The large elderly populations in Norfolk and Suffolk continue to grow and more and more people are being diagnosed with dementia. This presents a huge challenge for health and social care services and highlights yet more evidence for the TSS and the need to transform services and meet this growing demand.

The financial impact of the Trust will require savings of 20% or £32m over four years with a £12m requirement in Suffolk and £20m requirement in Norfolk. These levels of savings cannot be met by simple efficiency schemes – significant effort has gone into finding these savings over the past 10 years or so, but what is required now dwarfs these efforts. The sustained reduction in resources can only be met by the radical steps to change pathways and approaches to treatment in order to be able to meet both financial constraints as well as increasing demand. Beyond this time period, there is considerable concern that this figure will be further increased as part of the austerity measures governing public sector finances.

This is precisely the intention of the TSS, which has been born out of the Radical Pathway Redesign programme that was described in last year's Annual Report. This strategy fits with the NHS Chief Executive's view that the NHS needs a radical change in pathways to thrive and survive over the next few years. This programme will impact right across the Trust's range of services as well as having an impact on the size of the corporate functions and the way in which they operate. The TSS has focussed on the "care pathways" i.e. the journey that a service user takes through our service (assessment, care, treatments etc.). Such a programme requires an enormous level of engagement and participation from clinicians, staff, service users and carers as well as needing engagement with commissioners and other service partners.

We have seen one of the most significant shake-ups in structures in the NHS's history over the past year with the abolition of Primary Care Trusts (PCTs) and Strategic Health Authorities and their replacement with GP-led Clinical Commissioning Groups (CCGs) and the National Commissioning Board. The Trust now contracts with seven CCGs rather than two PCTs, and operational service management and service change is subject to a more complicated commissioning environment.

It is generally acknowledged that year on year reductions in an organisation's income (as proposed by the NHS Operating Framework) pose a severe risk to the viability and sustainability of the services of that organisation. We believe the TSS is vital to both ensuring the on-going viability of the Trust and in ensuring strong, safe and

responsive mental health services for the people of Norfolk and Suffolk.

The TSS is clinically-led. It has been developed by clinicians over a longer than planned period of time in order to get the right solutions. The Trust has deliberately held back from making savings in year to allow the TSS to develop and be clinically signed up to, including with external partners and commissioners. The Strategy has been subject to significant review by the Health Overview and Scrutiny Committees in Norfolk and Suffolk.

The Trust's workforce is clearly subject to significant change through the implementation of the Service Strategy. Staff represent the greatest asset of the Trust and account for 76% of current costs and many staff will be at risk of redundancy, or uncertain of their future. Staff morale is therefore likely to be affected during the times of change, which can impact on the quality of patient care and the Trust is working with Unions and staff to try and mitigate these consequences. Redundancy is a last resort and the Trust will seek to redeploy displaced staff wherever possible to minimise the trauma and costs of redundancy.

The Trust's financial risk rating was under great pressure in 2012-13 and without the implementation of the TSS, the rating would drop to below the accepted threshold.

The significant savings achieved from the merger have kept the Trust above this threshold in year, but the Trust is not stopping at these and a further £3m of savings is expected from corporate and support services in 2013-14.

The Board of Directors has agreed a plan for 2013-14 that maintains the Trust's financial position with a Financial Risk Rating of 3. This includes a planned surplus of just over £2m against an expected turnover of £210m. Turnover from NHS sources is expected to fall for three main reasons:

1 NHS contract income reduction of 1.3%.

2 Loss of income of £1.3m associated with the closure of 9 beds at the Meadowlands Low Secure Unit in Norwich.

3 Changes in specialist mental health commissioning means that the Trust no longer has the financial responsibility for out-of-trust placements for medium secure, low secure, CAMHS inpatient and CAMHS eating disorder services.

The financial plan for 2013-14 includes a cost improvement requirement of £15m or 7.5% of expenditure. Of this sum, £3m is expected from corporate and support services with the remainder found from the TSS and other service (i.e. outside the scope of TSS) changes.

Some of the key objectives for the Trust over the coming year will be as follows:

- Extend the Access and Assessment Service across the whole Trust. This service opened in Norfolk in February and is a key feature of the new service models in the TSS.

- Implement the new service models across adults, older adults and child and young people in line with the TSS.

- Continue the development of services for people with dementia in our communities, including the further roll-out of DIST services across Norfolk and Suffolk and introduce additional services in conjunction with our acute hospitals partners to provide better services for older people with dementia who are in acute hospitals.

- Commence the Norfolk Recovery Partnership working with our partners The Matthew Project and RAPT (Rehabilitation for Addicted Prisoners) to provide treatment and recovery services for people in Norfolk affected by drug and alcohol issues. This service increases the Trust's turnover by around £3m.

- Continue the Trust's programme for improving ward and patient care environments paying particular attention to patient safety and risk management.

- Develop new technical and estate solutions to support the new models of care proposed across Norfolk and Suffolk.

The Trust anticipates having to make similar levels of savings over the next few years. This level of savings will clearly place considerable

pressure on service delivery and Clinicians, managers and the Trust's Service Strategy Programme Team actively review the service changes and how savings can be achieved whilst maintaining quality. The Trust has developed a safety and quality dashboard to help with this monitoring.

Clinical Commissioning Groups (CCGs) have recognised these safety issues and are working closely with the Trust to help identify and manage any such issues. As part of this, the CCGs have agreed transformation funding of £1m to help maintain quality and safety during the change process.

The Directors of the Trust recognise that the current economic times will be very difficult, but firmly believe that the merged Trust is well placed to meet the financial and service challenges of the next few years and will strive to continue to provide and develop high quality and safe services and produce sound financial results.

Statement of Disclosure

As far as the Directors are aware, there is no relevant audit information of which the auditors are unaware.

The Directors have taken all of the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

NSFT
Staff Awards Night
2012.

Quality Account

Measuring and improving quality standards

2012-13 Statement Of Directors' Responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2012 to May 2013;
  - Papers relating to Quality reported to the Board over the period April 2012 to May 2013;
  - Feedback from the commissioners dated 2/5/2013 and 3/5/2013;
  - Feedback from governors dated 21/5/2013;
  - Feedback from local Healthwatch organisations dated 2/5/2013 and 10/5/2013;
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/5/2013;
  - The 2012 national patient survey July 2012;
  - The 2012 national staff survey October 2012;
  - The Head of Internal Audit's annual opinion over the trust's control environment dated 10/5/2013.

Care Quality Commission quality and risk profiles dated 31/3/2013;

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275).

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

By order of the Board

Date: 28 / 05 / 2013 Acting Chair 

Date: 28 / 05 / 2013 Acting Accounting Officer 

Independent Auditor's Report to the Board of Governors of Norfolk and Suffolk NHS Foundation Trust on the Quality Report

We have been engaged by the Board of Governors of Norfolk & Suffolk NHS Foundation Trust to perform an independent assurance engagement in respect of Norfolk and Suffolk NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 100% enhanced Care Programme Approach (CPA) patients receive follow up contact within seven days of discharge from hospital
- Admissions to inpatient services had access to crisis resolution home treatment teams

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with those documents listed below:

- Board minutes for the period April 2012 to 28 May 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to 28 May 2013;
- Feedback from the Commissioners dated May 2013;
- Feedback from the Governors dated May 2013;
- Feedback from local Healthwatch organisations dated 1 May 2013;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 15 April 2013;
- The 2012/13 national patient survey;
- The 2012/13 national staff survey;
- Care Quality Commission quality and risk profiles dated April 2013;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 10 May 2013;

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Governors of Norfolk & Suffolk NHS Foundation Trust as a body, to assist the Board

of Governors in reporting Norfolk & Suffolk NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and Norfolk & Suffolk NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report.
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

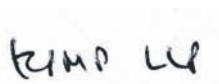
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Norfolk and Suffolk NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual.*



KPMG LLP, Statutory Auditor
Ipswich
28 May 2013

Statement from the Chief Executive

Norfolk and Suffolk NHS Foundation Trust (NSFT) formed over a year ago, and in this time we have worked hard to strengthen the quality of our services and improve on our high standards. By doing this we are now better positioned to address the structural and financial challenges facing the NHS. In October 2012 the Trust launched a Service Strategy, which sets out our proposals for redesigning many of our services. It is our response to the need for a more flexible individual response to the needs of service users, and financial pressures faced by NHS trusts across the country with a requirement to reduce costs by 5% each year for four years.

Our biggest priority in regard to the Service Strategy is maintaining patient safety and service quality. This is consistent with the Francis Report. Detailed plans have been developed which include clear quality goals, and we have a system in place to ensure that any changes are rigorously managed and monitored and we can ensure we make the right changes at the right time and in the right place.

Our clinical leaders have done an incredible amount of work engaging service users, carers, the third sector and staff in our plans, which were developed over a two year period.

The quality goals for our redesigns are focused on wellbeing and recovery, i.e. keeping people well and avoiding ill-health, and helping people regain control over their lives. We will be developing more services in the community, while providing high quality inpatient care for those with a clinical need for it.

There are also many changes in the wider NHS with the move from Primary Care Trusts to GP-led commissioning in April 2013. We look forward to working with our seven Clinical Commissioning Groups across Norfolk and Suffolk to ensure that there are first-rate services available to the people that need them most in each locality.

Improving the quality of our services continues to be at the forefront of everything our staff do.

Statement of accuracy

I confirm that to the best of my knowledge, the information contained in this document is accurate.

Andrew Hopkins
Acting Accounting Officer

Information about the quality account

The purpose of the quality account is to ensure that NHS organisations can demonstrate that they make improving quality a high priority. The quality account is a way in which the Board of Directors demonstrates that it takes seriously its responsibilities for promoting, monitoring and leading on quality.

Each year the quality account identifies a number of quality priorities which have been identified in consultation with stakeholders.

This year a survey was undertaken to enable as many people to respond to the consultation as possible. This survey was disseminated to service areas, Local Involvement Networks (LINks) and external organizations representing the diversity of the population. The survey was also available on the Trust website.

The feedback received from the survey was then collated and a draft list of proposed priorities presented to the Board of Directors to choose the final priorities for 2013-14.

Looking forward to 2013-14

Trust quality priorities 2013-2014

The Board of Directors agreed in February 2013 that the quality priorities for 2013-14 should be:

Patient safety
To implement a system which ensures that all patients in contact with mental health services access relevant physical healthcare screening and services.

Patient experience
All crisis/care plans will identify how to contact a mental health worker out of hours and what the Crisis Resolution & Home Treatment Team (CRHT) may be able to provide. Develop a leaflet that gives contact numbers and describes the role of the CRHT.

All inpatient areas will have a programme of activities which will be available over seven days and include evenings.

Clinical effectiveness
The Trust is committed to delivery of effective and appropriate clinical interventions consistent with NICE and other professional guidance. To complement the Trust's ongoing audits of compliance, and in response to service user feedback, a new quality propriety has been agreed. When a new medication is prescribed, the prescriber should always discuss this with the service user first. Information leaflets should be given and this should be recorded in the service user's record.

These priorities will now be a focus for the Trust and an action plan put in place to ensure that the targets will be met. The Board of Directors will receive a quarterly update on progress. Updates for stakeholders will be produced in the Trust magazine.

Feedback on quality priorities 2012-13

The quality account published in 2012 identified five quality targets. This section demonstrates the progress that has been made in the past 12 months.

Patient safety

We will discuss and fully check the physical health of our service users as they arrive on an inpatient unit and again at least once a year to ensure they are able to be as physically fit and healthy as possible while they are with us.

The following table shows the progress made through the year:

Jul 2012	Oct 2012	Jan 2013	Mar 2013
80.61%	**86.96%**	**91.57%**	**100%**

For community service users, physical health checks remain the responsibility of a person's GP but their care co-ordinator will support and encourage them to ensure they receive an annual health check. This will be addressed in the new quality priority for 2013-14.

To ensure that the improved governance arrangements introduced in Suffolk over the last year are integrated into all aspects of operational services and used across the Trust.

The Trust now has a fully integrated governance team and all arrangements apply across the Trust. This is evidenced by the successful merger of all quality policies and the achievement of NHSLA* level one in

December 2012. The action plan which arose from the patient safety review in Suffolk has been completed.

* NHSLA is NHS Litigation Authority which is a special health authority set up to administer schemes under which NHS bodies can pool the costs of any liabilities to third parties and to "promote the highest possible standards of patient care and to minimize the suffering resulting from any adverse incidents which do nevertheless occur".

Patient experience

Where people require assessment and treatment in an inpatient unit, lengths of stay will be the minimum required to achieve the desired clinical outcomes.

During 2012 the Trust put in place a number of new initiatives including a bed management service and discharge facilitation team to work with service users who have complex needs. The team is able to undertake the necessary work with various agencies to facilitate discharge.

Although the length of stay reported has risen this may be due to two factors. The length of stay reported is based on the length of stay for the people discharged within that month. The rise in length of stay may therefore be due to the new discharge team concentrating on people who have been in hospital for the longest time. The other factor may reflect that the Trust aim to care for people in their own homes is ensuring that only the most seriously unwell people are admitted to hospital and are then requiring longer stays.

Jul 2012	Oct 2012	Jan 2013	Mar 2013
26.8	**30.37**	**37.66**	**36.23**

All service users under Care Programme Approach (CPA) will have a crisis plan agreed with their family/carers where appropriate, so that everyone is clear about actions to be taken in a crisis.

During 2012 a review of the CPA process took place and new paperwork was introduced in October 2012 which identified the crisis plan as a mandatory requirement.

An audit carried out in January identified that Norfolk had been slow to adopt the new paperwork but that compliance with the audit criteria is 78% Trust wide for community service users and 51% for in-patients. This difference in compliance identifies that it is not always appropriate to undertake crisis planning immediately after admission as the participation of the service user is essential and can be difficult to achieve during periods of acute illness.

Crisis plans are an important tool, enabling service users and carers to deal with difficulties and to know who to contact for help. Crisis plans remain a priority for 2013-14.

Clinical effectiveness

By developing and putting into place new care pathways based on clinical evidence, we will ensure that a range of psychological therapies will be available to all service users who need it.

New care pathways formed the basis of the service strategy for the Trust which aimed to redevelop services to achieve the required government cost savings. A comprehensive process was implemented to develop and consult on the pathways and this has led to the following:

- Clinical psychology provision within every service line.
- Youth, Acute and Adult services also have psychotherapy posts identified.
- Larger teams will ensure that there is increased flexibility enabling service users to access therapies provided by other teams.
- Job descriptions will be written to explicitly state the expectation that Psychotherapists and psychologists will provide some cross team and cross locality working where necessary for less common interventions.
- A further piece of work is required to support access to therapies which do not necessitate a full time member of staff but are required.

In addition to the service changes, the Trust has already improved access to a variety of therapies including mindfulness, Cognitive

Analytic Therapy (CAT) (CAT is a collaborative form of time limited therapy), Cognitive Behaviour Therapy (CBT) (CBT is a therapy that looks at the relationships between thoughts / emotions and behaviours), Eye movement desensitization and reprocessing (EMDR) (EMDR is a form of psychotherapy used for post traumatic stress disorder), and Neuro Linguistic Programming (NLP) (NLP is a psychotherapy which looks at language and personal development to achieve change).

It is important to note that the quality improvement targets identified in previous years continue to be reported to the Board of Directors until they are confident that practice is embedded as business as usual.

Mandatory statements

The wording in the following statements is required in the Department of Health regulations for producing quality accounts. We have tried to provide some explanation of the terms used in the key, but if you would like any further explanation please contact the Patient Advice and Liaison Service (PALS) on Freephone 0800 279 7257.

Review of services

During 2012-13 Norfolk and Suffolk Foundation Trust provided and/or subcontracted six NHS services: adult services, children's services, drug and alcohol services, Improving access to psychological therapies (IAPT), learning disability services, older people's services and non-NHS Norfolk and Waveney or NHS Suffolk contracts including forensic services. The Trust has reviewed all the data available on the quality of care in all of these services.

The income generated by the NHS services reviewed in 2012-13 represents 93 per cent of the total income generated from the provision of NHS services by the Trust for 2012-13.

The quality of care the Trust has provided has been reviewed in a number of ways. These may be formal data collections – for example, audits, surveys, complaints or informal feedback from service users and carers. However data is gathered, the Trust system of meetings will ensure that it is reported, and that action plans for improvement are put in place where needed.

During 2012-13, three national clinical audits and one *national confidential enquiry covered NHS services that the Trust delivered.

Data type	Lead	Reported to	Action
Audit	Audit lead	Audit and Risk committee	Action plan developed and implemented by relevant lead clinician. Where there is learning for other areas, the action plan is shared
Complaint	Complaints manager	Service governance sub-committee	Action plan developed and implemented by relevant manager. Where there is learning for other areas, the action plan is shared
Feedback	Non-executive directors	Modern matrons and ward managers.	Action plan developed to resolve any issues that arise.
Feedback	Head of Governance	Service governance sub committee	Mock CQC inspections carried out by clinicians, governors and partner agency representatives

During that period, Norfolk and Suffolk NHS Foundation Trust took part in 67% of the national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in during 2012-13.

* A national confidential enquiry is a nationwide review of clinical practice which when completed leads to recommendations for improvement.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2012-13 were:

- Depression and anxiety – national audit of psychological therapies
- Prescribing Observatory for Mental Health (POMH); prescribing topics in mental health services.
- National audit of schizophrenia
- National confidential enquiry into suicide and homicide by people with mental illness

The national clinical audits and national confidential enquiries that the Trust participated in during 2012-13 were:

- Depression and anxiety – national audit of psychological therapies
- National audit of schizophrenia
- National confidential enquiry into suicide and homicide by people with mental illness

Norfolk and Suffolk NHS Foundation Trust agreed not to complete POMH audits in order to direct clinical audit activity towards local priority audit projects.

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2012-13, are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Name	Completed and status	Number of cases and percentage of registered cases required
National clinical audits		
National audit of schizophrenia	Completed	Data collection was completed in 2011-12
National audit of psychological therapies (anxiety and depression)	Completed (report pending)	• Part 1 – contextual one-off questionnaire about Trust service. • Part 2 – therapists' questionnaire • Cases identified 192 • Cases submitted 110 • Part 3 – retrospective audit of case notes – automatic data extraction via the Trust's electronic patient case management information system (PC- MIS) • Cases submitted 4593 • Part 4 – Service user satisfaction survey – Surveys sent out 2816 Surveys returned 720 (26%)
National confidential enquiries		
National confidential enquiry into suicide and homicide by people with mental illness	Continuous audit	

The reports of two national clinical audits carried out by Norfolk and Suffolk NHS Foundation Trust were reviewed in 2012/13 and the Trust intends to take the following actions or has taken action to improve the quality of healthcare provided:

* BME stands for black and minority ethnic communities

Audit	Actions
National audit of psychological therapies	An action plan will be developed when the 2012-13 report is available Progress against last year's action plans; Suffolk services: - Updated their assessment forms to improve reporting on ethnicity - Services engaged with local BME* and refugee services to promote access to the service amongst young males and BME communities - Recovery training for staff to assist in reaching a primary diagnosis at initial assessment Norfolk services: - Improved collecting data on the gender of referrals - Produced leaflets aimed at promoting the service to older people - Developed the use of feedback from stress control classes to increase the use of patient experience outcomes in the delivery of care.
National audit of psychological therapies	An action plan will be developed when the 2012-13 report is available Progress against last year's action plans; Suffolk services: - Updated their assessment forms to improve reporting on ethnicity - Services engaged with local BME and refugee services to promote access to the service amongst young males and BME communities - Recovery training for staff to assist in reaching a primary diagnosis at initial assessment Norfolk services: - Improved data collection on the gender of referrals - Produced leaflets aimed at promoting the service to older people - Developed the use of feedback from stress control classes to increase the use of patient experience outcomes in the delivery of care.
National audit of Schizophrenia	The Trust agreed to prioritise recommendations related to Standard 4 Physical Health because of the importance of this area to service user wellbeing. Agreed actions: - Develop a system between primary and secondary care that would support service users to attend appointments for physical health monitoring. - To incorporate the report recommendations into the radical pathway redesign process - Audit findings were shared with the Trust physical health team as part of their point prevalence study of physical health needs, recommendations to be completed 2013.

The reports of 66 local clinical audits were reviewed by the provider in 2012-13 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Audits noted in the 2011-12 Quality Account

Audit Title	Actions taken
Crisis plans	The crisis plan audit undertaken last year resulted from an incident within the Norfolk City locality and following the implementation of training and a communications review the repeat audit demonstrated an improvement in compliance from 35% to 72%. Crisis planning for 2012-13 is 78% Trust wide for community service users and 51% for in-patients. This difference in compliance demonstrates that it is not always appropriate to undertake crisis planning immediately after admission as participation of the service users is required and can be difficult during periods of acute illness. Crisis planning remains a critical area for the Trust and this has now been made a mandatory part of CPA.
Hand Hygiene	Following the decrease in compliance with hand hygiene technique reported in the 2011-12 quality account, an action plan to ensure gel was available, to observe practice and to ensure staff sinks were available was implemented. A follow up audit has found compliance of 95% for all criteria of the hand hygiene audit. Staff could demonstrate to the local infection prevention and control supporter (LIPACS) (see page 36 for more information) a correct hand hygiene technique lasting for the correct duration of 20-30seconds, demonstrating 93% Trust wide compliance.
Section 136 *	Following agreement of a new joint protocol between the Trust, police and social services in Suffolk, a re audit will take place in the next few months.
Record keeping	45% of the records complied with the audit criteria for having the date in the approved format. 92% of the records complied with the audit criteria for having a signature. A total of 824 sets of records were audited. The obligation to record when a service user is a military veteran has not yet been audited and different electronic systems in the Trust has led to differences in recording patterns. Veteran status is recorded as part of the Wellbeing service and is now on the new system used in the Access and Assessment teams.

* Mental health act section 136 enables the police to remove a person with a mental illness from a public place to a place of safety for assessment.

New Audits

Audit Title	Actions taken
Suicide prevention	
The Trust has carried out monthly audits which have measured its progress against nationally approved standards using evidence based audit tools (National Patient Safety Agency (NPSA) Preventing Suicide Toolkit) for inpatient areas. This has recently been piloted with community teams (data for community teams in the process of being collated). Following the pilot the audit will be rolled out to the remaining relevant teams on a three month basis, alternating the data collection between teams and services.	Following implementation of an action plan, compliance for discharges has improved from 95% in Feb 2012 to 96% in Jan 2013 in Norfolk and Waveney. In Suffolk the improvement over the same time frame has gone from 95% to 99%.
Annual Suicide Prevention Audit – Norfolk and Waveney 2010-11 (reported in 2012)	
This annual Suicide Prevention Audit is undertaken to monitor compliance against the Preventing Suicide 'A Toolkit for Mental Health Services' Audit Tool. Eighteen deaths were audited which was the second lowest number of deaths at a standardised rate (per 100,00 population), over the past five years. The Trust was 100% compliant with 56/82 audit criteria. Eleven of the remaining 26 criteria exceeded the 70% compliance level. Therefore 82% (67/82) of the criteria audited exceeded 70% compliance, which is the agreed level at which action plans are recorded centrally and monitored by Governance.	Action planning was completed following the annual report on suicides and service related deaths during 2010, as a result of this the Trust has; - Ensured contact is made by staff to service users within 48 hours of discharge from inpatient services. - Adjusted the Serious Incident (SI) checklist to ensure that incidents are included on team meeting agendas for discussion within two weeks. - Ensured that in instances where a service user dies unexpectedly, the Chief Executive sends a condolence letter to the next of kin providing contact details of a manager who can offer information and support. Reports on suicides and service related deaths during 2011and 2012 were completed for Norfolk and Suffolk services, and action points from these audits include; - To ensure that care plans include appropriate actions in periods of increased risk of suicide. - To give family/carers clear information on how to contact services where appropriate. - A new discharge letter that contains explicit advice to the GP about appropriate monitoring, prescribing and risks.

Audit Title	Actions taken
Modern matron audits	
The modern matrons have participated in a structured set of audits including – Covert Administration of Medication, Do Not Attempt Cardiopulmonary Resuscitation, Engagement and Observation of Service Users and Physical Health on Admission which included Nutrition, Care planning, Pressure Ulcers and Falls Prevention. Compliance over the initial three quarters of the audit had remained static, however, modern matrons are taking immediate action to improve practice in these areas and are continually providing evidence of progress.	The modern matrons take immediate action following the audit and submit a quarterly action update. Actions have included: - Improving physical health monitoring and signing care plans by providing localised staff training and addressing non compliance during staff supervision. - Discussion and feedback to, medical staff to address and amend areas of non compliance
Audits carried out by medical staff	
Medical staff have participated in many clinical audits during the year including – Physical Health Monitoring, Anemia in the Elderly, Medication Adherence, Consent in Forensic Services and Blood Monitoring. These have included audits against NICE* Guidelines, local policies and re-audits which have provided evidence of progress resulting from action taken.	Some of the actions taken include: - Set up a regular system to monitor the standards of monitoring of physical health for patients - Improve the system of referrals to the specialist services by negotiating a liaison service where a geriatrician visits the Julian Hospital - To amend T2** Forms to document capacity assessment - To encourage the use of information leaflets and document their use in the case notes to enable patients to give informed consent to treatment

* NICE is the National Institute of Clinical Excellence which undertakes audits and surveys to enable it to issue best practice guidance.

** A T2 form is used to evidence that a patient has consented to treatment.

The Trust participates in the National Confidential Enquiry (NCE) into Suicide and Homicide by People with Mental Illness as previously documented, with excellent compliance scores. Should the Trust have a serious case review (SCR) resulting from a child's death, these would be reported through the Norfolk and Suffolk Safeguarding Children's Boards and be reported in the three-year national report. However, for the period being looked at there have been no SCRs involving children known to the Trust. As a member of the Norfolk and Suffolk Safeguarding Children's Boards, the Trust will take account of all recommendations arising from SCRs, even when Trust services were not involved.

Research

The number of patients receiving NHS services provided or sub-contracted by the Trust from April 2012-2013 that were recruited during that period to participate in research approved by a research ethics committee was 550. This is a reduction from last year due to the number of mental health studies being undertaken nationally. The Trust would like to thank all patients who have taken part.

Participation in clinical research demonstrates the Trust's commitment to improving patient wellbeing and healthcare services. Research offers clinical staff the opportunity to keep abreast of the latest possible treatment options, and active participation in research is strongly believed to lead to successful patient outcomes. Our engagement with clinical research also demonstrates the Trust's commitment to testing and offering cutting-edge medical treatment and techniques, contributing to the evidence base for national health-care innovations and services.

The Trust was involved in conducting new research studies in the areas of schizophrenia, bi-polar, dementias, psychosis, eating disorders, learning difficulties and child and adolescent mental health. The Trust also launched a new research study alongside the start of the Trust Youth Service.

Some examples of where involvement in research has led to improvements in care include contributing towards the development of a best practice tool for crisis resolution teams, new medication trials looking to improve symptoms and quality of life of schizophrenia and dementias, studies evaluating the effectiveness and cost-effectiveness of new therapies in people with a range of conditions, and assessing support and training packages for carers and family members of people with eating disorders and dementia.

The research and development department has developed a key Trust strategy aligned with National Institute of Health Research (NIHR) initiatives to increase the Trust's capacity to undertake high-quality research and has launched a Trust research training programme open to all staff.

Goals agreed with commissioners

A proportion of the Trust's income in 2012-13 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body with which it entered into a contract, agreement or arrangement for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The Trust has a contract with NHS Norfolk and Waveney, NHS Suffolk and with the East of England specialist commissioning group for the provision of secure services. In addition the Trust has a contract with NHS Norfolk and Waveney for the provision of Improving access to psychological therapies (IAPT).

For the contract with NHS Norfolk and Waveney, a total of seven goals to improve quality were agreed as part of the main contract and a further three goals attributed to the contract to provide IAPT services. The seven goals agreed accounted for 1.5% of the total contract value and an additional 1% was allocated to system wide indicators. The rationale for these goals included suggestions from service user feedback as well as pre-defined national priorities. The goals covered all services delivered by the Trust, and the three domains of quality, patient experience, and patient safety and clinical effectiveness. The CQUIN contract with NHS Suffolk included ten goals covering the full value of the scheme.

The following table identifies the goals agreed with NHS Norfolk and Waveney for the main contract and the progress made in implementation. Unless specified the target for each goal was 100%.

Title of quality improvement goal	Progress	Weighting for payment
Improve service user experience	Implemented a patient feedback system. This will become electronic in the near future to facilitate real time reports.	20%
To reduce the average length of stay for working age adults on acute mental health admission wards, through the establishment of a Trust wide Discharge Facilitation Team	The discharge facilitation scheme is in place. The average length of stay has reduced slightly in Norfolk to 28.87 days from 29.72.	30%
To ensure that all service users admitted to inpatient units who are prescribed hypnotics, have a medication review	The audit undertaken in February indicated that where the service user remained on the ward, there was 100% compliance with medication reviews.	5%
All pregnant women or women with children under the age of 1 year, under the care of secondary mental health services should have their care planned in conjunction with other agencies (e.g. midwife, GP, health visitor)	The audit undertaken in February identified compliance of 92%.	5%
To continue to improve services for Young People through working towards achievement of "Your Welcome" status, utilising the "hear by right" mapping tool for CAMHS Continue progress made and increase target set for CQUIN 2011-12	This indicator has progressed including a young persons participation charter and strategy.	20%
Improve patient satisfaction by undertaking customer focused training to build on work undertaken in 2011-12	Customer care training is in place and 65 people trained. In addition a mystery shopper process is being implemented and further initiatives planned.	10%
The collection of data on patient harm using the NHS Safety Thermometer harm measurement instrument	Collected the relevant data which will now be used to improve physical health care for patients.	10%

The value of the scheme represents 1.5% of the total contract value and the above table shows the amount allocated to each goal.

The following table identifies the goals agreed with NHS Suffolk for the main contract and the progress made in implementation.

Title of quality improvement goal	Progress	Weighting for payment
Development of A&E liaison	Psychiatric liaison fully implemented	22.63%
Continued implementation of the patient safety action plan	The action plan has been completed	19.29%
Redesign of care pathways and packages	This has been completed as part of the Trust service strategy	20%
Improved service user experience	Implementation of the Friends and family test	5%
Improved outcomes for people with personality disorder	The action plan has been completed	5%
Improved quality assurance for people with a learning disability	Implemented a review system	5%
Implement the patient safety thermometer* Falls reduction	Safety thermometer introduced and falls plan implemented	5%
Improve CAMHS liaison with primary care	Referral helpline and single point of access implemented	5%
Every contact counts**	Staff training implemented	11.08%
Implementation of the Suffolk autism strategy	Autism awareness training package implemented	2%

* Patient safety thermometer is a National patient safety initiative which records pressure ulcers, falls, venous thrombo embolism and urine infections in people with a catheter.

** Every contact counts is an initiative to encourage health professionals to talk to patients about their physical health, raising awareness of weight, alcohol consumption and smoking.

The following table identifies the goals agreed with NHS Norfolk and Waveney for the Improving Access to Psychological Therapies (IAPT) contract and the progress made in implementation.

Title of quality improvement goal	Progress	Weighting for payment
Extension of service and improved/ targeted marketing to reduce the gender differential	Marketing strategy implemented	25%
Further develop the Mental Health First Aid associate scheme * (Norfolk only)	Scheme developed and the target of 25 people trained is exceeded with 66 trained	25%
Deliver marketing of service to result in increase in appropriate self referrals (Gt Yarmouth and Waveney only)	Marketing strategy implemented	35%
Improve data collection on PC-MIS to 90% (Norfolk)	Achieved in excess of the target for 3 of the 4 data fields	25%
Improve data collection on PC-MIS to 90% (Gt Yarmouth and Waveney)		15%
Improve access to the service for older people	Marketing strategy implemented	25%

The value of the scheme represents 2.5% of the total contract value and the above table shows the amount allocated to each goal.

* Mental Health First Aid is a course which teaches how to recognize signs and symptoms of common mental health problems, provide initial help and signpost the sufferer to support services.

Secure Services CQUIN 2012-13 Summary

A total of six goals to improve quality were nationally agreed for secure services by the 10 regional specialist commissioning groups. The rationale for these goals included suggestions from service user feedback, as well as pre-defined national priorities that reflect strategic drivers. These goals are specific to the Trust's Medium Secure Services based at the Norvic Clinic, Norwich and Foxhall House, Suffolk, as well as the Low Secure Services at Thorpe St. Andrew and Hellesdon Hospital, but they cover the same three domains of quality, patient experience, and patient safety and clinical effectiveness, as the CQUIN agreed with NHS Norfolk and NHS Suffolk for other Trust services.
The value of the scheme represents 2.5 per cent of the total contract value and approximately 85% compliance has been achieved in Norfolk and Suffolk.

The income received, which was conditional upon achieving quality improvement and innovation goals in the main contracts 2012-13, was £4,349,488.

This compares with the income received in 2011-12, which was £2,109,284.

Title of quality improvement goal	Progress	Weighting for payment
Implementing Clinical Dashboards for Specialised Services This indicator is aimed at ensuring that Providers implement and routinely use the required clinical dashboards for specialised services	The necessary evidence for completion of all the goals has been submitted to the specialist commissioning group	10%
Shared Pathway Recovery & Outcomes Services will introduce and implement a recovery and outcome based approach to the care pathway. This will include demonstrating recovery orientated practice in identifying, planning and achieving joint goals and outcomes with service users	The necessary evidence for completion of all the goals has been submitted to the specialist commissioning group	20%
The Secure Pathway implementing a standard pathway For all providers to introduce and monitor key milestones on the patient pathway in order to make the pathway more efficient and reduce length of stay	The necessary evidence for completion of all the goals has been submitted to the specialist commissioning group	20%
Access to specialised mental health services This CQUIN is designed to improve the robustness and rigor applied to assessments to determine if an individual requires a planned admission to a specialised mental health service	The necessary evidence for completion of all the goals has been submitted to the specialist commissioning group	20%
Secure Payment by Results (PbR) Currency Feasibility Project To implement the secure PbR Currency Feasibility Project. This includes the implementation of the clinical toolkit for the clustering of patients and grouping into forensic care pathways using both the mental health clustering tool and the Five Forensic Pathways (FFP) Tool	The necessary evidence for completion of all the goals has been submitted to the specialist commissioning group	10%
Optimising Length of Stay A fundamental element of many quality, innovation, prevention and productivity (QIPP) schemes is to optimise length of stay in order that service users are not within specialised mental health services for longer or shorter periods than is clinically appropriate. This CQUIN requires providers to understand the total care pathway and plan how they might work differently to optimise length of stay	The necessary evidence for completion of all the goals has been submitted to the specialist commissioning group	20%

Statements from the Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC). Its current registration status is 'registered to provide assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury'. The Trust has no conditions on registration.

The CQC has not taken enforcement action against Norfolk and Suffolk Foundation Trust during 2012-13.

The Trust has not been eligible for any special reviews or investigations by the CQC during 2012-13.

Quality and risk profile

The CQC publish a quality and risk profile (QRP) and this document is a compilation of all the information known about the performance of the Trust. This information is used by the CQC to identify whether the Trust is at risk of not complying with the essential standards.

The first QRP for the merged Trust was produced in February 2012 and a quarterly report to the service governance sub committee highlights where there have been increases or decreases in the risk of non compliance with each standard.

These changes in risk levels are always related to reports and information that we already have and so action plans for improvements are implemented as a result of the report.

Data quality

Norfolk and Suffolk NHS Foundation Trust will be taking the following actions to improve data quality:

- Excellent data quality is essential to the delivery of excellent quality care. NSFT will continue to ensure data quality improvements are made to support services through provision of easily accessible available performance reporting through Abacus and MIS, the Trust's business intelligence reporting systems, overseen by the Data Quality Group.
- Additionally, in 2013/14 with the implementation of the Trust Service Strategy, Localities will be held directly to account for all areas of performance, including data quality. 2013/14 is a shadow year for the introduction of commissioning under Payment by Results (PbR) and it is a priority for the Trust to ensure data quality processes are robust to provide assurance to commissioners new payment arrangements are fit for purpose but also to ensure the Trust is able to accurately invoice for all activities. In Norfolk, Locality Business Support Managers have been instrumental in driving data quality improvements forward, with clinical and administrative teams. As part of implementing the Trust Service Strategy, Business Support Managers will be appointed to the two Suffolk Localities in early 2013/14 so all localities will benefit from this key role.

Norfolk and Suffolk NHS Foundation Trust submitted records during 2012 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was:
  - 99.6% for admitted patient care;
  - Not applicable for out patient care; and
  - Not applicable for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:
  - 100% for admitted patient care;
  - Not applicable for out patient care; and
  - Not applicable for accident and emergency care.

The Norfolk and Suffolk NHS Foundation Trust information governance assessment report score for 2012 submitted in March 2013 was 79% and was graded not satisfactory.

The submission score has increased by 10% from the previous year.

Two requirements scored a level 0, and one requirement achieved a Level 1. To be fully compliant all requirements must score a Level 2 as minimum.

The overall level of compliance increased with 22 Requirements achieving a Level 3.

Action plans are being developed with regards to those requirements that did not achieve Level 2.

The information quality and records management attainment levels assessed within the information governance toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

Further information on information governance can be found at www.commissioningforhealth.nhs.uk

The Trust was not subject to the payment by results clinical coding audit during 2012-13 by the Audit Commission.

Quality Performance Review

This section summarises quality information specific to Norfolk and Suffolk NHS Foundation Trust.

Key performance and developments during 2012-13

Following the merger in January 2012, a lot of work has taken place to share good practice across the whole Trust. This has included the review of policies which helped the Trust achieve compliance with NHSLA level 1 in December 2012 with the ambition to work towards assessment for level 2 in December 2013.
The NHS litigation authority is a special health authority set up to enable NHS organisations to pool the costs of "liabilities to third parties for loss, damage or injury". Compliance is assessed at three levels with level one being the lowest, and level three the top. Compliance addresses the safety of the processes within the organisation which are deemed to contribute to risk. The premium paid reduces if a higher level of compliance can be achieved.

The Trust has been involved in a radical redesign of services, now called the Trust Service Strategy which has engaged all stakeholders in the development of new care pathways which share the fundamental principles of being service user and carer needs led, offering wellbeing for all with access to expert advice and reducing the need for admission to hospital.

At a time of change it is important to ensure that the quality of the new proposed model is good, but also to maintain the quality of the service provided, both before, during and after change. To ensure this quality the Trust has identified a number of quality outcomes which will be monitored by the Board of Directors and clinical commissioning groups to ensure ongoing quality.

Integral to the Trust's approach to quality is equality and diversity. Although there is no longer a requirement to carry out Equality Impact Assessments, the Equalities Act (2010) sets out public sector equality duties including an obligation to have due regard to the needs of people from groups with protected characteristics in designing and providing services.

The Trust has approved equality assessment frameworks for services and for policies to assist clinicians and managers in meeting our public sector equality duties. Assessments have been completed for service redesigns as part of the Trust Service Strategy.

In addition, in line with our Equality Delivery System objectives, we have introduced initiatives to address our identified priorities. These include a major consultation on and launch of our spirituality strategy and a one year project to tackle racist abuse of black and minority ethnic staff. The Trust continues to support a wide range of community initiatives such as Suffolk and Norwich LGB&T Pride, Black History Month, Multi-cultural Events, and Disability Involvement Events.

New services

In October 2012 a new eight bed unit opened in Oulton near Lowestoft called No. 5 to provide inpatient care to young people with mental disorders, including eating disorders. This unit involved young people in the design of the building as well as being able to influence what information and support should be available.

A five year contract to provide a fully integrated service for adults affected by drugs and alcohol has been awarded to the Trust in partnership with the Matthew project and the Rehabilitation for Addicted Prisoners Trust

(RAPT). The new "Norfolk Recovery Partnership" will start in April 2013.

The Suffolk Wellbeing service was opened on the 10 October 2012, providing a range of support systems for emotional wellbeing. The service was opened by Ruthie Henshall in Bury St Edmunds to coincide with World Mental Health day.

Awards

The trust holds an annual award ceremony which acknowledges the work and dedication of Trust staff. Some of the categories include:

- Volunteer of the Year Award
- Unsung Hero Award – non-clinical
- Unsung Hero Award – clinical
- The George Pearce Equality and Diversity Award
- Leadership and Motivation Award
- Exceptional Contribution Award

In addition to this internal award system, a number of individuals and teams have won awards in the past 12 months

Lark ward at Woodlands in Ipswich has won the team of the year award from the National Association of Psychiatric Intensive Care and low secure units.

Beverley Hallpike, Nurse consultant for dementia, has won a travel scholarship from the Florence Nightingale Foundation fellowship which will enable her to explore dementia care in other cultures, visiting Australia and China.

Helen Blee, clinical programme lead for ICT was part of a team that won the e-Health Insider Chief Clinical Information Officer Award for clinical leadership.

Trust-wide initiatives

Accreditation for Inpatient Mental Health Services (AIMS)

AIMS is an initiative from the Royal College of Psychiatrists' centre for quality improvement which identifies and acknowledges services which have high standards of organisation and patient care, and supports and enables others to achieve these.

In addition to the areas which have already attained accreditation, Churchill ward, Glaven ward, Waveney ward, Great Yarmouth Acute Services and Waveney Acute Services, the psychiatric intensive care unit, Rollesby Ward in Norfolk has deferred its accreditation awaiting completion of building work. Poppy Ward has achieved excellent accreditation. Avocet and Lark Wards at Woodlands were both deferred until they had submitted additional evidence. This has now been completed and the evidence accepted. Final accreditation should be announced in April 2013.

Northgate and Southgate wards at Wedgwood Hospital were assessed in January 2013 and are awaiting the final outcome.

The central cluster CRHT has taken part in a pilot scheme to extend the accreditation and was one of only two teams in the country to be awarded a rating of excellent.

Volunteers

The Voluntary Service has continued to develop during the year, and volunteers are continuing to help the Trust improve the patient experience through the roles which have been developed. There are now well over 100 volunteers registered and actively involved on wards, undertaking roles such as meet and greet services, sport activities, football coaching, art activities, music activities, acting as dining companions, and, of course, providing Pets as Therapy (PAT) dog visits to the wards. In the community settings, volunteers help staff run support groups, some volunteers accompany service users to medical appointments or to social activities or help with allotment groups.

We have worked in partnership with the colleges and universities in our region, and students volunteer with the Trust to gain experience in health and social care.

The Productive Ward Series/ Releasing Time to Care

The Productive Ward/Releasing Time to Care programme developed by the NHS Institute consists of a number of modules for learning at clinical level. It has been a welcome project support framework led by front-line clinical staff, and has supported staff in identifying

and implementing local service improvement initiatives to improve patient care and safety including safer handovers.
The Trust is looking at ways to supported dedicated ongoing training to teams in the clinical environment to ensure the process becomes embedded in every day practice. Plans to develop into community services initially via CRHT will resume following implementation of the new service strategy.

Leadership

Leadership in the Trust is currently captured through two main streams; Identification of leadership needs and developmental activities. The Trust is keen to support its staff in the roles and to develop the leadership of managers in order to be able to meet the overall Trust objectives.

Identification of leadership needs is facilitated by the Trust's appraisal system. Appraisals are available to all staff during a yearly appraisal window. The appraisal covers setting and reviewing objectives, personal development, training need activities and talent management, which is linked to succession planning. Doctors' appraisals are managed separately to support revalidation. This covers a number of areas evidencing good practice such as learning from incidents, obtaining feedback from colleagues and patients.

The developmental activities available are internal leadership development programmes for new managers and middle career managers. Personal development is available through the Trust and includes providing feedback to managers on their performance and learning environments such as individual or group coaching. Managers can also access regional and national leadership programmes including race equality leadership programmes. The Trust also hosts a leadership conference for all identified managers. Additional work this year has included work with staff on the development of the Trust's Vision, Values and Behaviours, which will help to shape the culture of the organisation.

Through investment, the Trust aims to link leadership to the improved quality and development of its services, better patient outcomes/experiences and an increase in innovation and new ways of working. Managers and staff are better placed to understand the Trust objectives and how their role contributes to achieving them.

Locality specific initiatives and innovations

Child and adolescent mental health service (CAMHS) website.
Since the January 2012 launch of the CAMHS website in Suffolk, its content has evolved partly on feedback from young people and carers, and partly to reflect the understanding around the evolving care pathways. The aim is to use the website as the place to go for young people, parents, families and professionals for relevant information on mental health in Suffolk.

It was planned that the site would not solely provide generalised information on various conditions, but would aim to show where support and help could be found at differing points of a care pathway. Often this support would not be from a Trust specialist CAMHS service but from an alternative provider.

The website continues to evolve and it is only now that the pathways can begin to take shape. We plan to further update the site by involving the graphics department and devising a method of showing a pathway that could then be replicated to be used by other teams for their own sites. Feedback regarding the site has been positive from a variety of users with agreement that to be helpful it has to continue to be local and relevant.

Hearing Voices
Since 2009 a group of clinicians interested in understanding and helping people distressed by voice hearing and other unusual experiences (often described as psychosis) have joined together to promote an acceptance approach to these experiences within mental health services in Suffolk. This approach promotes the idea that there is idiosyncratic meaning within people's experiences which can point to real life problems in the past and the present. Such life events can generate many emotional reactions including grief, shame, guilt and anger that can be worked through in a systematic way. The initiatives taken forward by Dr Denise Herron, Dr David Williams and Matthew

Morris have included two regional conferences "Giving Psychosis a Voice" in 2010 and 2012 with a third conference planned for 2013.

In addition to the conferences, almost 350 NSFT staff have attended "An Introduction to Working with Voices" training facilitated by David, Denise and Matthew in the last two years. The training focuses upon empowering staff to feel confident in working with the people we support within an acceptance approach.

In recognition of the work within East Anglia to promote an acceptance approach to voice hearing Dr David Williams, Matthew Morris and Dr Denise Herron were asked to present a workshop titled "A Quiet Revolution" at the 4th World Hearing Voices Congress in Cardiff, South Wales, in September 2012.

Therapeutic groups

The East Suffolk coastal community team has implemented a series of therapeutic groups including workshops for carers of people with obsessive compulsive disorder, a dialectic behaviour therapy group and a group to assist service users back into paid employment.

End of Life Care

Carlton Court Hospital has worked in conjunction with partners to provide three workshops promoting good end of life care for all.

Quality indicators

This section is newly mandated by the Department of Health.

Seven day follow up

This indicator is described as *"The proportion of those patients on CPA discharged from in patient care who are followed up within 7 days"*

The NSFT considers that this data is as described for the following reasons:

- NSFT has robust systems in place to check the quality of data
- Data is submitted to commissioners where it is scrutinised and challenged where necessary

Using the guidance issued by Monitor on the 22nd March 2013, the NSFT KPI for 7 day follow ups is 95.9% for 2012/13. This figure excludes valid follow up contacts that took place on the day of discharge. Based on the NSFT discharge policy which considers contacts that take place on the day of discharge to be valid follow up contacts, the figure is 97.6%.

The figure for previous years is based on the NSFT discharge policy which considers contacts that take place on the day of discharge to be valid follow up contacts.

This is in line with what has been reported externally. The guidance issued by Monitor will be brought to the attention of commissioners.

Prescribed information	Related NHS Outcomes framework domain	Data 2010-11	Data 2011-12	Data 2012-13
The percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric in-patient care. This is a national definition reported to Monitor.	Preventing people from dying prematurely Enhancing quality of life for people with long term conditions.	*NWMHFT* 96.17%	Due to the merger, data was presented separately for the first 9 months. The combined Trust position was 94.76%	*NSFT* 95.9%

Access to CRHT

This indicator is described as *"The proportion of inpatient admissions gatekept by the crisis resolution home treatment teams"*

The NSFT considers that this data is as described for the following reasons:

- NSFT has robust systems in place to check the quality of data
- Data is submitted to commissioners where it is scrutinised and challenged where necessary

The NSFT has taken the following actions to improve this percentage, and so the quality of its services, by:

- Business support managers check the systems and liaise with clinical staff to check any data that appears to be outside normal parameters
- Data is discussed at local management groups as well as Trustwide performance groups

Prescribed information	Related NHS Outcomes framework domain	Data 2010-11	Data 2011-12	Data 2012-13
The percentage of admissions to acute wards for which CRHT acted as gatekeeper. This is a national definition reported to Monitor.	Enhancing quality of life for people with long term condidtions.	*NWMHFT* 97.41%	Due to the merger, data was presented separately for the first 9 months. The combined Trust position was 95.89%	*NSFT* 92.40%

Readmission rates

The NSFT considers that this data is as described for the following reasons:

- NSFT has robust systems in place to check the quality of data

The NSFT has taken the following actions to improve this percentage, and so the quality of its services, by:

- Ensuring that discharge planning is robust and that the discharge policy is followed
- Ensuring patients receive a follow up visit within 7 days of discharge and telephone contact within 48 hours of discharge

Prescribed information	Related NHS Outcomes framework domain	Data 2010-11	Data 2011-12	Data 2012-13
The percentage of patients aged 0-14 *NB: NSFT does not have beds for under 14's*	Helping people to recover from episodes of ill health or following injury	No admissions	No admissions	No admissions
15 or over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust.		*NWMHFT* 7.32% *SMHP* 5.68%	*NWMHFT* 8.43% *SMHP* 4.0%	*NSFT* 6.2%

Staff survey

The NSFT considers that this data is as described for the following reasons:

The Trust has analysed the results and it is apparent that the results for one of the Trust's five localities scored particularly low for the outcome highlighted below, which has distorted the overall rating score. From the Trust's analysis, excluding this locality, the Trust would have been rated as 3.48 out of a possible score of 5, which is just 1.7% below the national average for mental health/ learning disabilities Trusts. This is virtually identical to the previous year's results for Norfolk and Waveney Mental Health Trust (3.48) and higher than Suffolk Mental Health Partnership's results (3.31). There were significant issues with service pressures and the availability of beds within the relevant locality at the time of the 2012 Staff Survey which the Trust was aware of and has taken action to address.

The NSFT has taken the following actions to improve this percentage, and so the quality of its services, by:

Reviewing the management arrangements for the locality which scored lowest, to improve the leadership and integrated working between teams across the clinical pathway within the locality. A bed management service was also introduced. There is evidence of the success of these actions. Since the survey was undertaken, the locality's CRHT Services have been accredited under AIMS with an 'excellent' rating; this is the first community service in the country to have been accredited. There has also been a very successful AMHP event which reflected improvements as a result of the revised management arrangements and new beds management service. There has also been a significant improvement in bed pressures with no patients currently placed outside the Trust. Taking account of the results of the 2012 Survey more generally, the Trust is prioritising improvements in employee engagement and wellbeing, the reporting of incidents (although the Trust has scored very highly in respect of the fairness of our reporting procedures) and mandatory and statutory training.

Prescribed information	Related NHS Outcomes framework domain	Data 2010	Data 2011	Data 2012
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	Ensuring that people have a positive experience of care	*NWMHFT* 3.43 *SMHP* 3.30	*NWMHFT* 3.41 *SMHP* 3.31	*NSFT* 3.32

National average: 3.54
Top scoring Trust: 4.06

Community service user survey

The NSFT considers that this data is as described for the following reasons:

The Trust commissions an outside agency, Quality Health which is an "approved provider" to undertake the survey. Unfortunately it is impossible to attribute the results to individual teams or services so any actions need to be implemented across all services and not targeted.

The NSFT has taken the following actions to improve this percentage, and so the quality of its services, by:

- Sharing the results across the Trust and with service user and carer groups.
- Introducing an electronic feedback system that enables staff to receive real-time comments from service users which is attributable to the team or service.

This feedback will then result in an action plan where required.

Prescribed information	Related NHS Outcomes framework domain	2010	2011	2012*
The trust "Patient experience of community mental health services" indicator score with regard to a patients experience of contact with a health or social care worker	Enhancing quality of life for people with long term conditions Ensuring that people have a positive experience of care	No data available	*NWMHFT* 8.5 *SMHP* 8.5	*NWMHFT* 8.7 *SMHP* 8.8

*Survey conducted in 2011 reported in 2012

Range of scores: 8.2 - 9.1

Incident reporting

The NSFT considers that this data is as described for the following reasons:

- Staff report all incidents using the electronic datix system.
- All incident reports are reviewed by the risk management team and clinical managers required to investigate and sign off each incident before closing the event.
- Health, safety and security audits are carried out on all Trust premises which includes review of incident reporting trends

In preparing the data for the Quality Account, it has become evident that new guidance issued in April 2012 which clarified the reporting of deaths was not followed. The reports from the NHS commissioning board note that not all organisations apply the national coding in a consistent way and the Trust is taking action to ensure that the coding on the Datix reporting system is changed.

Following a review of our data capture there is assurance in the system that apparent, actual and suspected suicide as well as significant self harm are now reported as they occur.

Furthermore, these are subject to discussion at the Incident and Patient Safety Group meetings.

If the new coding arrangements had been in place the data for April 2012 - September 2012 would have been 15 deaths which represents 0.6% compared with 0.8% for all mental health organisations.

The NSFT has taken the following actions to improve this percentage, and so the quality of its services, by:

- Staff are encouraged to report all incidents and the Trust has recently introduced an upgrade to the report form and Datix dashboard, which provides clinical managers with a live overview of the reported incidents in their area
- Incidents are reviewed by the patient safety team to identify themes and patterns, working with clinical areas and stakeholders, such as the Police, to implement changes where required
- Serious incidents are managed in accordance with national guidance

Prescribed information	Related NHS Outcomes framework domain	1 Apr 2011 to 30 Sept 2011	1 Oct 2011 to 31 Mar 2012	1 April 2012 to 30 Sept 2012	1 Oct 2012 to 31 Mar 2013
The number and where available the rate of patient safety incidents reported within the Trust during the reporting period and the number and percentage of such patient safety incidents that resulted in severe harm or death.	Treating and caring for people in a safe environment and protecting them from avoidable harm	*NWMHFT* 1,900 incidents reported * 30.7 incidents per 1000 bed days ** 6 incidents (0.03%) led to severe harm 1 incident (0.01%) led to a death *SMHP* 738 incidents reported 20.8 incidents per 1000 bed days *** 2 incidents (0.03%) led to severe harm 3 incidents (0.04%) led to a death ** The reporting rate of 30.7 incidents is rated 13th out of 57 mental health organisations and puts the Trust in the top 25%. *** The reporting rate of 20.8 incidents is rated 30th out of 57 mental health organisations and puts the Trust in the middle 50%	*NSFT* 2,503 incidents reported 25.7 incidents per 1000 bed days ** 2 incidents (0.08%) led to severe harm 1 incident (0.04%) led to a death ** The reporting rate of 25.7 incidents is rated 18th out of 56 mental health organisations and puts the Trust in the middle 50%.	*NSFT* 2,414 incidents reported 36 incidents per 1000 bed days ** 9 incidents (0.08%) led to severe harm 15 incidents (0.06%) led to a death (this figure has been adjusted to account for reporting changes as above) ** The reporting rate of 36 incidents is rated 11th out of 56 mental health organisations and puts the Trust in the top 25%.	*NSFT* 2,580 incidents reported Awaiting publication from NRLS 8 incidents (0.31%) led to severe harm 13 incidents (0.5%) led to a death NB This data is subject to change following final ratification and report from NRLS

* An incident is defined as "any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare". (www.nrls.npsa.nhs.uk) Organisations that report more incidents usually have a better and more effective safety culture because they are aware of the problems and able to act to improve.

** A bed day is used as a measure to enable comparison between Trusts of different sizes. The measurement accounts for differences in the number of beds a hospital may have and just considers the days the beds were occupied

Key quality indicators

The Board of Directors receives regular reports on the quality of services which are measured through the domains of patient safety, clinical effectiveness and patient experience. Key performance indicators (KPIs) are identified by the Board of Directors as internally generated or enforced by contractual obligations with partner organisations. These indicators are reported in a monthly business performance report, and other measures of quality are reported through the reporting system to evaluate services.

This table is presented for continuity. Where indicators have now been mandated, these have been reported on 41-45.

In 2012, the target applies to both Norfolk and Suffolk unless indicated with (N). In these cases no target is reported for Suffolk.

Key performance indicator	Target: (N) = Norfolk only	Merged Trust 1 Jan 2012 - 31 March 2012	Trust full year position 2012-13
Patient safety			
Seven-day follow up of service users following their discharge from inpatient services.	95%	94.76%	97.64%
Absconscions of detained patients from Adult wards as a ratio of 100 detained patients.	4.1 (N)	4.87	7.61
Ratio of inpatient serious untoward incidents (e.g. suicide) per 10,000 occupied bed days.	3.8 (N)	6.18	2.74
Clinical effectiveness			
Access to crisis resolution and home treatment services.	90%	95.89%	92.4%
Delayed transfers of care, relating to other support needs (like housing) following discharge from hospital.	<7.5%	0%	4.55%
Patient experience			
CPA patients having formal review within 12 months.	95%	97.08%	97.55%
Waiting times. The number of people waiting 18 weeks or greater.	-	20	99
Number of under 18 year old admissions to adult acute ward	-	6	15
Number of under 16 patients admitted to adult acute wards.	0	0	0

Evaluation of patient safety

The Trust considers and evaluates patient safety in a range of ways.

Evaluation of patient experience

In 2012 an electronic feedback system to replace the Patient Experience Tracker (PET) used in Norfolk was purchased.

This system enables service users to respond to survey questions using a digital pen which records the responses and enables staff to download reports. Unfortunately there have been a number of delays in implementing the system and so a paper based system has been adopted as an interim measure. The full digital system should be available by May 2013.

The feedback system contains the "Net promoter score" or "Friends and family test" which has been adopted nationally. The digital system enables the service user to give their feedback about the service which enables staff to identify where improvements are required and does not just rely on a scoring system.

As well as an electronic system, the Trust uses a variety of methods to evaluate patient experience, including surveys, informal feedback, reviewing the NHS Choices website and learning from compliments and complaints.

The Trust works closely with service users and carers as well as other organisations such as LINks in Norfolk and Suffolk and public governors, who provide vital feedback.

In the last six months NSFT has been able to develop locally based service user and carer forums across Norfolk. The forums will allow service users and carers to find out information, raise concerns and comment on how we can improve our services. This model is currently in the planning stage to be replicated in Suffolk.

There is now a mechanism in place to ensure that service user and carer views from across the Trust are fed back appropriately. An 'Overarching Development Group' has been set up to ensure the effective implementation of both the Service User Involvement and Carer Strategies across NSFT. The 'Overarching Development Group' includes a director to ensure Board level representation and that suggested, potential changes to services are driven strategically.

Complaints

The Trust remains committed to resolving complaints as quickly as possible in an open and transparent way. Complaints offer an opportunity for the Trust to learn about service provision and to initiate service improvements.

During April 2012 – March 2013 the Trust received 430 complaints. The majority of complaints related to "all aspects of clinical care" (49.5 %), followed by "attitude of staff" (14%).

At the time of reporting 354 complaints have been responded to. Of these complaints 19.8 % were upheld, 30.8 % were partially upheld and 40.4 % were not upheld by the Trust. 9 % of complaints were stood down.

The Trust has been informed that following the response to a complaint, 20 complainants requested review of their complaint by the Parliamentary and Health Service Ombudsman.

Learning from complaints

Bi-monthly performance monitoring through the Service Governance Sub-Committee ensures that all learning is made use of throughout the Trust. In many instances, learning is specific to an individual's care. Learning has included:

- Where a change of staff member occurs, the service user should be updated of that change as early as possible. This is to enable a planned transfer of care to a new staff member.

- A Trust service increased its available appointments to meet an increase in demand. This was in response to registered concerns of the waiting times being experienced.

- The importance of engaging proactively with family and carers to ensure collaborative working to support a service users recovery.

The Trust's Patient Advice and Liaison Service (PALS) continues to be available to provide support to service users, carers and members of the general public who seek to find information or to resolve their concerns without the desire or need to use the complaints procedure. PALS can be contacted on 0800 279 7257.

Serious incidents

The Trust continues to report all Serious Incidents (SI) in accordance with national guidance. Incidents may subsequently be stood down if an explainable cause is identified i.e. if a death is found to be as a result of natural causes, and will not be subject to a coroner's inquest.

From April 2012 to March 2013 161 SIs were reported by NSFT, of which 53 were unexpected deaths. At the time of reporting, 20 deaths have been determined due to a natural cause. These cases are closed and require no further investigation. The remaining involved service users who were accessing a range of inpatient and community services across the Trust. They were engaged with services at the time of their death or had been discharged within the previous six months.

A number of service improvement initiatives have arisen as a result of recommendations within the RCA reviews. These have followed themes including:

- Refresher training of inpatient services staff in the application of enhanced observations.
- Learning from serious incidents supported the service redesign of the way people access Trust services.
- Identification of the need to consider the Trust's current risk assessment training provision. A new training pathway is currently in development.

The Trust has had no Serious Incidents involving personal data as reported to the Information Commissioner's office in this period.

Patient environment action team (PEAT)

The NPSA requires each trust to undertake an assessment of each inpatient area on an annual basis, and issues guidance to be followed. The 2012 PEAT assessments were carried out across all inpatient areas of the Trust between January and March 2012. The NPSA only requires the inspections to take place in locations where there are 10 or more beds. Because some areas of the Trust provide care in small bungalows, such as in Walker Close in Ipswich, the assessments are carried out but not reported to NPSA.

The 2012 guidance can be accessed at www.npsa.nhs.uk/peat/

Two ward areas at Hellesdon Hospital have been closed since the 2011 inspection and the new dementia intensive care unit, Hammerton Court, opened in March 2012.

Foxhall House was included in the St Clements inspection so not reported separately.

The process has changed for 2013 and PEAT has been replaced by Patient led assessments of the care environment (PLACE).

These assessments will take place between April and June 2013 with the results being published in September. Following the publication of the results, each ward area will have access to the details of the assessment and will implement an action plan for improvements where necessary.

Site name	Environment 2011	Environment 2012	Food 2011	Food 2012	Privacy and Dignity 2011	Privacy and Dignity 2012
Carlton Court	Excellent	Excellent	Excellent	Excellent	Excellent	Excellent
Chatterton House	Excellent	Excellent	Excellent	Excellent	Good	Excellent
Fermoy Unit	Good	Good	Excellent	Excellent	Excellent	Good
Hellesdon Hospital	Good	Good	Excellent	Excellent	Good	Excellent
Julian Hospital	Good	Good	Good	Excellent	Excellent	Good
Meadowlands	Good	Excellent	Excellent	Excellent	Excellent	Good
Norvic Clinic	Excellent	Good	Excellent	Good	Excellent	Excellent
Northgate	Excellent	Excellent	Excellent	Excellent	Excellent	Excellent
St Clement's Hospital	Good	Good	Good	Excellent	Good	Excellent
Wedgwood House	Good	Good	Good	Excellent	Good	Good
Foxhall House	Excellent	–	Good	–	Excellent	–

Infection prevention and control (IPAC) activities

Key achievements resulting from the infection prevention and control activity for the year have been:

- Establishing a network of liaison staff, the local infection prevention and control supporters (LIPACS). These staff are supported with additional education and training to enable them to act as first points of contact for information and advice within their clinical area. They also provide local induction for new and relocated staff and carry out audits and embed remedial actions as directed by the infection prevention and control team.

- Integrating the infection prevention and control staff with the physical health staff: this has provided an opportunity to strengthen both agendas through joint working on a range of initiatives.

- No major outbreaks of infection and very limited impact on services due to Norovirus infections: two wards were closed to admissions for a total of eight days due to service users and staff presenting with symptoms suggestive of Norovirus.

- Through the communication and surveillance processes, very few service users have been identified with 'alert' organisms: these are MRSA, Clostridium difficile, extended spectrum beta lactamase producers (ESBL) and Vancomycin resistant enterococci (VRE). One patient was admitted with a diagnosis of Clostridium difficile, three patients were admitted who were known to be colonised with MRSA and one was identified as being colonised with MRSA following routine screening. A patient was identified with a urinary tract infection due to VRE. All patients were managed appropriately to prevent the further spread of these organisms.

- A successful programme of audit has been undertaken resulting in action plans to address any deficiencies identified. The hand hygiene audit tool has been improved to ensure robust monitoring: the most recent combined score for the results of this audit was 95%.

- The flexible approach to the programme of education and training has resulted in 91% of all Trust staff receiving an annual update on infection prevention and control.

- Key policies have been updated and assessed by the NHSLA : these have supported the Trust achievement of level one compliance.

Work continues to monitor and improve infection prevention and control activity. The prioritised actions for the forthcoming year are designed to ensure the Trust complies with all criteria stated in the Health and Social Care Act 2008 (revised 2010), CQC Regulation 12 objective 8 (cleanliness and infection control) and requisite national best practice standards. The audit plan for the year aims to monitor implementation of these actions.

Physical Health

It is recognised that the physical health needs of NSFT service users are as important as their mental health needs and should be addressed as part of their care package. This was highlighted in the document 'No Health without Mental Health (2011).

NSFT has set the monitoring of physical health for service users as a quality priority for the Trust. This includes checking basic observations such as blood pressure, pulse and weight; reviewing medication; discussions on healthy lifestyle and ensuring that standard screening and health checks have been carried out, for instance dental checks, visiting the opticians, cervical and prostate checks.

Within the Trust, the physical health team have been integrated with the infection prevention and control team to provide support and benefit to both agendas.

The main aim of the physical health team is to support clinical staff in ensuring that the physical health needs of service users, both in-patient and out-patient, are assessed, addressed, monitored and reviewed. The outcome should be to improve the physical health of service users, support the reduction of health inequalities and promote timely access to specialist services when specific conditions are identified, for instance, heart disease and diabetes.

A key achievement has been the establishment of the physical health forum with

members from across the Trust. These individuals are supported by a programme of education and training to be a point of contact for advice and intervention within their own clinical area.

There has been considerable focus on the reduction of pressure ulcers and prevention of falls within the trust. This has again involved education programmes with the additional support of the physiotherapy team.

An audit is currently being undertaken across all in-patient areas, to be extended to community teams, to establish the additional work and support required to improve the compliance with Trust policies related to monitoring and improving the physical health of service users.

Evaluation of clinical effectiveness

The clinical effectiveness strategy sets out the structures and processes for ensuring clinical effectiveness across the Trust.

This includes implementing NICE guidance and adopting nationally agreed best practice.

The Trust audit schedule includes audits that measure compliance against the NICE guidance and where non-compliance is identified, an action plan to improve is implemented.

Other measures of clinical effectiveness such as access to crisis resolution before a person is admitted to hospital and ensuring service users are followed up within 7 days of discharge from an in-patient ward, are reported to Monitor and the Trust continues to report excellent compliance with the target. See pages 41-42.

The Trust has been actively involved in the development of payment by results* (PBR) at both national and local level. Service users are allocated to a care pathway according to their diagnosis and the care that they require. The Trust is currently developing and implementing the next stage of this process which is a system to measure quality outcomes to demonstrate how effective treatment has been. These will be reported by service users and the data gathered will enable the Trust to report performance and benchmark itself against other Trusts.

* Payment by results is a system which pays the mental health service for the treatments that it provides. Previously the Trust would have received a lump sum to be divided across all of the services it provides.

Service user survey

The CQC requires Trusts to undertake national service user surveys each year. In 2012 the Trust undertook a survey of service users in the community and a survey of inpatients. Although the merger had taken place on the 1st April 2012, the sample for the surveys had been submitted in 2011 so there were separate surveys for Norfolk and Suffolk.

Community survey

A response rate of 33% was achieved in Norfolk and 36% in Suffolk – the national average was 32%.

Further information about the survey can be accessed via the CQC website on www.cqc.org.uk/publications or type 'service user survey' into the CQC website search box.

This national survey enables the Trust to be benchmarked against other mental health trusts.

The Trust was in the top 20 per cent nationally for the number of respondents who reported:

Norfolk	Suffolk
• Family definitely or to some extent involved as much as service user would like	• Confidence and trust in health and social care staff • Views definitely or to some extent taken into account about medication • Definitely or to some extent told about possible side effects of medication • Care plan definitely or to some extent sets out goals • Given or offered a copy of care plan (in last 12 months)

The Trust was in the bottom 20 per cent nationally for:

Norfolk	Suffolk
• Definitely or to some extent understands what is in care plan • Views definitely or to some extent taken into account in deciding what is in the care plan • Care plan definitely or to some extent covers what to do in a crisis • Given a chance to talk to care coordinator before review about what would happen • Asked about physical health needs by NHS mental health services • Definitely or to some extent given support to get help with care responsibilities in the last 12 months • Definitely or to some extent got the help they wanted when they called the crisis number	• Last saw someone from NHS mental health services less than 12 months ago • Told could bring a friend or relative or advocate to a care review meeting

As all of the issues identified are related to the CPA process, it was noted that new paperwork was implemented in October 2012 and training has been provided with regard to the updated policy. The new policy will therefore be audited quarterly and the results reported. In this way the results can be attributed to specific areas and a more targeted and meaningful action plan implemented.

Following discussion regarding the actions required to improve the survey results it was noted that the sample of service users is identified before the results of the survey in the previous year are known. There will therefore be a delay in identifying improvements from the next year's survey.

Inpatient survey

This survey is not a mandatory requirement and was undertaken by 26 mental health trusts.

A response rate of 32% was achieved in Norfolk and 30% in Suffolk.

This survey enables the Trust to be benchmarked against the other mental health trusts who participated.

The Trust was in the top 20 per cent nationally for the number of respondents who reported:

Norfolk	Suffolk
• Given enough notice of discharge from hospital	• Staff definitely knew about previous care received • Did not share a sleeping area with opposite gender • Always felt safe in hospital • Hospital food very good • Hospital ward or room very clean • Toilets and bathrooms very clean • Hospital definitely helped keep in touch with family • Nurses always listened carefully • Did not feel unfairly treated for any of the reasons given • Given enough notice of discharge from hospital

The Trust was in the bottom 20 per cent nationally for:

Norfolk	Suffolk
• Psychiatrist always listens carefully • Always given enough time to discuss condition and treatment with psychiatrist • When sectioned, rights were explained completely	• Definitely found talking therapy helpful • Made aware of how to make a complaint

As with the community survey, results are delayed and the Trust will ensure that results are seen in conjunction with other results, such as results from mock CQC inspections and regular feedback. Each inpatient area has developed an action plan for improvement.

Staff Survey

The National NHS Staff Survey is a mandatory requirement for NHS organisations, with results being used by the Trust to understand staff views and to inform improvements in the workforce arena.

The most recent survey took place in September to October 2012. This is the first Staff Survey since the creation of NSFT following Norfolk and Waveney Mental Health NHS Foundation Trust's (NWMHFT) acquisition of Suffolk Mental Health Partnership NHS Trust (SMHP) and achieved a response rate of 53%. This compares to a response rate in the previous year of 60% for NWMHFT and 51% for SMHP.

For context, in addition to the background of a recent merging of the two organisations, the survey took place towards the end of a period of significant restructuring within the corporate and support services. It also coincided with the commencement of a period of collective consultation on the Trust's Service Strategy, which includes proposals for significant workforce redesign to support the delivery of radically redesigned clinical services and the necessity for financial efficiencies.

The survey is structured around the four staff pledges set out within the NHS Constitution, with additional themes of staff satisfaction and equality and diversity.

For the 2012 survey, these have been presented as 28 key findings, ten less than in previous years. Scores are either presented as percentage rates or as a score out of five, with five being the maximum score.
The following summarises the response rate and the four best and worst key findings for the Trust:

	NSFT	National Average (mental health/ learning disabilities)	2011	
			NWMHFT	SMHP
Response Rate	53% (Above national average)	Unknown*	60%	51%
Best Four Scores				
Staffing working extra hours	65%	70%	66%	63%
Staff appraised in the last 12 months	91%	87%	70%	65%
Staff believing Trust provides equal opportunities for career progression and promotion	92%	90%	91%	88%
Staff receiving job relevant training, learning or other development in last 12 months	85%	82%	81%	82%
Worst Four Scores				
Staff Motivation at work	3.7	3.84	3.75	3.78
Staff reporting errors, near misses or incidents witnessed in last month	89%	93%	97%	96%
Staff able to contribute to improvements at work	67%	71%	66%	62%
Work pressure felt by staff	3.14	3.02	3.13	3.09

* National results report NSFT's results as being "above average" but the actual national average is not provided within the report the Trust receives.

Taking account of the feedback from the 2011 surveys, the Trust had revised its approach to appraisals implementing a three month appraisal 'window' in which appraisals must be undertaken. As a result of this, the Trust is now in the top 20% of Mental Health/Learning Disabilities Trusts in respect of its appraisal rate. The 2012 survey reports a rate of 91%. This is an increase from 70% for NWMHFT and 65% for SMHP in the previous year.

The Trust has also performed higher than average in the areas of staff receiving job relevant training, learning and development, staff believing the Trust provides equal opportunities for career progression, staff experience of discrimination at work and the percentage of staff working extra hours.

Despite a national trend in Mental Health/Learning Disabilities Trusts of declining performance since the 2011 survey and taking account of external and internal organisational factors influencing workforce issues at the time of the 2012 survey (some of which are set out above), there was no significant change in the Trust's performance across the majority of the key findings.

The finding in regard to the reporting of errors appears to be an anomaly in the context of the Trust being one of the highest reporting Trusts in the region and other findings within the Staff Survey, for example, 90% of respondents stated that the Trust does not blame or punish people who are involved in errors, near misses or incidents and 83% confirmed that the Trust encourages staff to report errors, near misses or incidents.

Taking account of the survey findings, the priority areas for focus are:

- Staff engagement;
- Staff wellbeing;
- Incident reporting;
- Statutory and mandatory training.

The Trust had already begun taking forward work in each of these areas prior to the Staff Survey results being published. Following consultation with staff, a Staff Charter is being developed setting out the Trust's values and an Employee Wellbeing Strategy is being presented to the Board of Directors for endorsement at its April 2013 meeting.

Awareness has been raised of incident reporting procedures, including whistle-blowing and plans have been implemented to improve statutory and mandatory training rates which are being closely monitored by the Board of Directors.

Further information about the survey, and a full breakdown of results, can be accessed via a dedicated website on http://www.nhsstaffsurveys.com/cms/

Statements from Norfolk Commissioning Support Unit, Suffolk Commissioning Support Unit, Norfolk Health watch, Suffolk Health watch, Overview and Scrutiny Committees

The Department of Health issued new guidance this year regarding which organisations should be invited to comment on quality accounts which reflected changes introduced by the Health and Social Care Act 2012. NSFT made the decision to continue to invite organisations from both Norfolk and Suffolk to respond. The following responses have been received.

The Norfolk Health Overview and Scrutiny Committee *has decided not to comment on any of the Norfolk provider Trusts' Quality Accounts for 2012-13 and would like to stress that this should in no way be taken as a negative comment.*

The Suffolk Health Overview and Scrutiny Committee. *Due to the County Council elections this year, the Suffolk Health Scrutiny Committee was unable to meet to discuss the content of this year's Quality Accounts during the timescales set by the Department of Health. In previous years, the Committee has not commented individually on providers Quality Accounts, as it has taken the view that it would be appropriate for Suffolk LINk to consider the documents and comment accordingly. The Committee is aware that the dedicated Quality Accounts Working Group established by Suffolk LINk has continued its work on Quality Accounts for 2012-13 and will be providing its views to the Healthwatch Board for formal ratification and submission to Suffolk providers.*

The Committee has, in the main, been happy with the engagement of local healthcare providers in the work of the Committee over the past year, and is keen that these relationships continue to develop to ensure the best possible health services for the people of Suffolk.

Consideration will be given to discussions with providers about how they are performing against their agreed targets, and potential scrutiny issues raised, when the Committee reconvenes in summer 2013.

***Healthwatch Norfolk** can confirm that it has reviewed the Quality Accounts for 2012-13. However, due to Healthwatch Norfolk only becoming operational from 1 April 2013 we do not believe it is appropriate for us to provide any detailed observations at this time but we will be working closely with NHS Norfolk and Suffolk and therefore will provide detailed and constructive comments on the Quality Accounts for 2013-14.*

***Healthwatch Suffolk** recognises that there have been challenges for Norfolk & Suffolk NHS Foundation Trust in its first full year since the merger of the former Norfolk and Suffolk Trusts. It is reassuring that, whilst the Trust has been involved in a radical redesign, there is a high commitment to maintaining quality and that a number of quality outcomes have been identified for monitoring to ensure that this is on-going.*

The report appears very comprehensive, however, it is quite dense with technical language that is not necessarily easily understandable by the wider public. Pulling out the salient points into boxes, and the use of more devices, such as pie charts and bar graphs, would help. In future such reports it would be good to see the text enhanced with comments and quotes from both service-users and staff. It would also be helpful to have more information on specific conditions, such as personality disorder and dementia, separated out for those readers with a specific interest.

It is pleasing to see that the Trust recognises the value of supporting service-users in maintaining their physical, as well as mental, health by encouraging their accessing the GP and having at least an annual physical health check.

The development of new services such as Suffolk Well-being, a fully-integrated service for adults affected by drugs and alcohol and an in-patient service in Lowestoft for young people is well-received, particularly the involvement of young people in the design of the latter, and their input into the information and support they would like.

It is heartening to see the Trust Awards whereby the work and dedication of staff is acknowledged. Also, to see that several of the in-patient areas have achieved accreditation from the Royal College of Psychiatrists, for achieving high standards of quality improvement. Finally, the expanding use of and acknowledgement of the role that volunteers can and do play in the care of people with mental health problems as an invaluable resource for improving the quality of care is well recognised.

It remains early days to see the full effect of the merger between Suffolk and Norfolk mental health services, as the Norfolk & Suffolk NHS Foundation Trust consolidates its redesign and continues to strive for excellence in its quality of care. Healthwatch Suffolk looks forward to watching progress in the future.

***North Norfolk CCG**, as host commissioner for Norfolk and Suffolk Foundation Trust on behalf of the Norfolk and Waveney CCGs are pleased to support the Trust in its publication of the 2012-13 Quality Account.*

Having reviewed the mandatory detail of the report, we can confirm that we are satisfied with its content.

The Trust identifies a clear programme of new audits that have been put into place to keep people safe through its programme of suicide prevention work, and we look forward to seeing improved outcomes for patients and in staff development from this work over the coming year.

North Norfolk CCG supports the Trust in their Quality priorities for 2013-14, however there are areas of development and further depth of information that would have offered additional strength of quality arrangements for the Trust within their setting of key priorities for the coming year:

- *Patient safety – it is noted that the plan to implement systems to enhance the physical health management and screening services offered to patients in contact with mental health services was also a key priority for 2012-13. Evaluation of progress made with this ambition would have provided a clear benchmark of improvements made and have provided some clear and measurable milestones for the progression of this work for the forthcoming year*

- *Patient Experience – The Trust identifies an on-going need to reduce in-patient lengths of stay and outlines the installation of new initiatives to support this work over 2012-13; however it reports an increase in the lengths of stay for that period and rationalises various reasons for this without providing clarity of the methodology for scrutinising this data to use as baseline for the forthcoming year.*
- *Patient Experience – Audit data around Crisis planning for in-patients shows a low compliance of 51% ascertaining that this is due to the inappropriateness of crisis planning for patients' directly following admission to an acute mental health setting. This would suggest that there should be changes made to the audit criteria to better reflect that the audit monitors only those patients for whom it is relevant.*

There are missed opportunities to highlight the IT project which is currently underway within the Trust and offers potential for improved communication and continuity around clinical documentation and care planning, nor does it outline the identification of any risks related to this work.

In addition the rolling programme of the Trust Service Strategy, while necessary to modernise services and enhance innovation, effectiveness and efficiency of services does also present the need for careful implementation and close monitoring in order to ensure a safe transition. Therefore we are pleased that a clear framework for review, monitoring, reporting and will be provided in order to deliver more assurance around the outcomes for patients.

Mark Taylor, Chief Officer,
North Norfolk CCG

***Ipswich and East Suffolk Clinical Commissioning Group** and **West Suffolk Clinical Commissioning Group**, as the commissioning organisations for Norfolk and Suffolk NHS Foundation Trust, confirm that the Trust has consulted and invited comment regarding the Quality Account for 2012-13. This has occurred within the agreed timeframe and the CCGs are satisfied that the Quality Account incorporates all the mandated elements required.*

The CCGs have reviewed the Quality Account data to assess reliability and validity and to the best of our knowledge consider that the data is accurate. The information contained within the Quality Account is reflective of both the challenges and achievements within the Trust over the previous 12 month period. The priorities identified within the account for the year ahead reflect and support local priorities.

Ipswich and East Suffolk Clinical Commissioning Group and West Suffolk Clinical Commissioning Group, are currently working with clinicians and managers from the Trust and with local service users to review the Service Redesign/ Service Strategy development. This work is to assure that this process continues to improve services and ensure quality, safety, clinical effectiveness and good patient/care experience are delivered across the organisation.

This Quality Account demonstrates the commitment of the Trust to improve services. The Clinical Commissioning Groups endorse the publication of this account.

***NSFT Governors.** The Chair and Vice-Chair of the Performance and Planning committee met with Sue Barrett, Head of Governance, to discuss and explore ways to build upon, and improve, the current review process.*

Areas discussed included the collection of responses from the public, and ways to improve the levels of influence that Governors currently have.

From this meeting, it was agreed that a small sub group from the committee be identified, to produce a response to come to the full committee for the June meeting 2014.

How you can get involved

If you would like to be involved in influencing the work of the Trust there are a number of ways that you can contribute.

As a member of Norfolk and Suffolk NHS Foundation Trust, individuals can help shape the way the Trust plans and provides mental health services in Norfolk and Suffolk. Membership is free, and members will receive regular information about the Trust's plans and developments. They will be invited to public meetings and receive a copy of our newsletter, Insight. Members are also able to stand for election as a governor, or vote in our annual governor elections. Join now by calling 0870 7071647 or by texting JOIN to 65000. Alternatively, visit www.nsft.nhs.uk to sign up online.

If you are a service user or carer, contact:

- The Service Users' Council, at serviceuserscouncil@nsft.nhs.uk
- The Carers' Council, at carerscouncil@nsft.nhs.uk

For more information about the Trust contact PALS on 0800 279 7257

Key and glossary for the Quality Account

AIMS	Accreditation in Mental Health Services
BME	Black and minority ethnic
CAMHS	Child and Adolescent Mental Health Service
CAT	Cognitive analytic therapy
CBT	Cognitive behaviour therapy
CPA	Care programme approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRHT	Crisis resolution and home treatment
DoH	Department of health
EMDR	Eye movement desensitisation and reprocessing
ESBL	Extended spectrum beta lactamase
FFP	Five forensic pathways
IAPT	Improving access to psychological therapies
IPAC	Infection prevention and control
KPI	Key performance indicator
Links	Local involvement networks
LIPACS	Local infection control prevention and control supporter
MRSA	Methicillin resistant staphylococcus aureus
NCE	National confidential enquiry
NHSLA	NHS Litigation Authority.
NICE	National Institute of Clinical Excellence
NIHR	National Institute of Health Research
NLP	Neuro linguistic programming
NPSA	National Patient Safety Agency
NRP	Norfolk Recovery Partnership
NSFT	Norfolk and Suffolk NHS Foundation Trust
NWMHFT	Norfolk and Waveney Mental Health Foundation Trust
PALS	Patients' Advice and Liaison Service
PAT	Pets as therapy
PbR	Payment by results
PCT	Primary Care Trust
PEAT	Patient Environment Action Team
PET	Patient experience tracker
PICU	Patient intensive care unit
PLACE	Patient led assessment of the care environment
POMH	Prescribing Observatory for Mental Health
QIPP	Quality innovation prevention and productivity
QRP	Quality and risk profile
RAPT	Rehabilitation for addicted prisoners trust
RCA	Root cause analysis.
SCR	Serious case review
SI	Serious incident
VRE	Vancomycin resistant enterococci

Regulatory Ratings

Performance Reporting

Quality, service and financial compliance to national and locally commissioned targets are reported to the Board of Directors via the Business Performance Report. The performance management framework support the organisational delivery to ensure delivery across all areas of performance has developed in 2012-13 to reflect the changes in management and operational structure since merger.

For the first three quarters of 2012-13 organisational accountability for performance was delivered via the Performance Review Group (PRG) which met monthly to review the Integrated Performance Dashboard (IPD). The IPD monitors 80 key performance indicators across the following areas:

- Organisational Delivery
- Quality, Safety and Experience
- Workforce, Development and Effectiveness
- Financial Delivery

The PRG was accountable to the Board of Directors via the Director of Operations (Norfolk) reporting to the Finance and Performance Committee (Board of Directors Sub-Committee).

The performance management framework was adjusted for Quarter 3 onwards to reflect the move to locality management. Norfolk and Suffolk NHS Foundation Trust comprises of 5 localities, 3 in Norfolk and 2 in Suffolk with 3 county wide services. Since January 2013 the Director of Finance has led performance reviews monthly with each locality separately. This has enabled greater focus on issues facing localities and has also allowed for a two way approach to accountability with localities able to comment on the performance of corporate services. The Director of Finance continues to report on the IPD to the Finance and Performance Committee.

Monitor Compliance Framework

The Trust continues be monitored against eight mental health targets and thresholds. Performance against these targets combines to provide the Trusts Governance Risk Rating (GRR).

Target	Threshold	Qtr 1	Qtr 2	Qtr 3	Qtr 4
CPA Patients receiving a follow-up within 7 days of discharge	95%	95.20%	97.13%	99.08%	98.31%
CPA Patients having formal review within 12 months	95%	95.23%	96.99%	98.34%	98.24%
Minimising delayed transfers of care	<7.5%	2.96%	4.40%	5.55%	5.39%
Admissions to inpatient services had access to CRHT teams	95%	87.02%	86.18%	97.80%	99.74%
Meeting commitment to service new psychosis cases by early intervention teams	95%	153.7%	144.43%	155.05%	148.83%
Data Completeness: Identifiers	97%	99.42%	99.73%	99.72%	99.66%
Data Completeness: Outcomes	50%	81.65%	81.78%	84.49%	84.70%
Self-certification against compliance regarding access to Health Care for people with a learning disability	6	6	6	6	6

Key to data tables On or above target | Within 5% of target | Missing target by more than 5%

Monitor Risk Ratings

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Finance	3	3	3	3
Governance	Amber/Green	Amber/Green	Green	Green

Following the merger of Norfolk and Waveney Mental Health Foundation Trust with Suffolk Mental Health Partnership NHS Trust a comprehensive review of business processes was undertaken. As a result of this review it was clear that Suffolk localities clinical processes were not fully aligned to the definitions of the Monitor Compliance Framework in relation to process and recording of activity associated with ensuring all inpatient admissions receive a face-to-face contact by the CRHT team prior to admission. This was highlighted in the PRG in May 2012. Immediate steps were taken to change business practices within Suffolk localities and a recovery plan was provided to commissioners and to Monitor which stated the Trust would have embedded new clinical and reporting processes by the end of Quarter 2 and would return to reporting compliance in Quarter 3. The Trust successfully delivered these change and has been compliant on this measure since Quarter 3 2012-13.

Contract Targets

In 2012-13 NSFT operated within 'block' contract arrangements with NHS Norfolk, NHS Great Yarmouth & Waveney and NHS Suffolk covering provision of mental health services covering Child and Adolescent Mental Health (CAMHS), People of Working Age, Older People, and Substance Misuse. The contracts included a range of agreed performance indicators. Please see below for the performance against each commissioner.

NHS Norfolk

Key Performance Indicator	2011-12 Outturn	2012-13 Target	2012-13 Actual
Percentage of patients with a valid MHCT assessment and care cluster	95.85%	99%	96.17%
Percentage of long-term (over 12 months) inpatients who have received an annual health check	76.92%	100%	100%
Percentage of substance misuse patients offered Hepatitis B vaccination[1]	95.96%	99%	98.3%
Ratio of older people inpatient falls per 1000 occupied bed days	29.13	22.76	21.17
Percentage of referrals to CAMHS waiting eight weeks or less from referral to assessment	67.95%	80%	63.33%
Early Intervention in Psychosis total caseload	233	235	218
Assertive Outreach total caseload	153	153	183

1 – Percentage relates to M1-M11 due to changing clinical systems in M12

NHS Great Yarmouth & Waveney

Key Performance Indicator	2011-12 Outturn	2012-13 Target	2012-13 Actual
Percentage of patients with a valid MHCT assessment and care cluster	97.04%	99%	93.96%
Percentage of long-term (over 12 months) inpatients who have received an annual health check	96.43%	100%	100%
Percentage of substance misuse patients offered Hepatitis B vaccination[1]	92.93%	99%	97.9%
Ratio of older people inpatient falls per 1000 occupied bed days	17.00	22.76	15.47
Percentage of referrals to CAMHS waiting eight weeks or less from referral to assessment	73.33%	80%	64.29%
Early Intervention in Psychosis total caseload	94	73	96
Assertive Outreach total caseload	54	53	53

1 – Percentage relates to M1-M11 due to changing clinical systems in M12

NHS Suffolk

Key Performance Indicator	2011-12 Outturn	2012-13 Target	2012-13 Actual
Percentage of CAMHS patients seen within 15 weeks of referral	92.00%	100%	94.12%
Number of new cases of psychosis served by early intervention teams	127	66	97
Assertive Outreach total caseload	163	175	158
Total Home Treatment episodes in year	854	950	1,437
Adult Acute Inpatient – Average length of stay	21	36	35
Percentage of care plans containing risk management, crisis and contingency plans	93.00%	95%	96.60%
Percentage of care plans where accommodation and employment status is assessed at review	98.5%	95%	99.30%
Median time waited for admitted and non-admitted patients from referral to treatment (weeks)	Not reported in 2011-12	6.6	1.7

Contract target – Medium and Low Secure NHS Midland and East Specialised Commissioning Group)

The Trust's contract with the East of England Specialised Commissioning Group for the provision of medium and low secure mental health services identified bed occupancy as a key target. The medium secure bed occupancy threshold was set at 90% with the low secure bed slightly lower at 85%. The terms of the contract stipulated that occupancy levels below the thresholds would trigger a payback clause in the contract on a cost-per-day basis. The end of year medium secure bed occupancy was slightly below the threshold and this did result in a minor adjustment to the contract income.

Key Performance Indicator	2011-12 Outturn	2012-13 Target	2012-13 Actual
Medium Secure bed occupancy including leave days	89.80%	90%	94.12%
Low secure bed occupancy including leave days	89.19%	85%	83.05%

Contract Target – Section 75

The Trust contracted with Norfolk County Council to provide Adult Social Care for people suffering with mental ill health.

The contract placed a responsibility on the Trust to deliver the specified service and to meet some of the national performance targets allocated to the council.

Key Performance Indicator	2011-12 Outturn	2012-13 Target	2012-13 Actual
Carers receiving assessment/review – NCC Section 75 adults only	325	400	300
Clients receiving a review	1,384	1,400	1,681
Percentage of Adults on CPA receiving secondary mental health services in settled accommodation	73.87%	55%	62.17%
Percentage of Adults on CPA receiving secondary mental health services in employment	4.99%	6.8%	6.75%

The Trust also has a section 75 agreement with Suffolk County Council. KPIs and reporting processes have been in development during 2012-13 for reporting in 2013-14.

Trust Governance

Compliance with NHS Foundation Trust Code of Governance 2012-13

The Board of Directors and the Board of Governors are committed to the principles of good corporate governance, as detailed in the NHS foundation trust code of governance. Since the Foundation Trust was authorised on 1 February 2008, work has been undertaken to ensure compliance with the code of governance, except for the following provision:

Provision
C.2.1

Description
Executive directors should be subject to re-appointment at intervals of no more than five years

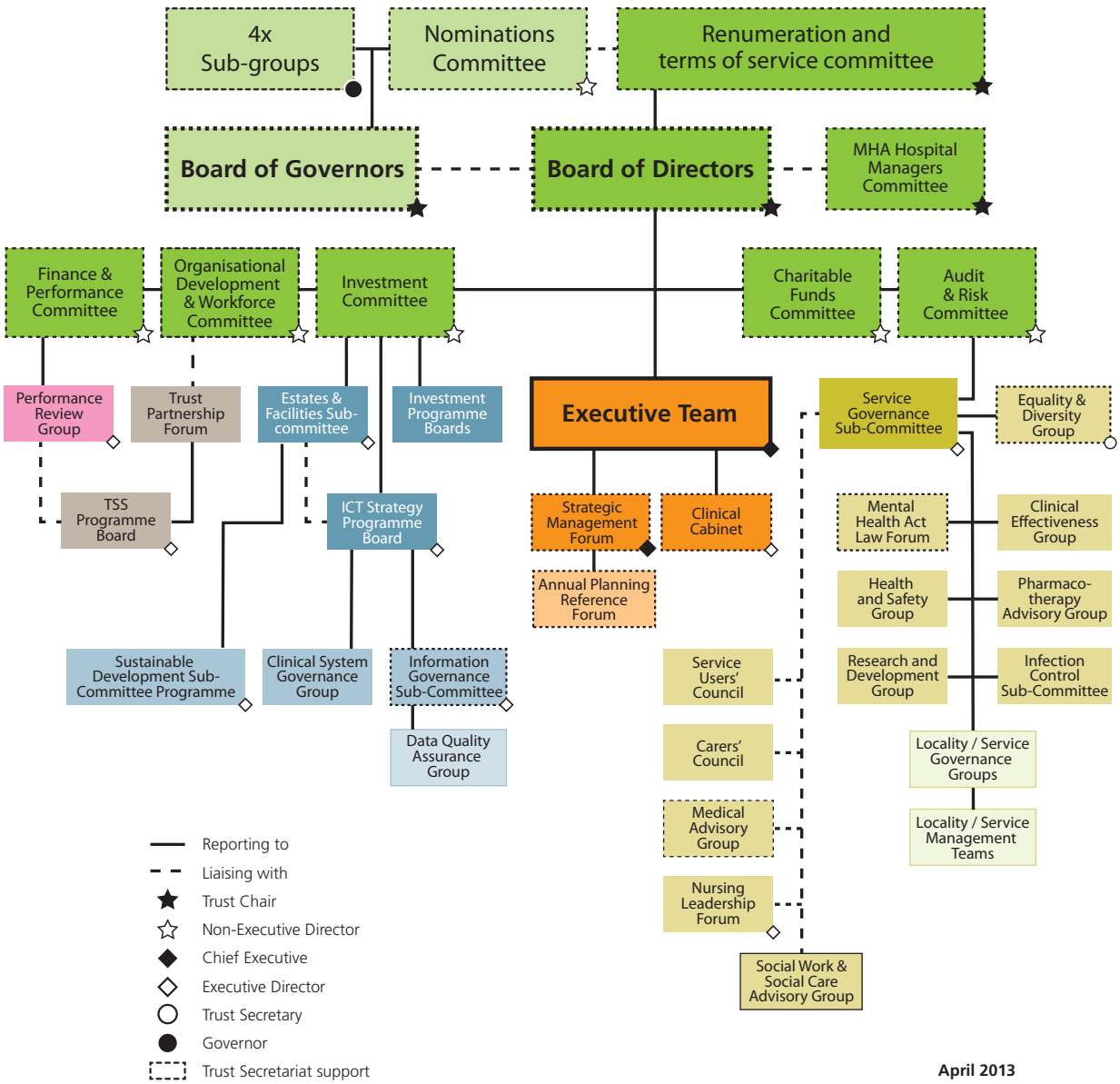
Commentary
Executive directors are appointed on substantive contracts. Remuneration & Terms of Service Committee chose not to change

Provision
C.2.2

Description
Any term beyond six years (e.g. two three year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-executive directors may in exceptional circumstances serve longer than six years (e.g. two three year terms following authorisation of the NHS foundation trust) but subject to annual re-appointment.

Commentary
The Trust's constitution sets a maximum period of nine years for non-executive director terms. No current non-executive director has currently served more than six years since the organisation became a foundation trust. However, this will threshold will be reached within the coming year. The nominations committee is aware of this position and will review these arrangements with a view to updating the constitution and ensuring non-executive director independence.

Management structure chart



The work of the Board of Governors

The Board of Governors met formally on four occasions and held several informal and developmental sessions.

Elections are normally held once a year with nominations opening in the autumn for announcement towards the end of the calendar year. However, because of the merger delays a number of elections results were declared in April 2012 and in December 2012 (for governors taking up their roles from 1 February 2013). The normal cycle of annual elections will now recommence. Details of election outcomes are shown in the table below.

The following outcomes were achieved by the Board of Governors and its subgroups:

- Appointed a new Non-executive Director
- Re-appointed two Non-executive Directors
- Appointed a new Chair (from 3 April 2013)
- Commented on the Trust's annual objectives and plans
- Chosen a quality indicator and contributed to the development of the quality account
- Extended the appointment of the auditors
- Carried out a self-evaluation
- Commented on the Trust Service Strategy
- Considered the Trust's approach to partnership working
- Elected a new lead governor
- Strengthened the work of the planning and performance subgroup and the Board of Governors in relation to holding the Board of Directors to account.
- Developed proposals for amendments to the Constitution in order to ensure that it remains up to date
- Approved the membership strategy
- Updated the election documentation
- Updated the arrangements for governor oversight of complaints
- Reviewed Trust performance information and refined the suite of information to scrutinise
- Reviewed the Board of Directors skill mix
- Reviewed and update the governors' code of conduct
- Attended community events across the two counties

The main duties of the Board of Governors are:

- To appoint or remove the chairman and other non-executive directors
- To approve the appointment of the chief executive
- To decide the remuneration and allowances, and other terms and conditions of office, of the non-executive directors (delegated to the nominations committee)
- To appoint or remove the Trust's auditor.

The 2011-12 annual accounts and the annual report were presented to the Board of Governors at the annual general meeting held on 3 October 2012.

The Trust has continued its membership of the Foundation Trust Governors' Association, and the Foundation Trust Network and governors and Trust staff have attended workshops and conferences, and reported back to the Board of Governors.

Board of Governors 2012-13 attendees

Attendee	Constituency	4 Apr 2012	4 Jul 2012	3 Oct 2012	9 Jan 2013	
Mary Rose Roe	Carer	✓	✓	✓	✓	Re-elected 1 Feb 2013 (opposed)
Peter Dyer	Carer	✓	✓	✓	A	Elected 1 Feb 2012 (unopposed)
Tony Betts	Public – N	✓	✓			Re-elected 1 Feb 2010 (opposed)
Nancy Boardley	Public – S		✓	✓	✓	Elected 1 Feb 2012 (opposed)
Susan Jane Dowling	Public – N					Elected 1 Feb 2013 (opposed)
Pauline Elliott	Public – S	A	✓	✓	✓	Re-elected 1 Feb 2010 (opposed)
Stephen Fletcher	Public – N				✓(D)	Elected 1 Feb 2013 (opposed)
John Hill	Public – S				✓D)	Elected 1 Feb 2013 (opposed)
Tony Jackson	Public – N	✓	✓	A		Re-elected 1 Feb 2010 (opposed)
Tony Lee	Public – N				✓(D)	Elected 1 Feb 2013 (opposed)
Jacqueline Middleton	Public – N	*	A	A	A	Re-elected 1 Feb 2013 (opposed)
Jane Millar	Public – S		A	✓	✓	Elected 23 Apr 2012 (opposed)
Guenever Pachent	Public – S		✓	✓	✓	Elected 23 Apr 2012 (opposed)
Maggie Prettyman	Public – N	A	✓	✓	A	Re-elected 23 Apr 2012 (unopposed)
Pat Southgate	Public – N	*	A	✓	✓	Re-elected 23 Apr 2012 (opposed)
Adrian Stott	Public – S		✓	✓	✓	Re-elected 23 Apr 2012 (opposed)
Marion Swan	Public – S	A	✓	✓	✓	Re-elected 23 Apr 2012 (opposed)
John Walker	Public	✓	✓	✓	✓	Elected 1 Feb 2010 (opposed)
Catherine Wells	Public – N				A	Elected 1 Feb 2013 (opposed)
Malcolm Blowers	Service User	*				Elected 1 Feb 2011 (unopposed)
Susie Enoch	Service User – S		✓	✓	✓	Elected 1 Feb 2012 (opposed)
Paul Gaffney	Service User – S		✓	A	✓	Elected 23 Apr 2012 (opposed)
James Hogan	Service User – N		✓	✓	✓	Elected 23 Apr 2012 (opposed)
Duncan Double	Staff	✓	✓	✓	✓	Re-elected 23 Apr 2012 (unopposed)
Karen O'Sullivan	Staff	✓	A	✓	✓	Re-elected 1 Feb 2013 (opposed)
David Rollinson	Staff	✓	✓	✓	✓	Elected 5 Mar 2013 (unopposed)
Linda Weatherley	Staff				✓(D)	Elected 1 Feb 2013 (opposed)
Kathleen Ben Rabha	Partner – SAVO	✓	✓	✓	✓	Appointed Apr 2012
Pip Coker	Partner – Julian Housing Support Ltd	A	✓	A	A	Appointed Mar 2008
Rosie Doy	Partner – UEA	✓	A	A	✓	Appointed Sept 2011
Jeff Halliwell	Partner – NHS Norfolk	✓	✓	A	A	Appointed May 2011
David Harrison	Partner – Norfolk County Council	✓				Appointed Mar 2012 - Resigned
Jenny Manser	Partner – Broadland Meridian	*			✓	Appointed Jan 2012
Bob Payne	Partner – UCS					Appointed Apr 2012
Paul Rice	Partner – Norfolk County Council				A	Appointed Jul 2012
Martin Royal	Partner – NHS Suffolk	*				Appointed in designate 1 Jan 2012
Mary Rudd	Partner – Suffolk County Council	✓	✓	A	A	Appointed Mar 2012
Kevin Wilkins	Partner – Norfolk Constabulary	A	A			Appointed Apr 2007
Paul Marshall	Partner – Suffolk Constabulary	*	A			Appointed in designate 1 Jan 2012
Gareth Wilson	Partner – Norfolk & Suffolk Constabularies			✓	✓	Appointed Aug 2012
Maggie Wheeler	Trust Chair	✓	A	✓	✓	

A = Apologies * Apologies not received (D) = Designate

Board of Directors attendees at Board of Governors meetings

Attendee	Constituency	4 Apr 2012	4 Jul 2012	3 Oct 2012	9 Jan 2013
Graham Creelman	Senior Independent Director	✓	✓	A	✓
Barry Capon	Non-Executive Director	A	✓	✓	✓
John Brierley	Non-Executive Director				A
Aidan Thomas	Chief Executive	✓	✓	A	✓
Peter Jefferys	Non-Executive Director	A		✓	✓
Brian Parrott	Non-Executive Director	✓	✓	✓	✓
Gary Page	Non-Executive Director			✓	✓
Andrew Hopkins	Director of Finance		✓		
Roz Brooks	Director of Nursing,				
	Governance & Patient Safety	✓			✓
Jane Marshall-Robb	Associate Director				
	– Human Resources	A		✓	A
Kathy Chapman	Director of Operations				✓
Robert Nesbitt	Trust Secretary	✓	✓	✓	✓
Leigh Fleming	Commercial Director				✓

A = Apologies

Register of interests

All governors are asked to declare any interests on the register of governors' interests at the time of their appointment or election. This register is maintained by the Trusts secretary. The register is available for inspection by members of the public.

Anyone who wishes to see the register of governors' interests should contact the Trust Secretary at Norfolk and Suffolk NHS Foundation Trust, Hellesdon Hospital, Drayton High Road, Norwich, NR6 5BE. Alternatively telephone 01603 421421.

Membership strategy summary

The total number of members for Norfolk & Suffolk NHS Foundation Trust as of 31 March 2013 was 13,407 excluding staff members. Membership has been steady but plans to increase recruitment and engagement were affected by delays in recruiting to the membership officer post. This is now underway with the intention of making a full time appointment early in 2013/14. This will create capacity to implement the membership strategy which aims to improve take up of membership by under-represented groups.

Governors have taken the opportunity to promote membership at various community events including Suffolk Lesbian, Gay Bisexual and Transgender (LGB&T) Pride, Norwich LGB&T Pride, Black History Month, Suffolk Mela, Ipswich Big Multi-Cultural day, and through the development of the Trust's spirituality and pastoral care strategy.

Members who wish to contact the Trust's governors may do so by emailing membership@nsft.nhs.uk or by writing to

Membership Office
Norfolk & Suffolk NHS Foundation Trust
Hellesdon Hospital
Drayton High Road
Norwich
NR6 5BE

New members are welcome. Membership is free. You can join by calling our membership helpline on 0870 7071647.

Membership Report

Public constituency	Last year (2012-2013)	Population	Index
As at start (1 April)	11,620		
New Members	1,331		
Members leaving	976		
At year end (31 March)	11,975	1,491,149	

Staff constituency	Last year (2012-2013)
As at start (1 April)	4,514
New Members	559
Members leaving	810
At year end (31 March)	4,263

Patient constituency	Last year (2012-2013)
As at start (1 April)	1,473
New Members	40
Members leaving	81
At year end (31 March)	1,432

Public constituency

Age (years):	Number of members	Population	Index
0 - 16	15	109,201	1
17 - 21	189	79,299	29
22+	9,949	1,302,649	95
Ethnicity:			
White	11,162	1,459,859	95
Mixed	74	12,079	76
Asian	154	6,760	283
Black	112	6,065	229
Other	23	5,942	48
Socio-economic groupings:			
ABC1	7,582	573,028	164
C2	2,733	209,853	162
D	684	198,457	42
E	849	201,182	52
Gender analysis:			
Male	4,369	727,532	74
Female	7,506	762,663	122

Patient constituency

Age (years):	Number of members
0 - 16	0
17 - 21	17
22+	1,233

Board of Directors

The Board of Directors meet at least 12 times a year, with four meetings held in public at locations across the Trust's catchment area. Attendance at Board meetings is set out in the following table.

Name	26 Apr 2012	24 May 2012		ARA 28 May 2012	28 Jun 2012	26 Jul 2012	23 Aug 2012		27 Sept 2012	AGM 3 Oct 2012	18 Oct 2012	22 Nov 2012		20 Dec 2012	24 Jan 2013	8 Feb 2013	28 Feb 2013		28 Mar 2013
		Public	Private				Public	Private				Public	Private				Public	Private	
Dr Hadrian Ball	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓
John Brierley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓
Roz Brooks	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A	A	✓
Barry Capon	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kathy Chapman	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A	A	✓	✓	✓	A	✓	✓	✓
Graham Creelman	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Leigh Fleming	✓	✓	✓	A	✓	A	A	A	✓	✓	A	✓	✓	✓	✓	A	A	A	✓
Andrew Hopkins	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓
Dr Peter Jefferys	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A	✓
Gary Page	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Brian Parrott	✓	✓	✓	A	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stuart Smith	✓	✓	✓	✓	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Aidan Thomas	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	A	✓	A	✓	✓	✓	✓	✓
Maggie Wheeler	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Debbie White							✓												

A = Apologies

Board of Directors' meetings

The Board of Directors is satisfied that the non-executive directors who served on the Board of Directors for the period under review are independent. A summary of the background of each of the Board members, together with details of their areas of expertise and experience, is set out below. The chair had no other significant commitments during the period of review.

Chair and Non-Executive Directors

Director	Expertise	Qualifications
Maggie Wheeler	• Previous Vice Chair of NHS Trust and PCT • Former social services manager • Director, trustee and former Chair, Age UK Norwich • Director of own company, providing research, facilitation and training	• Certificate of Qualification in Social Work (not currently registered) • Certificate in Management Studies
John Brierley	• Director of own company • Formerly executive director of the Norfolk Learning and Skills Council • Formerly Chief Executive of the Local Training and Enterprise Council and city treasurer of Norwich City Council. • Honorary treasurer of local MIND	• Member of the Chartered Institute of Public Finance and Accountancy (CIPFA)
Barry Capon	• Former Chief Executive of Norfolk County Council • Former Chair of Anglian Harbours NHS Trust • Former Commissioner of Criminal Cases Review Commission • Lay member of British Pharmacopoeia Commission	• Solicitor
Graham Creelman (SID)	• Consultant on creativity within organisations • Former Chair of the City of Norwich Partnership • Chair of Governors, Norwich University College of the Arts • Former Chair of Living East (East of England Cultural Consortium) • Former Managing Director of Anglia Television • Former Director of Regional Programming for ITV Network • Visiting Professor in Media at Norwich University College of the Arts • Vice-Chair of The Writers' Centre, Norwich • Extensive experience in television production • OBE for services to broadcasting	
Dr Peter Jefferys	• Consultant Old Age Psychiatrist & former Medical Director of Harrow & Hillingdon Healthcare NHS Trust • Lead Second Opinion Appointed Doctor for MHAC and Care Quality Commission • Psychiatric advisor Parliamentary & Health Services Ombudsman • Member Mental Health Review Tribunals • Chair Fitness to Practice Panels for GMC & General Social Care Council	• Licensed with General Medical Council – on specialist registers for General Psychiatry & Old Age Psychiatry • Fellowships of Royal College of Physicians of London & Royal College of Psychiatrists • Expert witness (mental capacity) recognised by Court of Protection & High Court

Director	Expertise	Qualifications
Brian Parrott	• Former Director of Social Services and former Chair of small PCT • Social Care (Adults and Children), Health and Local Government Consultancy • Chair, Suffolk Family Carers (until November 2012) • Co-chair, Association of Directors of Social Services Associates Network • Extensive experience of social services management and partnership working with NHS	• Certificate of Qualification in Social Work (currently registered)
Gary Page – Appointed April 2012	• CEO Global Markets for ABNAMRO BANK NV (2006-08). Career in financial services from 1986. • Chair of Trustees for a school in East London for boys aged 11-16 with Social Emotional and Behavioural Difficulties (2008-10). • Chair of Trustees for the Hoffmann Foundation for Autism providing supported living and day services in North London for adults with Autism.	• BA (Hons)
Stuart Smith	• Former director of business change programmes for Aviva and Norwich Union • Over 20 years of change management and consulting experience in the UK and overseas • Direction of complex change programmes • Delivery of UK wide property strategies • Direction of acquisition, merger, integration and joint venture activity • Leading role in demutualisation and flotation of Norwich Union • 35+ years in financial services as IT manager, management consultant and director of complex change programmes • Partner in Stuart Smith Partners LLP, a management consultancy organisation focused on complex change initiatives	

Executive Directors

Director	Expertise	Qualifications
Aidan Thomas (Chief Executive)	• Two former Chief Executive posts at NHS PCTs • Former Executive Director roles at NHS Trusts • 22 years on NHS Boards • Set up Epping Forest Primary Care Trust • Over 25 years experience within the NHS	• BA • MBA • MHSM
Dr Hadrian Ball (Medical Director)	• Consultant forensic psychiatrist since 1992	• Fellow Royal College of Psychiatrists • Doctor of Medicine • Diploma in Medical Jurisprudence • Health Foundation Leadership Fellow (2006-08)
Roz Brooks (Director of Nursing)	• Managed Trust Alcohol and Drugs Service (1997-2010)	• SRN/RMN • Diploma Health care Education, • BSC Nursing Practice,
Dr Kathy Chapman (Director of Operations, Norfolk and Waveney)	• Consultant Clinical Psychologist – qualified as a Clinical Psychologist in 1990 • Management of health and social care services since 2001 including Locality Manager within NWMHFT	• Doctor of Clinical Psychology • Post Graduate Diploma Managing Health and Social Care
Leigh Fleming (Commercial Director)	• Two previous director posts • Worked at Board level for 12 years • 28 years NHS experience	• Diploma in management studies • Significant professional development in all areas of responsibility
Andrew Hopkins (Director of Finance and Deputy Chief Executive)	• Former director of finance and information at Huntingdonshire PCT • Former consultant and auditor KPMG • Previous chair of Eastern Branch of Healthcare Financial Management Association • Member of the Eastern Region Collaborative Procurement Hub Board	• Member of the Chartered Institute of Public Finance and Accountancy (CIPFA)
Debbie White (Director of Operations, Suffolk)	• Qualified as a Social Worker in 1995 • Management of health and social care services since 2002 including Locality Manager and Associate Director within NWMHFT	• Diploma in Social Work

Audit & Risk Committee – 2012-13 attendance

	NSFT						
Name	11 Apr 2012	ARA 23 May 2012	13 Jun 2012	8 Aug 2012	10 Oct 2012	12 Dec 2012	13 Feb 2013
John Brierley	✓	✓	✓	✓	✓	✓	✓
Graham Creelman	A	✓	✓	✓	✓	✓	✓
Peter Jefferys	✓	✓	A +	✓	A +	✓	✓

A = Apologies + apologies received, submitted comments for meeting to Chair

Nominations Committee – 2012-13 attendance

Name	Constituency	23 May 2012	25 Jul 2012	26 Sep 2012	28 Nov 2012	29 Jan 2013
Graham Creelman	Senior Independent Director	✓	✓	✓	A	✓
Jacqueline Middleton	Public Governor	✓	✓	✓	✓	A
Dr Karen O'Sullivan	Staff Governor	A	A	A	✓	✓
Mary Rose Roe	Carer Governor	A	✓	A	✓	✓
ACC Kevin Wilkins	Partner Governor	✓	✓			
Pip Coker	Partner Governor			A	A	
Kathleen Ben Rhaba	Partner Governor					✓
Maggie Wheeler	Trust Chair	A	✓	✓	✓	A
Aidan Thomas	Chief Executive	A	A	A	A	A
Tony Jackson	Lead Governor	✓	A	A	A	
Guenever Pachent	Public Governor (Lead from Jan 2013)			✓	✓	✓
Susie Enoch	Service User Governor				A	✓
Jane Marshall-Robb	Associate Director – Human Resources	A	✓	A	✓	✓

A = Apologies

25 July 2012 – Joint meeting with the Remuneration & Terms of Service Committee; also present from the Remuneration Committee were Barry Capon, Brian Parrott and Stuart Smith with apologies received from John Brierley, Peter Jefferys and Gary Page.
28 March 2013 – This meeting was stood down.

Nominations Committee

The Nominations Committee is a sub-committee of the Board of Governors. It oversees the recruitment and terms and conditions of non-executive directors and the Chair and makes appointment recommendations to the full Board of Governors. No changes to the terms and conditions of non-executive directors were made during this financial year. The committee met jointly with the Remuneration and Terms of Service Committee on 27 July 2012 and reviewed the skill mix of the Board of Directors. The Nominations Committee considered commissioning an external evaluation of the Board of Directors at its meeting on 29 January 2013 but in the light of the plans to appoint a new Chair this work will be carried forward to 2013-14.

The committee membership and attendance is shown in the table below. The committee is constituted so that there are governor representatives from each of the constituencies (Public / Partner / Staff / User and Carer).

Appointments process

The committee ensures that the appointment process is robust and transparent. Independent recruitment consultants are used to help source high quality candidates and the panel includes a (non-voting) independent advisor who is usually a non-executive director or Chair of another foundation trust. The committee oversaw the recruitment to two vacancies in the year 2012-13.

In relation to the non-executive vacancy created by Deborah Cadman standing down, the committee recommended that Gary Page be appointed as non-executive director from April 2012. The full Board of Governors considered this recommendation and approved the appointment on 3 March 2012.

The committee also over-saw the process for the appointment of the new chair. The period covered by this appointment process crosses into 2013-14. This vacancy arose because Maggie Wheeler was nearing the end of her term of office. The Nominations Committee reviewed and consulted widely on the job profile and person specification and designed the selection process which was approved by the full Board of Governors on 9 January 2013. The selection process consisted of three focus groups with service users and carers, staff, and public and partner governors and representatives. The following day (26 March 2013) candidates undertook a chairing exercise and then a formal interview. The interview panel consisted of Guenever Pachent (lead governor, public -Suffolk), Dr Karen O'Sullivan (staff governor), Stephen Fletcher (public governor – Norfolk and chair of the service user council), Graham Creelman (Senior Independent Director) and Bob Piper (Chair of Black Country NHS FT). The panel made a unanimous recommendation to the full Board of Governors on 3 April 2013 and Gary Page was unanimously appointed Chair of the Trust from that date at an annual fee of £45k.

	Original appt	Reappt'd	Reappt'd	Reappt'd	Current term ends	Total since 1 Feb 2008
Barry Capon	1 Sept 2002 (for 4 years)	1 Sept 2006 (for 4 years)	1 Sept 2010 (for 6 months)	1 Mar 2011 (for 4 months)	31 Dec 2013 (max)*	5 years 2 months
Graham Creelman	1 Mar 2008 (for 4 years)	1 Mar 2012 (for 3 years)			29 Feb 2015	5 years 1 month
John Brierley	10 Nov 2005 (for 4 years)	10 Nov 2009 (for 3 years)	9 Nov 2012 (for 3 years)		9 Nov 2015	5 years 2 months
Dr Peter Jefferys	1 Sept 2011 (for 3 years)				31 Aug 2014	1 year 7 months
Gary Page	4 Apr 2012 (for 3 years)				(Note: appointed as Chair on) 3 Apr 2013	1 year
Brian Parrott	1 Jan 2012 (for 3 years)				31 Dec 2014	1 year 3 months
Stuart Smith	1 Mar 2008 (for 3 years)	1 Mar 2011 (for 2 years)	28 Feb 2013 (for 3 years)		28 Feb 2016	5 years 1 month
Maggie Wheeler	1 Apr 2003 (for 4 years)	1 Apr 2007 (for 4 years)	1 Apr 2011 (for 1 year)	1 Apr 2012 (to 31Dec 2013)	3 Apr 2013	5 years 2 months

* Fixed term of 2 years from date of merger

Annual Governance Statement

The Board has conducted a review of the effectiveness of the Trust's system of internal controls. The annual governance statement can be found within the accounts section.

Additional Information

In addition to this report, further information, as required by the NHS foundation trust code of governance is available on request from the Trust secretary at the address below:

Norfolk and Suffolk NHS Foundation Trust
Hellesdon Hospital
Drayton High Road
Norwich NR6 5BE
Telephone 01603 421421

Remuneration Report

Remuneration and Terms of Service Committee

The remuneration committee, comprising all the non-executive directors, sets the remuneration of executive directors. The members of the committee during the period, and their attendance at meetings, are set out below. No changes were made to executive pay and conditions in the financial year. The committee considered the executive skill mix of the board and reviewed this with the nominations committee at their joint meeting on 27 July 2012.

A Apologies
\+ Steve Ham, Deputy Director of Finance in attendance
* 27 July 2012 – joint meeting with the Nominations Committee

Remuneration & Terms of Service – 2012-13 attendance

Name		11 June 2012	27 July 2012 *	3 Sept 2012	3 Dec 2012	4 March 2013
John Brierley	Non-Executive Director	✓	A	Stood down	✓	Stood down
Gary Page	Non-Executive Director	A	A		✓	
Barry Capon	Non-Executive Director	A	✓		✓	
Graham Creelman	Senior Independent Director	✓	✓		A	
Andrew Hopkins	Acting Chief Executive	+	A		A	
Peter Jefferys	Non-Executive Director	✓	A		✓	
Brian Parrott	Non-Executive Director	A	✓		✓	
Stuart Smith	Non-Executive Director	A	✓		✓	
Aidan Thomas	Chief Executive	A	✓		✓	
Maggie Wheeler	Trust Chair	✓	✓		✓	
Sarah Ball	Head of Human Resources	✓				
Jane Marshall-Robb	Associate Director of Human Resources	✓	✓		A	

Directors' Remuneration Report

Name and title	Year to 31 March 2013				Year to 31 March 2012			
	Salary (Bands of £5,000)	Other Remuneration (Bands of £5,000)	Benefits in kind* (Rounded to the nearest £00)	Total Remuneration (Rounded to the nearest £00)	Salary (Bands of £5,000)	Other Remuneration (Bands of £5,000)	Benefits in kind* (Rounded to the nearest £00)	Total Remuneration (Rounded to the nearest £00)
Hadrian Ball Medical Director	20 to 25	140 to 145	-	163,500	20 to 25	140 to 145	-	165,500
John Brierley Non-Executive Director	15 to 20	-	-	16,000	15 to 20	-	-	16,100
Roz Brooks, Director of Nursing, Quality and Patient Safety	95 to 100	-	-	95,000	95 to 100	-	-	95,000
Barry Capon Non-Executive Director	10 to 15	-	-	11,000	10 to 15	-	-	11,000
Kathy Chapman Operational Director – Norfolk and Waveney	95 to 100	-	2,500	100,500	95 to 100	-	2,400	98,700
Graham Creelman Non-Executive Director, Deputy Chair and Senior Independent Director	15 to 20	-	-	16,100	15 to 20	-	-	16,400
Leigh Fleming, Commercial Development Director	95 to 100	-	700	98,700	95 to 100	-	400	95,800
Andrew Hopkins Director of Finance and Performance	110 to 115	-	1,200	111,200	115 to 120	-	2,400	119,200
Dr Peter Jefferys Non-Executive Director	10 to 15	-	-	11,000	5 to 10	-	-	6,500
Brian Parrott Non-Executive Director	10 to 15	-	-	11,000	0 to 5	-	-	2,800
Stuart Smith Non-Executive Director	10 to 15	-	-	11,000	10 to 15	-	-	11,000
Gary Page, Non-Executive Director from April 2012	10 to 15	-	-	11,200	-	-	-	-
Aidan Thomas Chief Executive	140 to 145	-	-	140,600	135 to 140	-	-	138,700
Maggie Wheeler, Chair	40 to 45	-	-	42,500	40 to 45	-	-	42,500
Debbie White, Director of Operations – Suffolk	95 to 100	-	-	98,600	25 to 30	-	-	25,100

*Benefits in kind relate to the provision of lease cars.

Pensions

	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Real increase in Cash Equivalent Transfer Value (Rounded to nearest £000)
Hadrian Ball Medical Director	2.5 – 5.0	12.5 - 15	70 - 75	210 - 215	1,335	1,220	115
Roz Brooks Director of Nursing, Quality and Patient Safety	2.5 – 5.0	10 - 12.5	30 - 35	100 – 105	678	582	96
Kathy Chapman Operational Director – Norfolk and Waveney	0 – 2.5	2.5 - 5	25 - 30	80 – 85	468	419	49
Leigh Fleming Commercial Development Director	0 – 2.5	5 - 7.5	30 - 35	90 – 95	564	509	55
Andrew Hopkins Director of Finance and Performance	2.5 – 5.0	7.5 - 10	30 - 35	95 – 100	512	458	54
Aidan Thomas Chief Executive	0 – 2.5	5 - 7.5	50 - 55	155 – 160	1,029	967	62
Debbie White Director of Operations – Suffolk	5.0 – 7.5	15 - 17.5	25 - 30	85 – 90	509	411	98

Pension benefits shown above relate to membership of the NHS Pension Scheme, which is available to all employees within the Foundation Trust. No additional pension payments are made by the Trust in relation to senior employees. As non-executive directors do not receive pensionable remuneration, there will be no entries in respect of pension for non-executive members.

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. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Fair Pay Disclosure

The Trust is required to disclose the relationship between the remuneration of the highest-paid director in the organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Trust for 2012-13 was £160k-165k. This was 7.3 times the median remuneration of the workforce, which was £22,517. In 2012-13 no employees received annualised remuneration in excess of the highest paid director.

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

	2012-13 £000	2011-12 £000
Band of highest paid director (full year effect)	160-165	165-170
Median total remuneration	£22,517	£26,557
Ratio	7.3 times	6.3 times

Andrew Hopkins
Acting Accounting Officer

Review of Tax Arrangements of Public Sector Appointees

As required by HM Treasury per PES(2012)17, the Trust must disclose information regarding "off-payroll engagements."

No. in place on 31 January 2012	3	No. of new engagements between 23 August 2012 and 31 March 2013	3
Of which:		*Of which:*	
No. that have since come onto the Organisation's payroll	2	No. of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	0
No. that have since been re-negotiated/ re-engaged to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	0	No. for whom assurance has been requested and received	0
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	0	No. for whom assurance has been requested and not received	0
No. that have come to an end	0	No. that have been terminated as a result of assurance not being received	0

The Trust has introduced a detailed Contract for the Provision of Services for self-employed contractors. The Contract includes clauses setting out the contractors obligations in respect of tax and National Insurance.
An audit has recently been undertaken of all self-employed contractors engaged by the Trust. Where not already in place, the new Contract is being issued.

"Our financial performance means the Trust is well placed to achieve the corporate objectives for 2013-14, and demonstrates substantial progress against our longer-term business plan"

Norfolk and Suffolk NHS
NHS Foundation Trust

Annual accounts

for the year ended 31 March 2013

your wellbeing in mind

Contents

Statement of the Chief Executive's responsibilities

as the Accounting Officer of Norfolk and Suffolk NHS Foundation Trust

The National Health Service Act 2006 ("NHS Act 2006") states that the chief executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the NHS Act 2006, Monitor has directed Norfolk and Suffolk NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Norfolk and Suffolk NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Date: 28 / 05 / 2013 Andrew Hopkins, Acting Accounting Officer:

Independent Auditors' Report

to the Board of Governors of Norfolk and Suffolk NHS Foundation Trust

We have audited the financial statements of Norfolk and Suffolk NHS Foundation Trust for the year ended 31 March 2013 on pages 13 to 54. These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2012/13.

This report is made solely to the Board of Governors of Norfolk and Suffolk NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Board of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 3 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

- give a true and fair view of the state of Norfolk and Suffolk NHS Foundation Trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended; and

- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts of Norfolk and Suffolk NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

SBeavis

Stephanie Beavis

for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
6 Lower Brook St,
Ipswich,
Suffolk,
IP4 1AP

28 May 2013

Annual Governance Statement

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation 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 Foundation 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 Foundation Trust Accounting Officer Memorandum.

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 and Suffolk NHS Foundation 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 and Suffolk NHS Foundation Trust for year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Trust has implemented a robust structure for ensuring that risk management, control and review processes have been properly established and monitored. Firm and clear leadership has been provided to focus these processes in the following ways:

- Executive Director lead with responsibility for risk management.
- Dedicated risk management team.
- Board approved risk management strategy.
- Board Assurance Framework in place that covers all main areas of activity, including targets and objectives and that focuses on key strategic, corporate and financial risks, including five year business plan risks.
- Regular monitoring of performance at a number of levels, including Audit and Risk Committee, Finance Committee, Service Governance Sub-Committee, Investment Committee, Senior Management Forum, Executive Directors, and Board of Directors.
- Locality and Service Managers are each supported by a Lead Clinician who provides clinical leadership to managerial and governance processes.
- All programmes and projects also maintain risk registers, which are managed by the respective programme and reported up the governance structure as appropriate.
- Regular monitoring of risk action plans to ensure all reasonable steps taken to minimise risk.
- All staff receive induction training that includes risk management, and key staff are further trained in root cause analysis and risk assessment.
- All serious untoward incidents are investigated using root cause analysis and the learning is

disseminated across the organisation through the Service Governance Sub-Committee and implemented through specific action plans.

The Board of Directors regularly reviews its governance structures and systems against latest guidance and reports from national enquiries to ensure that assurance and performance management systems are working effectively.

The Service Governance Sub-Committee undertakes more detailed reviews of service governance issues with regular reports to the Audit and Risk Committee, including risk register and Health Care Commission (HCC) reports.

4. The risk and control framework

The Trust has a robust approach and takes seriously its responsibilities for risks and control through a fully integrated approach to governance and risk. This is supported by a Trust wide Risk Management strategy, which provides the framework for the management of risk that covers processes relating to, clinical risk, Health and Safety risk and organisational (corporate and strategic) risk. This strategy was revised in January 2012.

The key elements of the Risk Management Strategy encompass a strategic intent by the Trust to develop a risk management culture that engages all staff. The Board of Directors is committed to ensuring risk management forms an integral part of its philosophy, practices and business plans. It also proves that the Trust is open with stakeholders, receptive to challenges and keen to learn. All identified risks are evaluated using a 5x5 scoring matrix that calculates risks, and change in risk by measuring likelihood and severity of consequences.

Each Locality, Service and Department assesses their services on a monthly basis and records a risk profile in the risk register. Each profile is scrutinised and monitored through the governance and risk department, who facilitate recording and reporting. The risk matrix is consistently used throughout the organisation:

- Low risks (green) and moderate risks (yellow) are held at local level.
- Significant risks (amber) and above are reported and monitored through the Trust's Service Governance Sub-committee and Audit and Risk committee.
- High risks (red) are reported to the Board of Directors.

The risk management policy and strategy describes the risk management process and provides clear lines of accountability to ensure that all risks are appropriately managed with action plans to mitigate against occurrence. The Trust has empowered staff to make sound judgments and decisions concerning the management of risk and risk taking. All services assess their own risk profiles, which are reported and recorded through to the Trust's risk register. All significant risks are entered onto the Trust risk register with an action plan to eliminate or reduce risks of all kinds. The Governance Team monitors individual risk registers with review by the Audit and Risk Committee. This includes the setting of target risk scores, which is the level of risk the organisation is prepared to accept and once achieved, the risk would no longer be reported as such. The target risk score indicates the risk appetite that the organisation is prepared to accept. Risks that reach their target continue to be monitored, but are not included on reports to the various committees.

The Trust has established an Assurance Framework, which is designed and operating to meet the requirements of the Statement of Internal Control (SIC) and provides the necessary weight of evidence that an effective system of control operates within the Trust. This Framework includes the following items:

- Board Assurance Framework that considers all strategic risks.
- Regular review of longer-term corporate and strategic risks by the Executive Team and Board of Directors.
- Registration with Care Quality Commission received in March 2010 with no conditions.
- Results of the Care Quality Commission specific reviews and outcomes from site visits, including Mental Health Act reviews.
- Comprehensive live risk register that includes all strategic, corporate, financial, clinical and other non-clinical risks.
- Regular reviews of risk register by the Board of Directors, Audit and Risk Committee, Service Governance sub-committee and Executive Directors' formal meeting.
- The role of the Deputy Director of Governance for Social Care to help the Trust with the management of integrated services.
- A regular programme of visits (including unannounced) to clinical areas by both Executive and Non-Executive Board Members.
- Feedback from external bodies, including Monitor, Care Quality Commission, National Patient Safety Agency and NHS Litigation Authority (NHSLA).
- Root Cause Analysis reports to include learning from patient safety issues and these are included in reports to the Board of Directors.

The Trust manages its information risks by undertaking an annual information governance audit using the NHS toolkit provided for this purpose and seeking to improve year on year. The Trust has undertaken the 2012 assessment (submitted in March 2011) which differs to the 2009 assessment and is 63% compliant. Action is being undertaken to embed the policies and procedures throughout the Trust.

A wide range of communication and consultation mechanisms also exists with relevant stakeholders, both internal and external, which includes the use of external assessors where appropriate to assist in determining the extent of a particular risk.

The Trust is fully compliant with the requirements of registration with the Care Quality Commission. The Trust was formally awarded registration with the Care Quality Commission (CQC) (without any conditions on this registration) on 26 March 2010. The Trust received a number of inspections from the CQC during 2012-13, which found the Trust to be fully compliant except for one report where one minor concern was raised, for which an action plan has been developed (March 2013). There are no other outstanding actions as regards CQC compliance with standards.

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 in to 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.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. Review of economy, efficiency and effectiveness of the use of resources

The Executive Team is responsible for overseeing the day-to-day operations of the Trust and for ensuring the economic, efficient and effective deployment of resources. The Executive Team works as part of the wider Senior Management Forum, whose membership includes all senior locality and directorate managers. This Team receives regular monthly financial and performance reports that highlight any areas of concern.

The Finance Committee is responsible for overseeing the development and implementation of strategic cost improvement plans. These are subject to full risk assessment and resources are deployed as appropriate to ensure plans are achieved.

Internal Audit undertakes a review of the Trust's internal control systems as part of the Annual Audit Plan (approved by the Audit and Risk Committee).

The Trust participates in a number of processes designed to secure better value for money from its use of resources. These include the use of shared financial services, a competitive tendering approach and membership and participation in the Eastern Collaborative Procurement Hub, which is designed to ensure non-pay expenditure, is incurred as efficiently as possible. The Trust is also a member of the Audit Commission's Mental Health Benchmarking Club and the most recent analysis of adult services shows the Trust continuing to perform in the top 5% nationally for efficiency and efectiveness.

The effective use of resources is also part of the essential core standards against which the Care Quality Commission monitors the Trust. The Governance department has a "live" monitoring system in which localities monitor on a monthly basis, their position against all the Care Quality Commission's core standards and domains. Any potential lapse or breach against these standards is reported to the governance department and through the Service Governance Sub Committee, the Audit and Risk Committee and the Board of Directors, with an appropriate remedial action plan, which is risk assessed and monitored until completed.

6. Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Services (Quality Accounts) Regulations 210 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Trust has produced an Annual Quality Account for 2012-13. The information contained in this report draws on information from the same systems that underpin the Trust's normal reporting processes, including activity management, performance management and risk and governance systems. The Report is developed through the Governance Team and all data is validated for accuracy and completeness by the referral of performance and activity data from the Trust's central information team back to the clinical teams for checking. The Service Governance Committee oversees this work and reports to the Audit and Risk Committee. The Trust's policies as regards the recording of data and data quality cover such work. The Board of Directors, Board of Governors and members of the public have been involved in determining how the Quality Account is developed; including which performance indicators will be measured.

7. Review of effectiveness

As Accounting 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 Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to 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 and Risk Committee, Internal Audit and Counter Fraud and a plan to address weaknesses and ensure continuous improvement of the system is in place.

- Reports from external audit.
- Significant assurance provided through the Head of Internal Audit's Opinion on the effectiveness of internal control.
- The Trust has achieved level 1 (good) against the NHSLA assessment standards. This assessment replaced the assessments made against the Clinical Negligence Scheme for Trusts (CNST) Mental Health and Learning Disability Clinical Risk Management standards and the Risk Pooling Scheme for Trusts (RPST). Following any merger of Trusts, the NHSLA score is reset and the maximum the Trust could be in 2012-13 is a level 1.
- Positive report from the Health and Safety Executive's review of arrangements for manual handling, workplace violence and handling stress.
- Annual report on the Trust's services by the Mental Health Act Commission.
- Annual suicide audit
- Results from clinical audit reviews
- Reports from external assessors as regards the financial and clinical governance systems and procedures within the Trust

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 of Directors
- Audit and Risk Committee
- Service Governance sub-committee
- Operational Risk Management Group
- Executive Directors and Trust Management Team
- Internal audit, Clinical Audit and Counter Fraud

The Head of Internal Audit Opinion for the period 1 April 2012 to 31 March 2013 states:

" ...that good assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently."

The Trust has a robust and systematic approach to risk management that ensures the effectiveness of the internal control system is constantly maintained and reviewed. The Trust's key policies and procedures are subject to annual review and the relevant committee and the Executive Team undertake this process, before taking the revised policy to the Board of Directors for final approval.

The development of the Board Assurance Framework (BAF) ensures that the Board of Directors is fully aware of the risks associated with the Trust meeting its strategic objectives. This Assurance Framework assigns a Director responsibility for each strategic objective. Action plans with key milestones, controls and assurance are identified and these plans monitored by the Governance Department. The BAF report to the Board of Directors highlights progress statements from both the responsible director and the Governance Department clearly identifying any concern with meeting the objectives.

Significant assurance is drawn from the arrangements for ensuring compliance with both Monitor and CQC requirements. The Service Governance sub-committee assesses compliance with standards and other compliance matters/declarations, which includes the development of action plans to meet any shortfalls or gaps in meeting these standards.

The production of the Trust's quality report is dependent on the systems and controls that support the Trust across its range of activities. During the year the Trust undertook surveys and workshops so that key stakeholders can help to determine the key reporting measures to be reported on in the coming year. The Trust agreed a number of new measures to be included in the 2012-13 Quality Account at a Public Board Meeting in February 2012. The Quality Account for 2012-13 is subject to an external assurance review in May 2013.

All of this work is linked to the Trust's risk register, which is updated for risks pertaining to compliance with CQC registration standards, Controls Assurance and Board Assurance Framework, but which is also updated on an everyday basis as new risks become apparent. This process enables staff to report incidents and concerns in a way that can be investigated and added to the risk register where appropriate so that remedial action can be taken.

The Audit and Risk Committee and the Board of Directors regularly receive risk management reports that incorporate information from all the above sources. Particular attention is paid to those risks with a higher impact/higher probability of occurring.

8. Conclusion

To the best of my knowledge and belief, based on the above processes, there are no significant control issues for the Trust.

Signed:  Andrew Hopkins, Acting Accounting Officer

Foreword to the accounts

These accounts for the year ended 31 March 2013 have been prepared by the Norfolk and Suffolk NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Signed:  Andrew Hopkins Acting Accounting Officer

Statement of Comprehensive Income

for the year ended 31 March 2013

	Note	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Operating income	3	**219,387**	**221,038**
Operating expenses	4	**(218,052)**	**(224,622)**
Operating surplus/(deficit)		**1,335**	**(3,584)**
Finance costs			
Finance income	8	**140**	**198**
Finance expense - financial liabilities	9	**(1,089)**	**(982)**
Finance expense - unwinding of discount on provisions	22	**(84)**	**(113)**
PDC dividends payable		**(3,425)**	**(3,475)**
Net Finance Costs		**(4,458)**	**(4,372)**
DEFICIT FOR THE YEAR		**(3,123)**	**(7,956)**
Other comprehensive income			
Impairments and reversals	11	**(1,391)**	**(6,545)**
Revaluation gains/losses on property plant and equipment	11	**2,706**	**42**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**(1,808)**	**(14,459)**

The notes on pages 17 to 54 form part of these accounts.
All revenue and expenditure is derived from continuing operations.

Statement of Financial Position

as at 31 March 2013

	Note	As at 31 March 2013 £000	As at 31 March 2012 £000
NON-CURRENT ASSETS:			
Intangible assets	10	**398**	368
Property plant and equipment	11	**145,200**	144,893
Trade and other receivables	13	**43**	41
Total non-current assets		**145,641**	145,302
CURRENT ASSETS:			
Inventories	12	**447**	332
Trade and other receivables	13	**10,482**	5,347
Non-current assets held for sale	14	**2,925**	3,234
Cash and cash equivalents	24	**19,383**	20,075
Total current assets		**33,237**	28,988
CURRENT LIABILITIES:			
Trade and other payables	15	**(24,116)**	(23,375)
Borrowings	18	**(1,170)**	(1,189)
Provisions	22	**(6,143)**	(1,986)
Tax payable	17	**(2,915)**	(2,521)
Other liabilities	16	**(5,964)**	(3,357)
Total current liabilities		**(40,308)**	(32,428)
TOTAL ASSETS LESS CURRENT LIABILITIES		**138,570**	141,862
NON-CURRENT LIABILITIES:			
Borrowings	18	**(18,377)**	(19,570)
Provisions	22	**(3,488)**	(3,765)
Other liabilities	16	**(464)**	(478)
Total non-current liabilities		**(22,329)**	(23,813)
TOTAL ASSETS EMPLOYED		**116,241**	118,049
FINANCED BY TAXPAYERS' EQUITY:			
Public dividend capital		**80,588**	80,588
Revaluation reserve	23	**25,683**	24,859
Income and Expenditure reserve		**9,970**	12,602
TOTAL TAXPAYERS' EQUITY		**116,241**	118,049

The financial statements on pages 13 to 54 were approved by the Board on 28 May 2013 and signed on its behalf by:

Andrew Hopkins, Acting Accounting Officer

Statement of Changes in Taxpayers' Equity

	Total	Public dividend capital	Revaluation reserve	Income and expenditure reserve
	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2012	**118,049**	**80,588**	**24,859**	**12,602**
Deficit for the year	**(3,123)**	0	0	(3,123)
Revaluations - property, plant and equipment	**2,706**	0	2,706	0
Transfers to the income and expenditure account in respect of assets held for sale	**0**	0	0	0
Impairments and reversals	**(1,391)**	0	(1,391)	0
Transfer of the excess of current cost depreciation of historical cost depreciation to the Income and Expenditure Reserve	**0**	0	(491)	491
Taxpayers' Equity at 31 March 2013	**116,241**	**80,588**	**25,683**	**9,970**
Taxpayers' Equity at 1 April 2011	**132,508**	80,588	31,837	20,083
Deficit for the year	**(7,956)**	0	0	(7,956)
Revaluations - property, plant and equipment	**42**	0	42	0
Transfers to the income and expenditure account in respect of assets held for sale	**0**	0	(86)	86
Impairments and reversals	**(6,545)**	0	(6,545)	0
Transfer of the excess of current cost depreciation of historical cost depreciation to the Income and Expenditure Reserve	**0**	0	(389)	389
Taxpayers' Equity at 31 March 2012	**118,049**	**80,588**	**24,859**	**12,602**

Statement of Cashflows

for the year ended 31 March 2013

	31 March 2013	31 March 2012
	£000	£000
Cash flows from operating activities		
Operating surplus/(deficit)	**1,335**	(3,584)
Non-cash income and expense:		
Depreciation and amortisation	**6,350**	6,039
Impairments and reversals	**1,459**	4,728
Loss on disposal	**(4)**	0
Increase in trade and other receivables	**(5,457)**	(788)
Decrease in other assets	**309**	0
Increase in inventories	**(115)**	(100)
Increase in trade and other payables	**2,400**	4,152
Increase/(decrease) in other liabilities	**2,593**	(191)
Decrease in taxes payables	**(228)**	(40)
Increase/(decrease) in provisions	**3,796**	(270)
Other movements in operating cashflows	**(5)**	175
NET CASH GENERATED FROM OPERATIONS	**12,433**	**10,121**
Cash flows from investing activities		
Purchase of intangible assets	**0**	(168)
Purchase of property, plant and equipment	**(8,253)**	(21,078)
Sales of property, plant and equipment	**592**	0
Net cash generated used in investing activities	**(7,661)**	**(21,246)**
Cash flows from financing activities		
Interest received	**140**	198
Loans received	**0**	4,000
Loans repaid	**(1,056)**	(974)
Interest paid	**(571)**	(470)
PDC dividends paid	**(3,287)**	(3,561)
Capital element of finance leases and PFI	**(107)**	(97)
Interest element of finance leases and PFI	**(583)**	(512)
Net cash used in financing activities	**(5,464)**	**(1,416)**
Decrease in cash and cash equivalents	**(692)**	**(12,541)**
Cash and Cash equivalents at 1 April	**20,075**	32,616
Cash and Cash equivalents at 31 March	**19,383**	**20,075**

Notes to the Accounts

1. Accounting Policies

1.1 Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet with the accounting requirements of the FT ARM which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.2 Accounting convention

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

1.3 Critical accounting judgements and key sources of estimation uncertainty

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

1.4 Income

Income in respect of service provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

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

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

1.5 Expenditure on Employee Benefits

1.5.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.5.2 Pension Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsba.nhs.uk/pensions.

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

Employers pension costs contributions are charged to operating expenses as and when they become due.

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

1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when and to the extent that they have been received; and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property Plant and Equipment

1.7.1 Recognition

Property Plant and Equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- It is expected to be used for more than one financial year; and
- The cost of the item can be measured reliably.

Property Plant and Equipment assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- Have a cost of at least £5,000; or
- Form a group of assets which individually have a cost of more than £250, and collectively have cost of at least £5,000, where the assets are functionality interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

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

1.7.2 Measurement

1.7.2.1. Valuation

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

All assets are subsequently measured at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any accumulated depreciation and impairment losses. Fair values are determined as follows:

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

Non property assets that have short lives and/or their values are low are held at depreciated historic cost.

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

Revaluation and Impairment

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

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

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

Impairments

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

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

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

1.7.2.2. Subsequent Expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is derecognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable costs are added to the asset's carrying value.

Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

1.7.2.3. Depreciation

Freehold land, properties under construction, and assets held for sale are not depreciated.

For all other assets depreciation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets.

The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year-end, with the effect of any changes recognised on a prospective basis.

For each class of asset, the range of estimated useful life is as follows:

	Years
Building structure	15 to 80
Building external works	25 to 80
Building engineering and installations	10 to 30
Dwellings	30 to 45
Engineering plant and equipment and medical equipment	5 to 15
Vehicles	5 to 7
Furniture	5 to 10
Fixtures and fittings	5 to15
Soft Furnishings	5 to 7
Office Equipment	5
IT Hardware and Software	3 to 5

Property, plant and equipment which has been reclassified as "Held for Sale" ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI Contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

1.7.3 Derecognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales; and
- the sale must be highly probable i.e.:

– management is committed to a plan to sell the asset;
– an active programme has begun to find a buyer and complete the sale;
– the asset is being actively marketed at a reasonable price;
– the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
– the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to retained earnings.

Property plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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

1.7.4 Donated, government grant and other grant funded assets

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

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

1.7.5 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as "On-Statement of Financial Position" by the Trust. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and
- Payment for the replacement of components of the assets during the contract "lifecycle replacement".

1.7.5.1 Services Received

The fair value of services received in the year is recorded under the relevant expenditure headings within "operating expenses".

1.7.5.2 PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.7.5.3 PFI Liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI asset and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease on the operating lease liability for the period, and is charged to "Finance Costs" within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.
An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

1.7.5.4 Lifecycle Replacement

Lifecycle costs are maintenance costs spread over the term of the contract and form part of the operating expense.

1.7.5.5 Assets contributed by the Trust to the operator for use in the scheme

There were no assets contributed by the Trust.

1.8 Intangible Assets

1.8.1 Recognition

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

1.8.1.1 Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

1.8.1.2 Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

1.8.1.3 Research and development

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- The Trust intends to complete the asset and sell or use it;
- The Trust has the ability to sell or use the asset;
- How the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- Adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset; and
- The Trust can measure reliably the expenses attributable to the asset during development.

1.8.2 Measurement

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

Subsequently, intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.8.3 Amortisation

Intangible assets with finite useful economic lives are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.9 Revenue government and other grants

Government grants are grants from Government bodies other than income from Primary Care Trusts or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.10 Leases

1.10.1 Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

1.10.2 Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as a finance lease.

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

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value.

1.12 Cash

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

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

1.13 Provisions

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

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

All known obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

1.14 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 22 but is not recognised in the Trust's accounts.

1.15 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return received assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses when the liability arises.

1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

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

1.17 Financial instruments and financial liabilities

1.17.1 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

1.17.2 De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

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

1.17.3 Classification and measurement

Financial assets are categorised as "loans and receivables".
Financial liabilities are categorised as "other financial liabilities".

1.17.4 Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

1.17.5 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

1.17.6 Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

1.17.7 Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

The policy of the Trust is to provide for all debts where the age of the debt indicates a significant risk of non-payment or where there is a clear indication that the individual debt will not be repaid at that particular point in time. The provision is reviewed every financial quarter. A decision is made to write off a debt when the amount has already been provided for when a) all avenues for recovery have been exhausted, or b) when it is no longer economically viable to pursue the outstanding amount.

There are some occasions where debts will be written off without being provided for through the bad debt provision first. This would occur when circumstances arose between reviews of the bad debt provision which would indicate that the asset was impaired. These conditions are the same as those set out above when an asset would be written off following a provision being made.

1.18 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.19 Value Added Tax

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

1.20 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign current is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the balance sheet date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the balance sheet date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the Health Service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the income statement on an accruals basis, including losses which would have been made good through insurance cover had Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.23 Standards and interpretations in issue not yet adopted

At the time of authorisation of these financial statements, IAS 1 (revised) had been issued (in 2007) but had not yet been adopted by HM Treasury. It is not, therefore, reflected in these statements. The effect of the revision of IAS 1 is presentational only; it does not change the recognition, measurement or disclosure of transactions or events.

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted:

Effective for future financial years:	Published by IASB	Financial year for which the change first applies
IFRS 9 Financial Instruments Financial Assets Financial Liabilities	November 2009 October 2010	Uncertain. Not likely to be adopted by the EU until the IASB has finished the rest of its financial instruments project.
IFRS 10 Consolidated Financial Statements	May 2011	Effective date of 2013-14 but not yet adopted by the EU.
IFRS 11 Joint Arrangements	May 2011	Effective date of 2013-14 but not yet adopted by the EU.
IFRS 12 Disclosure of Interests in Other Entitles	May 2011	Effective date of 2013-14 but not yet adopted by the EU.
IFRS 13 Fair Value Measurement	May 2011	Effective date of 2013-14 but not yet adopted by the EU.
IAS 12 Income Taxes amendment	December 2010	Effective date of 2013-14 but not yet adopted by the EU.
IAS 1 Presentation of financial statements on other comprehensive income (OCI)	June 2011	Effective date of 2013-14 but not yet adopted by the EU.
IAS 27 Separate Financial Statements	May 2011	Effective date of 2013-14 but not yet adopted by the EU.
IAS 28 Associates and joint ventures	May 2011	Effective date of 2013-14 but not yet adopted by the EU.
IAS 19 (Revised 2011) Employee Benefits	June 2011	Effective date of 2013-14
IAS 32 Financial Instruments: Presentation – amendment Offsetting financial assets and liabilities	December 2011	Effective date of 2013-14 but not yet adopted by the EU.
IFRS 7 Financial Instruments: Disclosures – amendment Offsetting financial assets and liabilities	December 2011	Effective date of 2013-14 but not yet adopted by the EU.

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

1.24 Accounting standards, amendments and interpretations issued that have been adopted early

The Trust has not early adopted any new accounting standards, amendments or interpretations.

2. Operating segments

Norfolk and Waveney Mental Health NHS Foundation Trust and Suffolk Mental Health Partnership NHS Foundation Trust merged on 3 January 2012 to form Norfolk and Suffolk NHS Foundation Trust. This represents a "machinery of government change".

Following the merger, the Trust has two operating segments; Norfolk and Suffolk.

	2013 Norfolk	**2013 Suffolk**	**2013 Total**	2012 Norfolk	2012 Suffolk	2012 Total
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Operating Income	**138,699**	**80,688**	**219,387**	136,604	84,434	221,038
Operating Expenditure	**(137,164)**	**(80,888)**	**(218,052)**	(140,012)	(84,610)	(224,622)
	1,535	**(200)**	**1,335**	**(3,408)**	**(176)**	**(3,584)**

Income from healthcare activities is included at note 3.1 Income from patient care activities – provision of health care services.

Income balances with a single external customer that amount to a material proportion of income are disclosed in note 28 to the accounts, Related Party Transactions.

3. Operating income

3.1. Income from patient care activities

3.1.1. Income from patient care activities – Provision of healthcare services

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Block Contract income	**184,603**	182,679
Clinical Partnerships providing mandatory services (including S75 agreements)	**11,383**	10,760
Clinical income for the Secondary Commissioning of mandatory services	**4,326**	5,329
Other non-protected clinical income	**3,914**	2,089
	204,226	**200,857**

3.1.2. Source of income from patient care activities

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
NHS Foundation Trusts	**14**	47
NHS Trusts	**38**	95
Department of Health	**(1)**	0
Strategic Health Authorities	**203**	368
Primary Care Trusts	**191,541**	188,984
Local Authorities	**11,771**	10,895
Non NHS Other	**660**	468
	204,226	**200,857**

3.1.3. Mandatory income

Under the NHS Trust's Terms of Authorisation, the Trust is required to provide mandatory health services. The allocation of operating income between mandatory health services and other services is detailed below.

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Mandatory Services	**200,312**	198,768
Non Mandatory Services	**3,914**	2,089
	204,226	**200,857**

3.1.4. Private patient income

The statutory limitation on private patient income in Section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

3.2. Other operating income

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Research and development	**1,484**	1,950
Education and training	**3,549**	3,524
Non-patient care services to other bodies	**6,798**	10,683
Other income	**3,330**	4,024
	15,161	**20,181**

The majority of revenue arises from the supply of services. Revenue from the supply of goods represents an immaterial proportion of total revenue.

4. Operating expenses

4.1. Operating expenses comprise

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Services from NHS Foundation Trusts	**1,382**	1,363
Services from NHS Trusts	**535**	1,135
Services from other NHS bodies	**3,218**	1,575
Purchase of healthcare from non-NHS bodies	**4,740**	5,133
Employee Expenses - Executive directors	**1,063**	666
Fees paid - Non-executive directors	**146**	168
Employee Expenses - Staff	**161,203**	164,168
Drug costs	**3,398**	3,489
Supplies and services - clinical (excluding drug costs)	**694**	564
Supplies and services - general	**6,057**	5,449
Establishment	**2,751**	4,016
Research and development	**101**	68
Education and training	**918**	1,247
Transport	**3,665**	4,353
Premises	**9,466**	7,065
Rentals under operating leases	**2,221**	1,680
(Increase)/decrease in provision for impairment of receivables	**(150)**	256
Increase in other provisions	**89**	0
Depreciation and amortisation	**6,350**	6,039
Impairments	**1,459**	4,728
Audit fees - statutory audit	**108**	133
Other auditors remuneration - other services	**33**	200
Consultancy fees	**332**	111
Clinical negligence	**359**	427
Redundancy and reconfiguration costs	**6,287**	8,308
Other	**1,627**	2,281
Total	**218,052**	**224,622**

4.2. Auditors' remuneration

The Board of Governors has appointed KPMG LLP as external auditors of the Trust. The audit fee for the statutory audit of the financial statements was £91k including VAT (2011-12 £111k). This was the fee for an audit in accordance with the Audit Code issued by Monitor. The audit fee for the review of the Quality Accounts was £12k excluding VAT (2011-12 £12k).

Non audit fees paid to KPMG disclosed in note 4.1 relate to pension advice and the audit fee for the charitable fund which is borne by the Trust. In addition the Trust paid KPMG non audit fees of £40k in relation to capital related VAT advice.

The engagement letter signed on 31 March 2010 states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) in respect of services provided in connection with or arising out of the audit shall in no circumstances exceed £1million in the aggregate in respect of all such services.

5. Arrangements containing an operating lease

5.1. As lessee

Payments recognised as an expense	**Year ended 31 March 2013 £000**	Year ended 31 March 2012 £000
Lease payments	**2,221**	1,285
Total	**2,221**	**1,285**

Total future minimum lease payments due	**Year ended 31 March 2013 £000**	Year ended 31 March 2012 £000
Payable:		
Not later than one year	**1,746**	1,681
Between one and five years	**4,157**	4,034
After five years	**5,386**	4,842
Total	**11,289**	**10,557**

5.2. As lessor

Rental income	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Rent recognised as income	**147**	130
Total income	**147**	**130**

Total future minimum lease payments due	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Receivable:		
Not later than one year	**103**	69
Between one and five years	**308**	11
Total	**411**	**80**

6. Employee costs and numbers

6.1. Employee costs

	Total year ended 31 March 2013 £000	Permanently Employed £000	Other £000	Total year ended 31 March 2012 £000
Salaries and wages	**128,440**	**124,164**	**4,276**	134,861
Social Security costs	**9,672**	**9,304**	**368**	10,019
Employers Contributions to NHS Pensions Authority	**15,052**	**14,384**	**668**	15,482
Other pension costs	**0**	**0**	**0**	97
Termination benefits	**6,287**	**6,287**	**0**	8,308
Agency/contract staff	**9,102**	**0**	**9,102**	4,619
Total	**168,553**	**154,139**	**14,414**	**173,386**

The total employer pension contribution payable for the year to 31 March 2013 was £15,052k (31 March 2012 £15,482k). In addition to the above, £46k (2011-12 £244k) of salaries of permanently employed staff were capitalised during the period.

6.1.1. Staff exit packages

Exit package cost band	Number of compulsory redundancies Year ended 31 March 2013	Number of other departures Year ended 31 March 2013	Number of compulsory redundancies Year ended 31 March 2012	Number of other departures Year ended 31 March 2012
<£10,000	**17**	**5**	9	12
£10,000-£25,000	**1**	**1**	6	44
£25,001-£50,000	**2**	**2**	14	42
£50,001-£100,000	**0**	**3**	12	17
£100,001-£150,000	**0**	**3**	7	11
£150,001-£200,000	**0**	**0**	1	2
£200,000+	**0**	**1**	0	1
Total number of exit packages by type	**20**	**15**	**49**	**129**
Total resource cost (£000)	**114**	**994**	**2,618**	**5,690**

Total cost relates to those packages that have been agreed with individual employees.

6.2. Average number of persons employed

	Total year ended 31 March 2013	Permanently Employed	Other	Total year ended 31 March 2012
Medical & dental	**268**	187	81	222
Administration and estates	**1,084**	1,024	60	1,068
Healthcare assistants and other support staff	**823**	815	8	970
Nursing, midwifery and health visiting staff	**1,250**	1,245	5	1,324
Scientific, therapeutic and technical staff	**325**	311	14	310
Social care staff	**61**	60	1	112
Other	**0**	0	0	0
Total	**3,811**	**3,642**	**169**	**4,006**

Please note that this measures whole time equivalent staff and not headcount.

6.3. Directors' emoluments

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Directors' remuneration:		
Employee benefits and fees paid	**805**	1,158
Employer's Contributions to NHS Pensions Authority	**111**	185
Total	**916**	**1,343**

These figures are the amounts charged to the income and expenditure account in the year. All substantively employed executive directors were members of the NHS Pensions Scheme during the course of the year. There were no liabilities or guarantees provided to directors in the year.

6.4. NHS Pension Scheme

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration

is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

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

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

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

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

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

6.5. Retirements due to ill-health

During 2012-13 there were three (2011-12 – six) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £205k (2011-12 – £878k). The cost of these ill-health retirements will be borne by the Business Services Authority-Pensions Division.

7. Better payment practice code

7.1. Better payment practice code – measure of compliance

	Year ended 31 March 2013 Number	Year ended 31 March 2013 Value	Year ended 31 March 2012 Number	Year ended 31 March 2012 Value
Total Non-NHS trade invoices paid in the year	**34,411**	**53,439**	38,421	70,215
Total Non-NHS trade invoices paid within target	**30,290**	**44,394**	36,698	66,966
Percentage paid within target	**88%**	**83%**	96%	95%
Total NHS trade invoices paid in the year	**1,048**	**9,379**	1,305	11,748
Total NHS trade invoices paid within target	**875**	**8,045**	1,173	10,755
Percentage paid within target	**83%**	**86%**	90%	92%

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

8. Finance Income

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Interest on loans and receivables	**140**	198
	140	**198**

9. Finance costs

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Interest on loans and overdrafts	**562**	470
Finance Costs in PFI obligations		
- Main Finance Costs	**325**	338
- Contingent Finance Costs	**202**	174
	1,089	**982**

10. Intangible assets

	Software licences (purchased) £000
Cost or Valuation: At 1 April 2012	917
Reclassifications	334
At 31 March 2013	**1,251**
Amortisation at 1 April 2012	549
Provided during the year	304
Amortisation at 31 March 2013	**853**
Net book value at 31 March 2013	**398**
Purchased	398
Total at 31 March 2013	**398**
Asset financing	
Owned	398
Net book value 31 March 2013	**398**

Prior Year	Software licences (purchased) £000
Cost or Valuation: At 1 April 2011	726
Additions purchased	168
Reclassifications	23
At 31 March 2012	**917**
Amortisation at 1 April 2011	356
Provided during the year	170
Reclassifications	23
Amortisation at 31 March 2012	**549**
Net book value at 31 March 2012	**368**
Purchased	368
Total at 31 March 2012	**368**
Asset financing	
Owned	368
Net book value 31 March 2012	**368**

11. Property Plant and Equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture and Fittings £000	Total £000
Cost or Valuation: At 1 April 2012	25,159	116,717	3,193	5,318	5,305	326	12,585	5,644	174,247
Additions purchased	0	0	0	7,110	0	0	0	0	7,110
Impairments charged to revaluation reserve	(707)	(600)	(84)	0	0	0	0	0	(1,391)
Revaluations	(100)	(14,136)	(691)	0	0	0	0	0	(14,927)
Reclassifications	0	5,901	475	(9,226)	359	0	1,308	849	(334)
Transfers from/to assets held for sale	(644)	66	299	0	0	0	0	0	(279)
At 31 March 2013	**23,708**	**107,948**	**3,192**	**3,202**	**5,664**	**326**	**13,893**	**5,698**	**164,426**
Depreciation at 1 April 2012	297	11,722	380	0	2,726	291	10,119	3,819	29,354
Charged during the year	0	3,922	87	0	549	15	1,208	265	6,046
Impairments charged to income and expenditure	138	1,017	304	0	0	0	0	0	1,459
Revaluations	(389)	(16,468)	(776)	0	0	0	0	0	(17,633)
Reclassifications	(46)	0	5	(1)	(770)	13	3	796	(0)
Depreciation at 31 March 2013	**0**	**193**	**0**	**(1)**	**2,505**	**319**	**11,330**	**4,880**	**19,226**
Net book value at 31 March 2013	**23,708**	**107,755**	**3,192**	**3,203**	**3,159**	**7**	**2,563**	**1,613**	**145,200**
Purchased	23,708	105,057	3,192	3,203	3,159	7	2,563	1,613	142,502
Finance Lease	0	493	0	0	0	0	0	0	493
On-balance sheet PFI contracts	0	2,205	0	0	0	0	0	0	2,205
Total at 31 March 2013	**23,708**	**107,755**	**3,192**	**3,203**	**3,159**	**7**	**2,563**	**1,613**	**145,200**
Freehold	23,182	103,156	3,192	3,203	3,159	7	2,563	1,613	140,009
Leasehold	526	4,599	0	0	0	0	0	0	5,191
Net book value 31 March 2013	**23,708**	**107,755**	**3,192**	**3,203**	**3,159**	**7**	**2,563**	**1,613**	**145,200**

Property Plant and Equipment – prior year

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture and Fittings £000	Total £000
Cost or Valuation: At 1 April 2011	27,996	111,201	6,590	5,885	4,953	331	10,144	6,045	**173,145**
Additions purchased	0	1,513	287	17,172	167	0	200	654	**19,993**
Impairments charged to revaluation reserve	(1,831)	(4,071)	(550)	0	0	0	0	(7)	**(6,459)**
Revaluation surpluses	42	(7,410)	(1,303)	0	(13)	0	0	(70)	**(8,754)**
Reclassifications	0	16,140	56	(17,739)	234	18	2,241	(973)	**(23)**
Transfers from/to assets held for sale	(1,048)	(656)	(1,887)	0	0	0	0	0	**(3,591)**
Disposals	0	0	0	0	(36)	(23)	0	(5)	**(64)**
At 31 March 2012	**25,159**	**116,717**	**3,193**	**5,318**	**5,305**	**326**	**12,585**	**5,644**	**174,247**
Depreciation: At 1 April 2011	0	11,333	728	0	2,418	296	9,048	3,913	**27,736**
Charged during the year	0	3,921	146	0	357	18	1,094	333	**5,869**
Impairments charged to income and expenditure	297	3,385	791	0	0	0	0	255	**4,728**
Reclassifications	0	589	18	0	0	0	(23)	(607)	**(23)**
Revaluation surpluses	0	(7,410)	(1,303)	0	(13)	0	0	(70)	**(8,796)**
Disposals	0	0	0	0	(36)	(23)	0	(5)	**(64)**
Reclassified as held for sale	0	(96)	0	0	0	0	0	0	**(96)**
Depreciation at 31 March 2012	**297**	**11,722**	**380**	**0**	**2,726**	**291**	**10,119**	**3,819**	**29,354**
Net book value at 31 March 2012	**24,862**	**104,995**	**2,813**	**5,318**	**2,579**	**35**	**2,466**	**1,825**	**144,893**
Purchased	24,275	99,346	2,813	5,318	2,565	35	2,466	1,825	**138,643**
Finance Lease	587	3,527	0	0	14	0	0	0	**4,128**
On-balance sheet PFI contracts	0	2,122	0	0	0	0	0	0	**2,122**
Total at 31 March 2012	**24,862**	**104,995**	**2,813**	**5,318**	**2,579**	**35**	**2,466**	**1,825**	**144,893**
Freehold	24,275	99,346	2,813	5,318	2,565	35	2,466	1,825	**138,643**
Leasehold	587	5,649	0	0	14	0	0	0	**6,250**
Net book value at 31 March 2012	**24,862**	**104,995**	**2,813**	**5,318**	**2,579**	**35**	**2,466**	***1,825***	**144,893**

Analysis of protected assets

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture and Fittings £000	Total £000
Net book value									
NBV – Protected assets at 31 March 2013	4,222	65,100	0	0	0	0	0	0	69,323
NBV – Unprotected assets at 31 March 2013	19,486	42,653	3,192	3,203	3,159	7	2,563	1,613	75,877
Total at 31 March 2013	**23,708**	**107,753**	**3,192**	**3,203**	**3,159**	**7**	**2,563**	**1,613**	**145,200**

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture and Fittings £000	Total £000
Prior year									
Net book value	7,815	69,647	0	0	0	0	0	0	77,462
NBV – Protected assets at 31 March 2012									
NBV – Unprotected assets at 31 March 2012	17,047	35,348	2,813	5,318	2,579	35	2,466	1,825	67,431
Total at 31 March 2012	**24,862**	**104,995**	**2,813**	**5,318**	**2,579**	**35**	**2,466**	**1,825**	**144,893**

11 Property, plant and equipment cont.

An interim valuation of all land and buildings was undertaken as at 31 March 2013 on the basis set out in the accounting policies. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, in so far that these terms are consistent with the agreed requirements of the Department of Health and HM Treasury at that time.
A full valuation is undertaken every five years, and interim valuations are undertaken every three years. The next full revaluation will take place in 2014-15. The revaluation was performed by Boshier and Company Chartered Surveyors.

Impairment reviews are undertaken annually to ensure that the carrying values reflect fair values. Impairments totalling £2,763k have been recognised in the 2012-13 financial year, £1,459k of which has been charged to the income and expenditure account.

The Trust is the lessor of assets on operating leases. These leases are immaterial in value and relate to the renting of a small part of an owned asset (e.g. part of a building, space on a roof) and therefore this is not accounted for separately to the overall asset in terms of depreciation and impairments.

12. Inventory

	31 March 2013 Total £000	31 March 2012 Total £000
Drugs	**371**	280
Consumables	**50**	26
Energy	**26**	26
Total	**447**	**332**

13. Trade and other receivables

	31 March 2013 £000	31 March 2012 £000
Current		
NHS receivables	**4,450**	1,853
Other receivables from related parties	**1,428**	350
Provision for impaired receivables (note 13.1)	**(86)**	(304)
Prepayments	**1,633**	1,447
Accrued income	**289**	0
PDC receivable	**0**	138
Other receivables	**2,768**	1,863
Total current trade and other receivables	**10,482**	**5,347**
Non current		
Prepayments	**43**	41
Total non-current trade and other receivables	**43**	**41**
Total	**10,525**	**5,388**

13.1. Provision for impairment of receivables

	Total £000	Total £000
At 1 April	**304**	**38**
Arising during the period	**21**	**353**
Utilised during the period	**(68)**	**(4)**
Unused amounts reversed	**(171)**	**(83)**
At 31 March	**86**	**304**

13.2. Impaired debtors

	31 March 2013 £000	31 March 2012 £000
Current and up to three months past due	**0**	226
In three to six months	**8**	35
Over six months	**78**	43
Total	**86**	**304**

13.3. Non-impaired debtors

	31 March 2013 £000	31 March 2012 £000
Current and up to three months past due	**7,736**	2,946
In three to six months	**329**	72
Over six months	**225**	0
Total	**8,320**	**3,018**

14. Non-current assets held for sale and assets in disposal groups

	2013 £000	2012 £000
Net Book Value at 1 April	**3,234**	0
Assets classified as available for sale in the year	**925**	3,495
Assets sold in year	**(588)**	(175)
Impairments of assets held for sale	**0**	(86)
Assets no longer classified as held for sale	**(646)**	0
Net Book Value at 31 March	**2,925**	**3,234**

15. Trade and other payables

	31 March 2013 £000	31 March 2012 £000
Current		
NHS payables	**1,185**	586
Amounts due to other related parties	**28**	724
Trade payables - capital	**1,497**	2,534
Other trade payables	**3,545**	1,107
Other payables	**1,981**	1,969
Accruals	**15,880**	16,455
Total current trade and other payables	**24,116**	**23,375**

Other payables include £1,929k outstanding pension contributions as at 31 March 2013 (31 March 2012 £1,266k).

16. Other liabilities

	31 March 2013 £000	31 March 2012 £000
Current		
Lease incentives	**38**	43
Deferred income	**5,926**	3,314
	5,964	**3,357**
Non current		
Lease incentives	464	478
	464	**478**
	6,428	**3,835**

17. Taxes payable

	31 March 2013 £000	31 March 2012 £000
Current		
Taxes payable	**2,915**	**2,521**
	2,915	**2,521**

Taxes payable include PAYE and national insurance contributions.

18. Borrowings

	31 March 2013 £000	31 March 2012 £000
Current		
Bank overdrafts	**0**	0
Loans from Department of Health	**534**	534
Loans from Foundation Trust Financing Facility	**522**	522
Private Finance Initiative liabilities	**114**	106
Finance lease liabilities	**0**	27
Total current borrowings	**1,170**	**1,189**
Non-current		
Loans from Foundation Trust Financing Facility	**8,150**	8,673
Other Loans	**6,131**	6,665
Obligations under finance leases	**0**	21
Obligations under Private Finance Initiative contracts	**4,096**	4,211
Total non-current borrowings	**18,377**	**19,570**
	19,547	**20,759**

Timing of loan repayments	31 March 2013 £000	31 March 2012 £000
Current		
In one year or less	**1,056**	1,056
Between one and two years	**1,056**	1,056
Between two and five years	**3,169**	3,170
Over five years	**10,056**	11,112
Total	**15,337**	**16,394**
	£000	£000
Of which:		
- wholly repayable within five years	**5,281**	5,282
- wholly repayable after five years, by instalments	**10,056**	11,112
	15,337	**16,394**

The Trust has two loans with the Foundation Trust Financing Facility. Both loans are unsecured loans between the Trust and the Secretary of State for Health. The first loan received was £4,720k received in the 2008-09 financial year. Repayments of capital and interest fall due in September and March of each year to September 2028. Interest is payable at 3.87% per annum.

The second loan received was £5,200k of which £1,200k was received in March 2011, and a further £4,000k was received in the 2011-12 financial year. Repayments of capital and interest fall due in June and December of each year to June 2030. Interest is payable at 3.18% per annum.

A further loan of £8,000k is an unsecured capital investment loan from the Department of Health. The loan was received in September 2010. Repayments of capital and interest fall due in March and September of each year to September 2025. Interest is payable at 2.74%.

19. Private Finance Initiative

19.1. PFI schemes off-Statement of Financial Position

There were no off-statement PFI schemes

19.2. PFI Schemes on-Statement of Financial Position

The Trust has a 30 year contract that commenced on the 27 May 2002, under the Private Finance Initiative with GH Bury for the provision of a fully serviced Mental Health in-patient facility in Bury St Edmunds. At the end of the contract the asset reverts to the Trust. Under IFRIC 12 the asset is treated as an asset of the Trust; the substance of the contract is that the Trust has a finance lease and payments comprise two elements - imputed finance lease charges and service charges.

The PFI contract has been calculated using the Department of Health approved template incorporating a 2.5% annual inflation uplift for future years. Past years' inflation is calculated to bring the annual unitary charge in line with the amount actually paid.

	31 March 2013 £000	31 March 2012 £000
Not later than one year	**657**	627
Later than one year, not later than five years	**2,796**	2,667
Later than five years	**12,060**	12,715
	15,513	**16,009**
Less interest element	**(11,303)**	(11,692)
Net PFI obligations	**4,210**	**4,317**

19.3. Charges to expenditure

The total charged in the year to expenditure in respect of off-statement of financial position PFI contracts was nil and the service element of the on-statement of financial position PFI contracts was £1,069k (2012 £1,005k) The Trust is committed to the following charges:

	31 March 2013 £000	31 March 2012 £000
Not later than one year	**1,096**	1,046
Later than one year, not later than five years	**4,664**	4,450
Later than five years	**20,482**	21,212
	26,242	26,708

19.4. Imputed finance lease obligations under PFI commitments

Commitments in respect of the lease rentals of the PFI comprise

	31 March 2013 £000	31 March 2012 £000
Rentals due within one year	**657**	627
Rentals due within 2nd to 5th years (inclusive)	**2,796**	2,667
Rentals due later than five years	**12,060**	12,715
Sub total rentals due	**15,513**	**16,009**
less interest element	**(11,303)**	(11,692)
Total	**4,210**	**4,317**

20. Finance Lease obligations

Trust has no finance lease obligations (2011/12 £48k)

21. Prudential Borrowing Limit

The Trust is required to comply with and remain within a prudential borrowing limit. This is made up of two elements:

- The maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio test set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.
- The amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and the Compliance Framework can be found on the website of Monitor, the independent Regulator of Foundation Trusts.

The Trust had in total of £15.3m loans outstanding at 31 March 2013 (2012 - £16.4m). Further details can be found at note 18.

Monitor has given the Trust a prudential borrowing limit of £42.6m for the year ended 31 March 2013 (2012 - £28.5m), based on the Trust's current financial risk rating. Should the risk rating change, the prudential borrowing limit would also change.

The Trust has an approved working capital facility of £16.4m (2012 – £14.9m).

The Trust has not used its working capital facility in either 2012/13 or 2011/12.

The Trust has successfully passed the four ratio tests set out in Monitor's Prudential Borrowing Code.

Financial Ratio	Prudential borrowing limits	Year ended 31 March 2013		Year ended 31 March 2012	
		Actual ratio	Approved ratio	Actual ratio	Approved ratio
Minimum dividend cover	>1x	2.7x	>1x	2.1x	>1x
Minimum interest cover	>3x	17.3x	>3x	16.3x	>3x
Minimum debt service cover	>2x	6x	>2x	5.3x	>2x
Maximum debt service to revenue	<2.5%	0.74%	<2.5%	0.70%	<2.5%

22. Provisions for liabilities and charges

	Current		Non Current	
	31 March 2013 Total £000	31 March 2012 Total £000	31 March 2013 Total £000	31 March 2012 Total £000
Pensions relating to former staff	**259**	265	**2,158**	2,340
Legal claims	**540**	500	**0**	0
Redundancy	**4,788**	0	**0**	0
Other	**556**	1,221	**1,330**	1,425
Total	**6,143**	**1,986**	**3,488**	**3,765**

Current year	Total	Pensions relating to former staff	Legal claims	Redundancy	Other
	£000	£000	£000	£000	£000
At 1 April 2012	**5,751**	**2,605**	**500**	**0**	**2,646**
Arising during the period	**5,331**	**50**	**436**	**4,788**	**57**
Utilised during the period	**(883)**	**(289)**	**(219)**	**0**	**(375)**
Reversed unused	**(652)**	**0**	**(177)**	**0**	**(475)**
Unwinding of discount	**84**	**51**	**0**	**0**	**33**
At 31 March 2013	**9,631**	**2,417**	**540**	**4,788**	**1,886**

Prior year	Total	Pensions relating to former staff	Legal claims	Redundancy	Other
	£000	£000	£000	£000	£000
At 1 April 2011	**6,134**	2,716	262	768	2,388
Arising during the period	**1,421**	75	366	0	980
Utilised during the period	**(1,392)**	(265)	(115)	(528)	(484)
Reversed unused	**(525)**	0	(13)	(240)	(272)
Unwinding of discount	**113**	79	0	0	34
At 31 March 2012	**5,751**	**2,605**	**500**	**0**	**2,646**

Expected timing of cash flows at 31 March 2013

	£000
Within one year	6,143
One to two years	350
Two to five years	1,051
Over five years	2,087
Total	**9,631**

The pensions' provision relates to the NHS Pensions Agency in respect of Injury Benefits awards, payable to former employees of the Trust to dormer staff is calculated using actuarial information on named individuals and is reviewed on a quarterly basis.

The provision for legal claims relates to unresolved claims arising from tribunal hearings, equal pay claims, clinical negligence claims, and other legal matters. Other provisions include £1,507k in respect of Injury Benefits awards. The redundancy provision relates to the anticipated costs arising from the Trust Service Strategy review. The provision only covers the anticipated costs for the 12 months following the end of this financial year, as plans after that date are not sufficiently developed to identify further costs with any level of certainty.The value and expected timings of the injury benefit provisions are calculated by reference to information available at the balance sheet date, provided by the Trust's advisors. As new evidence comes to light, the value of the provision can change either up or down. Similarly, new evidence can affect the expected timings of cashflows.

The NHS Litigation Authority includes a provision of £946k as at 31 March 2013 in respect of clinical negligence liabilities of the Trust (31 March 2012 £1,342k).

23. Revaluation Reserve

	Property plant and equipment £000
Revaluation reserve at 1 April 2012	**24,859**
Revaluation and impairment losses on property plant and equipment	**(1,391)**
Net gain on revaluation of property plant and equipment	**2,706**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	**(491)**
Revaluation reserve at 31 March 2013	**25,683**
Revaluation reserve at 1 April 2011	31,837
Revaluation and impairment losses on property plant and equipment	(6,545)
Net gain on revaluation of property plant and equipment	42
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	(389)
Other recognised gains and losses	(86)
Revaluation reserve at 31 March 2012	**24,859**

24. Cash and cash equivalents

	2013 £000	2012 £000
At 1 April	**20,075**	32,616
Net change in year	**(692)**	(12,541)
At 31 March	**19,383**	**20,075**
Broken down into:		
Cash at commercial banks and in hand	**82**	472
Cash with the Government Banking Service	**19,301**	19,603
Cash and cash equivalents as in Statement of Financial Position	**19,383**	**20,075**
Cash and cash equivalents as on Statement of Cash Flows	**19,383**	**20,075**

The Foundation Trust holds money on behalf of patients. This money is excluded from the cash figure recognised in the accounts. As at 31 March 2013 the cash held on behalf of third parties was £300k (31 March 2012 - £356k).

25. Capital commitments

As at 31 March 2013, the Trust has entered into contracts to purchase property plant and equipment for £263k (31 March 2012 - £2,915k). These commitments are expected to be settled in the following financial year.

26. Subsequent events

Subsequent to the Statement of Financial Position date, no events which would require adjustments to the accounts or disclosure have occurred.

27. Contingencies

The Trust has no contingent liabilities or assets at 31 March 2013 (31 March 2012 - £nil).

28. Related party transactions

Norfolk and Suffolk NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health. During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Trust (2011-12 - £nil).

	Income £000	Expenditure £000
Department of Health	**888**	**0**
East of England Strategic Heatlh Authority	**3,739**	**3**
NHS Norfolk	**76,712**	**2,224**
South East Essex PCT	**20,087**	**0**
NHS Great Yarmouth and Waveney	**31,050**	**1,477**
Suffolk PCT	**69,239**	**68**
Ipswich Hospital NHS Trust	**19**	**995**
Other NHS Bodies	**1,645**	**3,844**
Other	**12,367**	**41,264**
Total value of transactions with related parties in 2012-13	**215,746**	**49,875**
Department of Health	1	0
East of England Strategic Heatlh Authority	3,854	4
NHS Norfolk	78,810	1,543
NHS Great Yarmouth and Waveney	32,971	530
South East Essex PCT	19,057	0
Suffolk PCT	70,184	78
Ipswich Hospital NHS Trust	4	981
Other NHS Bodies	1,500	5,161
Other	11,252	49,914
Total value of transactions with related parties in 2011-12	**217,633**	**57,681**

	Receivables £000	Payables £000
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2013	**0**	**0**
Department of Health	**120**	**894**
East of England Strategic Health Authority	**428**	**150**
NHS Great Yarmouth and Waveney	**312**	**1,657**
NHS Norfolk	**2,111**	**2,954**
South East Essex PCT	**607**	**10**
Suffolk PCT	**1,086**	**225**
Ipswich Hospital NHS Trust	**292**	**219**
Other NHS Bodies	**261**	**666**
Other	**1,666**	**4,016**
Total balances with related parties at 31 March 2013	**6,792**	**10,791**
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2012	0	0
Department of Health	138	1,300
East of England Strategic Health Authority	8	120
NHS Great Yarmouth and Waveney	12	224
NHS Norfolk	458	788
South East Essex PCT	119	0
Suffolk PCT	1,060	61
Ipswich Hospital NHS Trust	0	152
Other NHS Bodies	197	1,487
Other	769	3,772
Total balances with related parties at 31 March 2012	**2,761**	**7,904**

The Department of Health is regarded as a related party. During the year Norfolk and Suffolk NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

The Trust also had £7,859k of expenditure with NHS Professionals for temporary staff costs (2012: £7,449k). In addition, the Trust has had a significant number of material transactions with other local Government bodies, namely Norfolk County Council and Suffolk County Council.

The Trust is the corporate trustee of the Norfolk and Waveney and Suffolk NHS Trust Charitable Funds. The members of the Trust Board of Directors act on behalf of the Trust in its capacity as corporate trustee. During the year none of the Trustees or members of the key management staff or parties related to them has undertaken any material transactions with the Charitable Trust.

Board Members (and other senior staff) take decisions both on Charity and Exchequer matters but endeavour to keep the interests of each discrete and do not seek to benefit personally from such decisions. Declarations of personal interest have been made in both capacities and are available to be inspected by the public.

29. Losses and special payments

There were 71 cases of losses and special payments totalling £318k approved during the year to 31 March 2013 (84 cases and £175k in the year to 31 March 2012). These payments are the cash payments made in the period and are not calculated on an accruals basis. There were no individual cases where the net payment exceeded £100,000 (£nil for the year to 31 March 2012).

30. Financial Instruments

IAS 32, 39 and IFRS 7, Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

The Trust is not exposed to significant financial risk factors arising from financial instruments. Because of the continuing service provider relationship that the Foundation Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Foundation Trust in undertaking its activities.

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. The Foundation Trust's transactions are almost all undertaken in sterling and so it is not exposed to foreign exchange risk. It holds no significant investments other than short-term bank deposits. Other than cash balance, the Foundation Trust's financial assets and liabilities carry nil or fixed rates of interest and the Foundation Trust's income and operating cash-flows are substantially independent of changes in market interest rates.

Credit risk is the possibility that other parties might fail to pay amounts due to the Foundation Trust. Credit risk arises from deposits with banks as well as credit exposures to the Foundation Trust's commissioners and other debtors. Surplus operating cash is only invested with banks that are rated independently with a minimum rating of A1, P1, F1 or A+. The Foundation Trust's cash assets have been held in the year with Barclays Bank plc, Citibank, Lloyds TSB, Nordea Bank, Royal Bank of Scotland, Santander UK, Svenska Handelsbanken and the Office of the Post Master General. The Foundation Trust's net operating costs are incurred largely under contracts with local Primary Care Trusts, which are financed from resources voted annually by Parliament. As Primary Care Trusts are funded by Government to by NHS patient care services, no credit scoring of them is considering necessary. An analysis of the ageing of debtors and provision for impairment can be found at Note 13 "Trade and other receivables".

Liquidity risk is the possibility that the Trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding from an adequate amount of committed credit facilities. NHS Foundation Trusts are required to comply with the Prudential Borrowing Code made by Monitor, the Independent Regulator of Foundation Trusts, and further details of the Foundation Trust's compliance can be found at Note 21 "Prudential Borrowing Limit".

30.1. Financial assets by category

Assets as per balance sheet	31 March 2013 £000	31 March 2012 £000
NHS receivables (net of provision for impairment of receivables)	**4,450**	728
Accrued income	**20**	0
Other receivables (net of provision for impairment of receivables)	**1,697**	916
Non current assets held for sale	**2,925**	3,234
Cash at bank and in hand	**19,383**	20,075
Total	**28,475**	**24,953**

30.2. Financial liabilities by category

Liabilities as per balance sheet	31 March 2013 £000	31 March 2012 £000
NHS payables	**1,185**	586
Loans	**19,548**	16,394
Other payables	**22,529**	20,748
Capital payables	**1,378**	2,534
Obligations under finance leases	**0**	48
PFI and finance lease obligations	**4,210**	4,317
Total	**48,850**	**44,627**

31. Fair value

In accordance with IAS 32, 39 and IFRS 7, the fair value of financial assets and liabilities (held at amortised cost) is not considered significantly different to book value.

31.1. Maturity of financial liabilities

Maturity of financial liabilities:	31 March 2013 £000	31 March 2012 £000
Less than one year	**34,569**	25,058
In more than one year but not more than two years	**1,056**	1,191
In more than two years but not more than five years	**3,169**	3,568
In more than five years	**10,056**	14,810
	48,850	**44,627**

If you would like to become a member of the Trust send an email to membership@nsft.nhs.uk or call 0870 7071647.

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If you would like this information in large print, audio, Braille, alternative format or a different language, please contact the Patients' Advice and Liaison Service (PALS) and we will do our best to help.

Email PALS@nsft.nhs.uk or call PALS Freephone 0800 279 7257.

This Annual Report and a separate Annual Review are also available online at www.nsft.nhs.uk

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