If you would like to become a member of the Trust send an email to membership@nsft.nhs.uk or call 0800 1114452.

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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

your wellbeing in mind

Norfolk and Suffolk NHS Foundation Trust Annual Report + Accounts April 2011 to March 2012

Norfolk and Suffolk NHS
NHS Foundation Trust

Annual Report and Accounts

April 2011 to March 2012

your wellbeing in mind

Norfolk and Suffolk NHS Foundation Trust

Annual Report and Accounts April 2011 to March 2012

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

Contents

The second part of this Annual Report contains the Audited Accounts, which has its own contents page.

From the Chair

Partnership for the future

It is interesting to look back on last year's predictions and see how many of them have come to pass. A year ago, I suggested that we would need to add resilience to our emotional repertoire. Resilience is about being buoyant and having the ability to adapt to change – which is a constant challenge in today's environment.

Collectively, we may not be feeling at our most buoyant right now, but I strongly sense that we are getting back into shape following the changes brought about by the merger of Norfolk and Waveney Mental Health NHS Foundation Trust's (NWMHFT) and Suffolk Mental Health Partnership NHS Trust's (SMHPT) services on 3 January 2012. The merger was a long process – longer even than anticipated – and it brought with it uncertainties in both counties, some of which continue.

A year ago we were two organisations, this year we are one. So far we have retained – albeit in a changed form – some services, but in the future we may lose services, or succeed in taking on new business. Although we tendered successfully for the Wellbeing Services in Suffolk, it is ever harder to predict what shape we will be in next year as more services are put out to tender.

Alongside the merger, we are developing a radical redesign of services. Led by clinicians, this will ensure that we get the best out of the money and resources available. Both the merger and the radical redesign will help protect our front-line services, but these are tough times, and these changes still mean that some people are losing their jobs, and others have to work differently.

The year has seen us open new inpatient facilities for adults of working age and older people in Suffolk as a precursor to moving off the St Clement's site in Ipswich. We have also opened Hammerton Court in Norwich, a state-of-the-art dementia unit incorporating the best of technology and the best environmental features.

The executive directors have remained as a stable group and have been joined by Debbie White, Director of Operations – Suffolk. For nine months prior to the merger Aidan Thomas and Dr Hadrian Ball, along with Trust Secretary Paula Bourthis, were working in Suffolk, particularly on patient safety improvements. Finance Director Andrew Hopkins and Dr Luk Ho stepped into Aidan and Hadrian's roles in Norfolk.

Following a targeted recruitment exercise, Dr Peter Jefferys joined us as a non-executive director. His clinical background augments the rigorous attention paid by non-executive directors to patient safety.

We now also have two non-executive directors from Suffolk on the Board: Deborah Cadman joined us briefly, before taking up the post of Chief Executive of Suffolk County Council; the Governors then recruited Gary Page; and Brian Parrott joined us at the point of merger.

This balance will also be reflected in the Board of Governors, which will include elected and partner governors from both NWMHFT and SMHPT. I believe the relationship between the Boards of Directors and Governors is characterised by mutual respect, honesty and good humour. Our Governors have a wealth of experience and are well placed to rise to the new challenges of holding us to account, enshrined in the Health Act (2009) – a role they had anticipated by developing a Performance sub-group in the last year.

I have said that we operate in a tough environment, and I think it will get tougher. Nothing we do is in isolation and where we are successful, positive partnerships are a feature of that success. Our relationships with our third sector colleagues help to make services more sustainable in these times, when money for social care and healthcare is reduced, and in a context where those who use our services are experiencing threats to their housing, benefits and work prospects.

This Trust enjoys a good reputation nationally, and has developed its local relationships to a point where I believe we are respected by third sector, county council and commissioner colleagues. Working together is going to be the only way forward if we are to protect services and maintain jobs.

Maggie Wheeler
Chair

Chief Executive's report

New services in a new era

For many staff this has undoubtedly been a tough year. A challenging savings programme was achieved – in part – by savings in some of our front-line services. A number of these services were reorganised during the year, but the Trust achieved its financial targets in a difficult economic climate.

This was also a significant year for the Trust's services in a number of other important ways.

Firstly, the achievement of merger with Suffolk Mental Health Partnership NHS Trust (SMHPT) in January 2012 marked the end of 'Norfolk and Waveney' and 'SMHP' as a name and the start of a new era as Norfolk and Suffolk NHS Foundation Trust (NSFT). This change means that the Trust can develop many new services, including new inpatient services for children and improved psychological therapies, while achieving much better financial security.

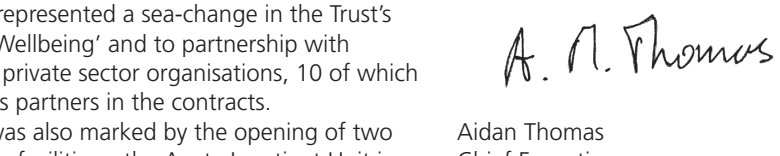
Norfolk and Waveney Mental Health NHS Foundation Trust (NWMHFT) won new contracts for Wellbeing Services in both Norfolk and Great Yarmouth & Waveney. This too was highly significant, not only because of the commercial success of the bids but also because they represented a sea-change in the Trust's approach to 'Wellbeing' and to partnership with voluntary and private sector organisations, 10 of which are included as partners in the contracts.

The year was also marked by the opening of two significant new facilities – the Acute Inpatient Unit in Ipswich, and Hammerton Court in Norwich. The Acute Inpatient Unit provides new facilities for people in the east of Suffolk for the first time in 150 years – an important legacy for the new Trust – while Hammerton Court offers state-of-the-art inpatient facilities for people with dementia. It is also a tangible focus for our work with our partners in education and the Dementia Alliance in establishing a Dementia Academy.

The first new dementia support teams in the community were set up during the year, helping to establish a new pattern of service development in Norfolk and hopefully, in time, in Suffolk.

The Trust also commenced work with service users, carers and other stakeholders designing new pathways of care to address both the financial pressures of the coming years and the introduction (in a year's time) of a tariff for mental health services. The Trust is leading the way in this area in the East of England.

A hard year, but a positive and successful one for the Trust's services, and one which holds promise for the future.



Aidan Thomas
Chief Executive

About the Trust

Your wellbeing in mind

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

The Trust's mission is to provide high-quality' accessible services that deliver personalised care supported by strong partnerships with stakeholders and other agencies.

Service users and carers will be at the centre of all aspects of the Trust's work. It supports and enables people with mental health problems, or who need to improve their wellbeing, to live a fulfilling life and, where possible, recover.

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 healthcare, 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 psychology 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 (NWMHFT) and the Suffolk Mental Health Partnership NHS Trust (SMHPT) came together on 3 January 2012 to become Norfolk and Suffolk NHS Foundation Trust (NSFT).

The Trusts worked together for more than 12 months to realise the merger, recognising the similarities between the Norfolk and Suffolk communities. As a combined organisation the quality, number and accessibility of services can increase, creating a more efficient and effective organisation.

The merger has brought together the best aspects of services in Norfolk, Suffolk, Great Yarmouth and Waveney.

Norfolk and Suffolk NHS Foundation Trust

A guide to our services

Norfolk and Suffolk NHS Foundation Trust (NSFT) was born from the merger of Norfolk and Waveney Mental Health NHS Foundation Trust (NWMHFT) and Suffolk Mental Health Partnership NHS Trust (SMHPT).

It has drawn together the best elements of both organisations to create a Foundation Trust that will lead the way for years to come.

Here is our simple, at-a-glance guide to the services provided by the new Trust, and the cities and towns where those services are based.

In terms of our inpatient services, more and more people can be treated in new, green, state-of-the-art buildings.

These include Justin Gardner House – which includes both a psychiatric intensive care unit and a low secure unit – at Hellesdon Hospital, in Norwich. Across the city, at the Julian Hospital, is our brand-new Hammerton Court Dementia Intensive Care Unit. Ipswich is also home to cutting-edge facilities, such as the Foxhall House low secure unit and the Woodlands mental health facility.

1 Norwich
- Inpatient services for adults and older people
- Psychiatric Intensive Care Unit (PICU)
- Low secure unit
- Trust Alcohol and Drugs Service
- Child and Adolescent Services (CAMHS)
- Adult and older people's community services
- Forensic Services
- Criminal Justice Liaison Service
- Wellbeing Service
- Rehabilitation hostels

2 Great Yarmouth
- Adult inpatient services
- Trust Alcohol and Drugs Service
- Child and Adolescent Services (CAMHS)
- Criminal Justice Liaison Service
- Adult and older people's community services
- Wellbeing Service

3 Lowestoft
- Child and Adolescent Services (CAMHS)
- Adult community services

4 King's Lynn
- Adult and older people's inpatient services
- Adult and older people's community services
- Child and Adolescent Services (CAMHS)
- Criminal Justice Liaison Service
- Wellbeing Service

5 Carlton Colville
- Adult and older people's inpatient services
- Adult and older people's community services

6 Dereham
- Adult community services
- Trust Alcohol and Drugs Service

7 Wymondham
- Adult and older people's community services
- Wellbeing Service

8 Beccles
- Adult community services

9 Kelling
- Adult and older people's community services
- Wellbeing Service

10 Ipswich
- Community mental health services
- Adult inpatient services
- Child and Adolescent Services (CAMHS)
- Improving Access to Psychological Therapies (IAPT)
- Assertive outreach
- Later life services
- Eating disorder services
- Learning disability services
- Open rehabilitation services
- Psychiatric Intensive Care Unit (PICU)
- Low Secure unit

11 Bury St Edmunds
- Community mental health services
- Child and Adolescent Services (CAMHS)
- Assertive outreach
- Later life services
- Eating disorder services
- Improving Access to Psychological Therapies (IAPT)
- Criminal Justice Liaison Service
- Psychology
- Adult inpatient services

12 Haverhill
- Learning disability services

13 Sudbury
- Community mental health services

14 Stowmarket
- Early intervention services
- Child and Adolescent Services (CAMHS)
- Learning disability services

15 Oulton
- Learning disability services

16 Thetford
- Community mental health services
- Improving Access to Psychological Therapies (IAPT)

17 Newmarket
- Community mental health services
- Later life services

18 Kesgrave
- Community mental health service

Financial review

Continuing a strong financial performance

This part of the Directors' Report provides a review of the financial performance for the year ending 31 March 2012. The year has been one of significant change – both in terms of the merger of Norfolk and Waveney Mental Health NHS Foundation Trust (NWMHFT) and Suffolk Mental Health Partnership NHS Trust (SMHPT), as well as the increasing pressures on finances from the austerity measures being applied more widely across NHS and public services.

Although the actual date of merger was 3 January 2012, and before that date they were managed as separate organisations, under current government accounting rules the two organisations are now treated as always having been a single organisation. The accounts are prepared on this basis.

The Trust's financial performance has been in line with plans and has resulted in a Monitor financial risk rating of '3' (good) and a surplus before exceptional items of £2.0m. The exceptional items reflect the costs of change and restructuring associated with the merger (£5.4m) and impairment of property valuations (£4.6m). These items are 'one-off' in nature and therefore tend to mask the underlying performance.

This section includes information relating to cash management, efficiency savings, capital programme, income generation and the financial outlook for the Trust. More information on 2011–12 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 ongoing 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 2010–11

The Annual Report and Accounts show comparative information with the combined accounts of the two organisations' 2010–11 financial year. This should help give readers an understanding of the financial performance and impact of any significant issues on the Trust's financial position.

Summary of financial performance

As at 31 March 2012, the Trust had delivered the following performance:

- Surplus of £2.0m before exceptional items (a deficit of £8m is identified in the Statement of Comprehensive Income after applying these exceptional items).
- Financial risk rating of '3', in line with the planned rating for the year and that planned for in the merger financial modelling.
- A cash balance of £20.1m at 31 March 2012, which is a reduction on the previous year's performance, but which reflects the outlay on the merger costs of change and a substantial capital programme in 2011–12.

This performance leaves the Trust well placed to achieve its corporate objectives for 2012–13, and demonstrates substantial progress against its longer-term business plan.

The Trust's total income fell by £1.3m between 2010–11 and 2011–12 resulting in a total turnover for the year of £221m. This movement on income is explained in the following table:

Analysis of changes in turnover (income)	NWMHFT	SMHPT	Total
	£m	£m	£m
Deflation adjustment	(1.7)	(1.2)	(2.9)
Wellbeing	0.7		0.7
Funding for Activity pressures	1.5		1.5
Older People	0.8		0.8
Patient Safety		0.6	0.6
Suffolk Support Services		(1.0)	(1.0)
Research and Development	0.7		0.7
Other funding adjustments and service developments	0.1	(0.8)	(0.7)
Non-recurrent transformational support from SHA		2.9	2.9
Total additional income	2.1	0.5	2.6
Less: Contracts transferred to other providers	(0.4)	(3.5)	(3.9)
Net Increase in funding	1.7	(3.0)	(1.3)

The NHS financial settlement for 2011–12 resulted in a 1.5% reduction (the deflation adjustment) on healthcare services contracts. In 2012–13 the reduction will increase to 1.8%.

The Trust commenced the delivery of its Wellbeing Services in Norfolk and in Great Yarmouth and Waveney during the year, which were both won under competitive tendering exercises. The Trust has also been successful in its bid to provide Wellbeing Services in Suffolk and these will commence in 2012–13.

The Trust, with the support of NHS Norfolk and Waveney, has introduced Dementia Intensive Support Teams in parts of Norfolk, which help to avoid hospital admissions and enable patients to remain at home, and was also able to argue for additional activity to be funded. The Trust was also successful in securing additional funding for research and development of £0.7m in Norfolk, which is in line with the Trust's strategic intent to increase the level of research studies in the Trust.

In Suffolk a considerable amount of non-recurring funding was provided to support the patient safety programme and the transformation of services (some £3.5m in total). This was offset by reductions in the income earned through Support Services in Suffolk, which provides non-healthcare services (for example estates and facilities management, information technology) to NHS Suffolk, GPs in Suffolk and other organisations. A number of contracts were transferred to other providers during the year in Suffolk including substance misuse services and supported housing.

The Trust's principal sources of income are from four 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 £189m or 86% of turnover in 2011–12.

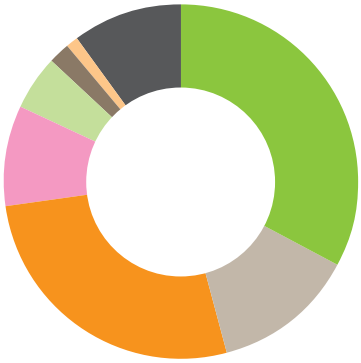
The most significant costs faced by the Trust during the year were those affecting pay. While the pay award in 2011–12 only applied to staff earning less than £21,000 per year, a significant cost pressure continues to exist from the annual incremental progression through pay scales (a 2% increase) that forms part of the national terms and conditions of the Agenda for Change pay system. The chart overleaf demonstrates that pay accounts for 78% of total costs (please note that this excludes the exceptional charges identified in the pie chart, which otherwise reduce this percentage to 74%) so it is quite clear that staff will always represent the most significant, important and valuable resource that the Trust has.

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 £13m. This figure includes £3m of non-merger-related transformational costs, including redundancies relating to Cost Improvement Programme schemes and staff leaving the organisation through the nationally negotiated Mutually Agreed Resignation Scheme (MARS). These costs have not been considered exceptional for the purposes of calculating the underlying performance of the Trust. A full analysis of costs is contained in note 4 to the accounts.

The Trust has implemented a single corporate structure across the merged organisation that was agreed by Directors following a consultation with affected staff in both predecessor organisations. This new structure has seen 90 whole time equivalent (WTE) staff leave the organisation. The Trust has spent £5.4m on the costs of change of the merger, most of which relate to redundancy payments for staff who chose not to have a role in the new organisation and were granted voluntary redundancy (61 WTE staff), but the remainder of staff who left were made compulsorily redundant as part of this process. This figure also includes the costs of programme management for this part of the merger (£0.5m).

The Trust had a £9.1m cost improvement plan (CIP) during 2011–12, which was 94% achieved with the balance being offset by additional income. The CIP programme included the initial savings from the merger

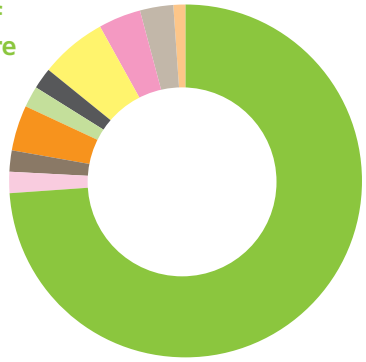
Sources of Income 2011–12



NHS Norfolk	33%
NHS Great Yarmouth & Waveney	13%
NHS Suffolk	27%
Secure Services	9%
Clinical Partnerships	5%
Education and Training	2%
Research and Development	1%
Other income	10%

Total income of £221.24m

Analysis of Expenditure 2011–12



Pay	(£169.0m) 74%
Drugs and Clinical Supplies	(£4.1m) 2%
Specialist Placements	(£5.5m) 2%
Premises	(£8.7m) 4%
Establishment	(£4.0m) 2%
Transport	(£4.4m) 2%
Exceptional Items	(£13.0m) 6%
Other Costs	(£6.9m) 4%
Depreciation	(£6.0m) 3%
Public Dividend Payment	(£3.5m) 1%

Total costs of £220m

as well as a number of initiatives in direct care service. The Trust looked at changes to the organisation of its services including locality and service management, recovery services, Child and Adolescent Mental Health Services and services in primary care.

The Trust undertook a review of its approach to identifying and delivering CIP and put in place a new programme midway through the year that focuses on care pathways rather than specific services. This approach is known as Radical Pathway Redesign and is explained further elsewhere in this report. This programme will deliver savings from 2012–13.

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 EBITDA margin of 5.8%
- Proportion of budget achieved of 89%
- An income and expenditure surplus of 1.1%
- A return on assets of 3.9%
- A liquidity ratio of 14.3 days

The overall rating is 3. These metrics are calculated after Monitor applied an Investment Adjustment to recognise the one-off costs of change. While this has been a robust performance, the reduction in liquidity means that we have less resources for capital expenditure over the next year. The reduction in liquidity is a consequence of having to incur 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 has previously set a private patient income cap of zero, and therefore has not generated any private patient income to date. However, following a revision of the private patient income rules, the Trust is now able to generate up to 1.5% of its income from private patients, although the Trust has not undertaken any such activity thus far.

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 £3.475m in 2011–12. The dividends are based on 3.5% of the average value of net relevant assets during the financial year payable 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 revaluation 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) £14.9m.

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 (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 Wedgwood 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 £16.4m as at 31 March 2012.

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

Capital Schemes – Year ended 31 March 2012	**NWMHFT**	**SMHPT**	**Total**
	£m	£m	£m
Hammerton Court, Julian Hospital, Norwich	10.927		10.927
Wedgwood Unit, Bury St Edmunds		2.490	2.490
Information, Communication and Technology (ICT)	1.314	0.360	1.674
Woodlands Unit, Heath Road, Ipswich		1.499	1.499
Statutory compliance including health and safety, fire safety, disability discrimination	0.763	0.142	0.905
West Norfolk Estates Rationalisation, King's Lynn	0.789		0.789
Mariner House, Ipswich		0.316	0.316
Other Projects (£0.15 million or less)	0.891	0.670	1.561
Total	**14.684**	**5.477**	**20.161**

The most significant project undertaken during the year was the continuing development of Hammerton Court, which opened in March 2012. This Dementia Intensive Care Unit is a 36-bed unit based on the Julian Hospital site in Norwich.

In Suffolk the continued development on the Woodlands and Wedgwood Units saw capital expenditure incurred of just under £4m.

The Trust also completed the work at its sites in King's Lynn (Chatterton House and the Fermoy Unit) to offer improved service user and office environments.

The Trust's Information, Communications and Technology strategy has been further developed to support the merger and the integration of the two Trusts and 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 capital programme for 2012–13 will see the completion of the development on the Wedgwood site (older people's services) and the continuing development of the Information, Communications and Technology strategy.

Private Finance Initiative (PFI)

The Trust currently provides services from one location – the Wedgwood 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 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) and 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 three 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 31 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 £0.198m during the year, which is marginally higher than that earned in 2010–11. 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 not so far made any investments in this respect.

Post-balance sheet events

The Board of Directors confirms that there are no post balance sheet events applicable to the 2011–12 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 2011–12 are contained within the 2011–12 Annual Report and Accounts for the Funds Held on Trust, and a copy of these documents may be requested without charge from the director of finance from January 2013 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 2011–12.

Financial outlook

Over the next five years the Trust and the NHS as a whole face what is probably the most financially challenging environment that we have ever seen. The period will be characterised by reducing income, increasing efficiency requirements (around 5% each year) and increasing costs (pay awards, food, fuel, energy etc.).

In other words, there is considerable and growing deficit between income coming in and costs going out; hence the need for service innovation and transformation to help deliver the cost improvement programme and ensure the financial stability of the organisation. The Trust will have to save around £40m over the next four years to meet this gap, which represents a 20% reduction in income over this period.

It is also fair to say that 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. In Norfolk we will soon have the largest elderly (age 65 and over) population in the country and Suffolk is not far behind. This presents challenges for all health and social care services in our area and highlights the need to transform services and meet growing demand, particularly for the growing number of people with dementia.

In response to this outlook the Trust has adopted two main programmes of action. Firstly the merger between the Norfolk and Suffolk mental health trusts has given the Trust a stronger base for meeting the challenge and will enable a significant saving in corporate and support costs to be made. This helps to protect front-line services from some of the cost improvement pressures and is one of the key benefits of the merger. Secondly the Trust is developing a transformational approach towards savings with the Radical Pathway Redesign process. This process focuses on the 'care pathways', i.e. the journey that a service user takes through our service (assessment, care, treatments etc.). The programme is led by clinicians, but involves working with our staff, service users, carers, commissioners and partner agencies and looks at how care pathways can be improved, both in terms of quality and efficiency, to meet the 20% reduction.

The Trust's cost improvement requirement for 2012–13 stands at £14m, or 6.3%. Of this sum, £3.6m will be delivered by way of the merger, with the remainder to be found from the Radical Pathway Redesign process.

The Board of Directors has agreed a plan for 2012–13 that maintains the Trust's sound financial position with a Financial Risk Rating of 3, combined with development in certain areas and in conjunction with commissioners' priorities. In 2012–13 we will:

- Implement the new Wellbeing Service across Suffolk, including the ability for people to self-refer to the service;
- Continue the development of services for people with dementia in our communities, including the further roll-out of Dementia Intensive Support Team (DIST) services across Norfolk and Suffolk, and we will work with our partners to help acute hospitals provide better services for older people with dementia who are in acute hospitals;
- Develop a Child and Adolescent Mental Health (CAMHS) inpatient unit and an Intensive Support Team to work with this unit and across Norfolk and Waveney to ensure that if children have to spend time away from their families it is for a short period and closer to home;
- Continue the Trust's programme for improving ward environments, paying particular attention to patient safety and risk management.

The Trust anticipates having to make similar levels of savings over the next four years. This level of savings will clearly place considerable pressure on service delivery and the Trust's strategic change programme (or cost improvement programme) is actively reviewing service provision and how savings can be achieved. It is vital to do this so that the Trust can continue to thrive and provide high quality services that offer good value for money.

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.

Quality Account

Measuring and improving quality standards

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

We have been engaged by the Board of Governors of Norfolk and Suffolk NHS Foundation Trust to perform an independent assurance engagement in respect of Norfolk and Suffolk NHS Foundation Trust's Quality Account for the year ended 31 March 2012 (the 'Quality Account') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Admissions to inpatient services had access to crisis resolution home treatment teams; and
- Minimising delayed transfers of care

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 Account in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by the Independent Regulator of NHS Foundation Trusts ('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 Account is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Account is not consistent in all material respects with the sources specified below; and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account 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 Accounts.

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

We read the other information contained in the Quality Account and considered whether it is materially inconsistent with the sources specified below. The sources with which we shall be required to form a conclusion as to the consistency of the Quality Account are limited to:

- Board minutes for the period April 2011 to June 2012;
- Papers relating to quality reported to the Board over the period April 2011 to June 2012;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations, dated January 2012;
- The 2011 national patient survey completed December 2011;
- The 2011 national Staff Survey completed 2011;
- Care Quality Commission quality and risk profiles dated April 2012; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2012

The following sources of information were not made available to the auditors during the review of the Quality Account, and as such have not been considered:

- Feedback from the Commissioners; and
- Feedback from Local Involvement Networks (LINks)

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

and Suffolk NHS Foundation Trust as a body, to assist the Board of Governors in reporting Norfolk and 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 2012, to enable the Board of Governors to demonstrate that it has discharged its 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 and 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;
- Analytical procedures;
- 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 Account; and
- Reading the documents.

A limited assurance engagement is less 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 Account in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The nature, form and content required of Quality Accounts are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS foundation trusts.

In addition, 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 2012:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* except that feedback from LINks and Commissioners has not been received;
- the Quality Account is not consistent in all material respects with the sources specified as available; and
- the indicators in the Quality Account subject to limited assurance have not been 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 Accounts except that:
  - The delayed transfer of care indicator incorporates delays for social care patients, which under Monitor guidance should be excluded from this indicator.

KPMG LLP

KPMG LLP, Statutory Auditor

Chartered Accountants
6 Lower Brook Street
Ipswich
Suffolk

Statement from the Chief Executive

We have experienced a great deal of change over the last few months, as Norfolk and Suffolk NHS Foundation Trust was formed from the merger of Norfolk and Waveney Mental Health Foundation Trust and Suffolk Mental Health Partnership NHS Trust, but throughout we have been determined to maintain and exceed the same high standards of healthcare.
In fact, the entire purpose of our new Trust is to provide high quality mental healthcare and to support the wellbeing of people in our region.

With our service users in mind, many of our clinical staff have been looking again at the way we provide care, looking at the whole journey a person might take through our services. Together with service users, family carers and other health agencies outside the Trust, they have been suggesting how we could improve that experience, while at the same time also keeping within our finances and addressing the many changes the NHS is facing. This programme is called Radical Pathway Redesign.

Quality very much underpins that programme. As well as leading to better outcomes for our service users, having a high quality service means that we can attract and retain the very best staff and continue to meet expectations. We want to have the best mental health services nationally.

Over the past year, staff in our Trust have done a huge amount to improve quality. Dozens of service improvements have been introduced; some of these have been very significant.

In March 2012, we opened Hammerton Court, our Dementia Intensive Care Unit in Norwich. This beautiful building, with state-of-the-art equipment and impressive green credentials, forms an important part of our Radical Pathway Redesign programme. While our Dementia Intensive Support Teams (DIST) support people as much as they can in their own homes, recognising families' wishes to acquire the skills to allow them to care for their loved one at home for as long as possible, sometimes people do need to stay in hospital. That's where Hammerton Court comes in. The unit is home to the Norfolk Dementia Care Academy, supporting the development of both professionals and family carers. Continuing our commitment to dementia care, the Trust also hosts DeNDRoN, the Dementias and Neurodegenerative Diseases Research Network, the ongoing aim of which is to research factors affecting how and when people develop dementia.

We are also about to open a new inpatient unit for children from Norfolk and Suffolk. This will allow us to provide excellent care for children and their families without the need for lengthy journeys. Again, this is part of our Radical Pathway Redesign programme to improve the experience of people using our services.

Last year, we opened a new mental health hospital – Woodlands – next to Ipswich Hospital in Suffolk and we are currently carrying out major refurbishment work at Wedgwood House on the West Suffolk Hospital site in Bury St Edmunds. These new high quality purpose-built facilities have contributed greatly to the quality of care that our teams can provide.

In Suffolk we have already completed a huge amount of work in improving patient safety, building on recommendations following an external review. The changes in Suffolk were wide-reaching, and included an overhaul of the systems and processes (what we term 'governance') of the former Trust. That learning is also now being applied in the former Norfolk and Waveney Mental Health NHS Foundation Trust area.

Our drive to improve quality is not just limited to the production of this Quality Account. We consider quality to be at the heart of everything that we do and it is something that we expect everyone in our Trust to take responsibility for.

Statement of accuracy

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

A. M. Thomas

Aidan Thomas
Chief Executive
28 May 2012

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 to promote, monitor and lead on quality.

Drivers for quality

There are a number of drivers that contribute to quality development within the Trust. These include:

- Working with commissioners to identify expectations and quality improvements required
- Listening to feedback from a variety of sources including NHS Choices, compliments and complaints and Local Involvement Networks (LINks)
- Public consultation events
- Working with partner organisations including Norfolk and Suffolk county councils, charities and third sector organisations, such as MIND, Age UK and Rethink
- Adherence to national targets and priorities

To ensure the involvement of all stakeholders, service users, carers, staff, commissioners, governors and members of the public, the Trust held a series of five public involvement events across Norfolk and Suffolk. These involved a presentation about how quality is managed within the Trust.

At these events, three separate workgroups were asked the following questions:

1. What is the Trust doing well?
2. What is the Trust not doing so well?
3. What should our quality priorities be for 2012–13?

The feedback received from the events was then collated and mapped to quality priorities identified as part of the identified drivers. The final draft list of proposed priorities was then presented to the Board of Directors to choose the final priorities for 2012–13.

Looking forward to 2012–13

Trust quality priorities 2012–13

The Board of Directors agreed at a public meeting in February 2012 that the quality priorities for 2012–13 should be:

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.

For community service users, physical health checks remain the responsibility of a person's GP but their care coordinator will support and encourage them to ensure that they receive an annual health check.

- 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.

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.
- 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.

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.

These priorities will now be a focus for the Trust and an action plan will be 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 *Insight*.

Feedback on quality priorities 2011–12

The Quality Account published in 2011 identified four quality targets in NWMHFT and five in SMHPT. Following the patient safety review held in Suffolk, the decision was made to focus on the subsequent action plan and this became the quality priority.

This section demonstrates the progress that has been made in the past 12 months.

Norfolk priorities

Patient safety

- Service users should feel confident that their physical health needs will be met whilst an inpatient.

Following a baseline audit and the implementation of an action plan, the number of people who have given consent for assessment and have been offered a physical health assessment has risen as shown.

	Baseline (June 2011)	Target	Quarter 3 (Dec 2011)	Target met?
Weight	39%	70%	93%	Yes
Height	39%	70%	79%	Yes
BMI (Body Mass Index)	22%	70%	86%	Yes
Blood pressure	63%	85%	79%	No
Pulse	59%	85%	100%	Yes
Temperature	49%	85%	100%	Yes

Physical health remains a priority for the Trust and all localities will be asked to ensure that actions are put in place to improve compliance with this target. A further audit will take place in July 2012.

Patient experience

- Service users should know how to complain if they have any concerns about the service received and should be made aware of the timescales for the complaints process.

A programme of awareness raising took place across the Trust and a baseline audit was carried out to identify service users' understanding of the complaints process. A further audit has demonstrated an 11% increase in the number of people being provided with a complaints information leaflet and a 37% increase in the number of people being told how to make a complaint. The number of people who knew the expected response time remained static and overall indicated that most people did not know that information. It will be recommended that this is included in the next reprint of the leaflet.

- Service users will be provided with information packs for in-house and external services.

The Trust developed an information pack following consultation with service users. The Trust plans to have an online version of this and to include specific documents in the pack. The pack is currently being developed to meet the needs of individual teams and will be available from May 2012.

Clinical effectiveness

- Service users will be given a copy of their care plan which they will be asked to sign to demonstrate that they have been consulted and agree with the plan.

Following a baseline audit and putting an action plan into place, the number of people who have signed to demonstrate their involvement has risen from 55% to 76%. This figure is still below expectations and a further action plan and re-audit will be completed.

Suffolk priorities

The SMHPT patient safety review was adopted as the Trust priority and a comprehensive action plan was agreed with our commissioner, NHS Suffolk, and put into place. Topics included in the action plan included:

- Care programme approach
- Ward management
- Clinical supervision
- Suicide prevention audit
- Review of environment, especially ligature points
- Nursing and medical leadership
- Governance structures in place (serious incident reporting, complaints)

Progress has been achieved on all aspects of the action plan and NHS Suffolk has agreed that the actions implemented have become 'business as usual'.

The Trust will continue to implement the remaining work on the 2010–11 safety report, including the development of a nursing strategy to be launched in May 2012, a personality disorder strategy and improved working between teams.

We will ensure that the learning from the three legacy homicides subject to enquiry in Suffolk is implemented if these are reported in year.

The Trust is working with GPs and stakeholders to improve access and referral arrangements to child and adolescent mental health services and this is reflected in the Commissioning Quality and Innovation (CQUIN) scheme for 2012–13.

It is important to note that the quality improvement targets identified in previous years will continue to be reported to the Board of Directors until they are confident that the practices in question are 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. The Trust has tried to provide some explanation of the terms used in the Glossary of Abbreviations (see page 37), 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 2011–12 Norfolk and Suffolk NHS Foundation Trust, previously NWMHFT and SMHPT, 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 2011–12 represents 91% of the total income generated from the provision of NHS services by the Trust for 2011–12.

The quality of care the Trust has provided has been reviewed in a number of ways, including 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.

Examples of how the Trust reviews the quality of care

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

During 2011–12, four national clinical audits and one national confidential enquiry (NCE)* covered NHS services that the Trust delivered.

During that period, the former Norfolk and Waveney Mental Health Trust took part in 75% of the national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate.

During 2011–12, the former Suffolk Mental Health Trust participated in 75% of the national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries in which the Trust was eligible to participate during 2011–12 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
- Falls and non-hip fractures – national audit of falls and bone health
- National confidential enquiry into suicide and homicide by people with mental illness.

** 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 in which the NWMHFT and SMHPT participated, and for which data collection was completed during 2011–12, 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
National clinical audits		
National audit of falls and bone health **Rate of falls 2.9% (NWMHFT) in comparison to national average (3.8%)**	Completed	N/A – Audit of organisation of services
National audit of psychological therapies [anxiety and depression (NAPT)]	Completed	**Part 1** – contextual one-off questionnaire about Trust service **Part 2** – therapists' questionnaire Cases identified 177 Cases submitted 112 **Part 3** – retrospective audit of case notes – automatic data extraction via the Trust's electronic patient case management information system (PC-MIS) Cases submitted 1637 **Part 4** – Service user satisfaction survey Surveys sent out 2851 Surveys returned 1928 (67.6%)
National audit of schizophrenia	Completed (report pending)	***Sample of 100 cases drawn as per Royal College of Psychiatrists instruction*** **Clinicians case note audit** Cases required 100 Cases submitted NWMHFT 83 (83%) Cases submitted SMHPT 100 (100%) **Service user questionnaire** Cases submitted NWMHFT 100 20 responses (20%) NWMHFT Cases submitted SMHPT 100 24 responses (24%) SMHPT **Carer questionnaire** 200 sent out, 10 responded (5%) NWMHFT 200 sent out, 10 responded (5%) SMHPT
POMH	Completed	Baseline 217 Re-audit 209 Supplementary audit 161
National confidential enquiries		
National confidential enquiry into suicide and homicide by people with mental illness	Continuous audit	

The reports of three national clinical audits carried out by the former Norfolk and Waveney Mental Health NHS Foundation Trust were reviewed in 2011–12 and the Trust intends to take the following actions or has taken action to improve the quality of healthcare provided:

Topic	Actions
Depression and anxiety	Amend GP/professional referral form to make recording of gender mandatory. Amend self-referral form so that gender recording is a requirement. Develop a strategy for improving service access for older people. Monitor outcomes from Patient Experience Questionnaires through quarterly reports, including consideration of how different forms of treatment affect treatment outcomes and how this may be attributed to the therapeutic alliance. Develop a Trust-wide system for the use of Patient Experience Questionnaires which will improve how information from service users is gained and used.
Falls and non-hip fractures	Revise the way falls are recorded on the Trust's incident reporting system to provide more detailed data to enable a better understanding of outcomes and trends. Falls training to be provided to new staff on induction and annual e-learning for existing staff. Fall prevention became a CQUIN* target.
National audit of Schizophrenia	An action plan will be developed when the feedback is available

The reports of four national clinical audits carried out by the former Suffolk Mental Health Partnership Trust were reviewed in 2011–12 and the Trust intends to take the following actions, or has taken action, to improve the quality of healthcare provided:

Topic	Actions
POMHS Topic 7c Lithium monitoring	• Assertive Outreach Team (AOT) manager to authorise the purchase of a number of reliable portable weighing scales for staff to keep in their vehicles, enabling them to weigh patients at home and at other community contacts. • Non-nursing and medical AOT staff to be engaged in weighing patients, to support nursing and medical colleagues. • Weights to be recorded in the 'physical health' section of the Risk Profile on Epex**.
POMHS Topic 6c – Assessment of side effects of depot antipsychotics	• Development of a Depot Monitoring Chart. • AOT staff to be more proactive in encouraging patients to get blood tests done, making appointments for them and/or accompanying them to appointments as appropriate. • Staff not to leave blood test request forms with patients but to bring them back to the office and place in team diary to ensure the need for test is followed up by team. • Consider assessment of capacity in patients who refuse blood tests. If they lack capacity to consent to blood tests, consider whether they can be required to have blood tests in their own best interests according to the Mental Capacity Act 2005. • Test results to be recorded in the 'physical health' section of the Risk Profile on Epex. • AOT staff to pilot the use of the LUNSERS*** rating scale for side effects with patients having depot injections. • Completed LUNSERS rating scales to be scanned in to Epex. • Completion of LUNSERS, or attempts to complete, to be recorded on the patient's depot administration card. • Assessments of movement disorders to be recorded in the 'physical health' section of the Risk Profile on Epex and on the patient's depot administration card.
POMHS Topic 11a – Prescribing antipsychotics for people with dementia	• There is now a protocol for this which was recently drafted by us and agreed by the Primary Care Trust (PCT) and is based on the Department of Health (DoH) guidelines. • An audit is being carried out on the use of hypnotics and antipsychotics and relationship to falls in the elderly (includes patients with dementia) on three Later Life Psychiatry wards. • Training sessions by one of the psychologists from the Later Life Service for care staff in residential/ nursing homes to manage behavioural and psychological symptoms of dementia without resorting to using antipsychotics.
National audit of Psychological Therapies (NAPT)	• Ensure that the ethnicity question is asked by duty workers taking initial referral. • Staff to continue to work with black and minority ethnic (BME) groups and to promote services to young males. • Ensure that all cases have a diagnosis recorded. • Staff undergoing recovery training to ensure they are able to reach a primary diagnosis at initial assessment. • Managing expectations by providing clear information about services offered, number of sessions, type of treatment available, mode of treatment etc.

** CQUIN stands for Commissioning Quality and Innovation, and this initiative was introduced to ensure that a proportion of a provider's income from the commissioner is based on the achievement of agreed quality targets.*

*** Epex is the Suffolk patient information system*

**** LUNSERS is a well validated and widely used self-rating assessment for measuring the side effects of antipsychotic medications.*

The reports of 42 local clinical audits in NWMHFT and 21 in SMHPT were reviewed by the provider in 2011–12 and the Trust is taking the following actions to improve the quality of healthcare provided:

In Norfolk

- Crisis plans are an important part of the Care Programme Approach (CPA) and Non-CPA in managing risk. The Trust ensures that any shortfall in the completion of paperwork is addressed. Clinical Audit has been used by the clinical staff in one community mental health team to improve the compliance for the completion of crisis plans. This successful collaboration between the multi-disciplinary team and the audit team has led to the identification of the root causes of the measured levels of compliance. An action plan has been produced that includes training and a communications review. Repeat auditing in 2012 will be used to monitor change.
- The annual Suicide Prevention Audit results in recommendations for changes to practice being reported to the Service Governance Sub-Committee and Audit and Risk Committee so that progress can be verified and monitored until closure. The audit is repeated annually to monitor change and identify where further actions are required.

For any areas of non-compliance, an action plan is produced and monitored locally:

- As a result of the actions identified in the Physical Health on Admission Audit there was a significant improvement in measuring and documenting of physiological observations. The recording of height, weight, body mass index, blood pressure, temperature and pulse all increased significantly. On average, the increase in compliance was from 45% to 90% during 2011–12.
- An action plan was produced as a result of the Falls Prevention Audit. This included the implementation of focused training and revised paperwork. This resulted in the overall total number of service users with falls assessments initiated improving from fair compliance (54%) in quarter 1 to good compliance (87%) in quarter 3. There was also a marked improvement in the numbers of falls assessments that were fully completed over the same time-frame.
- As a result of the CPA Care Plan Audit, an action plan was put in place to ensure that service users were involved in their care planning. The Trust checked to see whether this was happening, asking service users to sign their care plans. As a result there has been an increase in the compliance regarding the percentage of service users in secondary mental healthcare aged under 65 (and fitting the audit selection criteria) who had been given the opportunity to discuss and sign their care plan (or who had a valid reason for not doing so). Compliance has increased from 55% to 76% in 2011–12.
- As a result of the actions put in place following the Safeguarding Children and CPA Risk Assessment Audit, there was an increase in the compliance between quarter 1 and quarter 3 from 59% to 70% for the percentage of active parents under CPA who are identified as parents or main carer/guardians and for whom a risk assessment and ongoing plan of support (including contingency planning if needed) has been conducted.

In Suffolk

- As a result of the Infection Control – Quarterly Hand Hygiene Audit, meetings have been held in 2011–12 between the Infection Control Nurse, the Hygiene Champions and the Clinical Audit Lead to discuss progress. Following the Hand Hygiene Audit in January 2012, results were discussed locally and it was noted that response rates were at 90% and the compliance to hand hygiene technique was at 90% for all of the responses returned. A repeat audit has taken place during February 2012. Response rates were improved at 99% and the compliance to hand hygiene technique was 80%. The results of the audit were discussed at the Infection Control Committee in March 2012 and action is currently being planned by the Infection Control Nurse to address the issues raised and to improve practice.
- The results of the Knowledge of NICE* Guideline CG89: 'When to Suspect Child Maltreatment' audit have shown that:
  - 76.9% of clinicians had read the guideline 'When to Suspect Child Maltreatment'. This is below the 100% recommended target set by NICE.
  - 97.4 % of clinicians were able to state who the 'Named Nurse' is and 74.3% were able to name the 'Named Doctor' who had recently taken on the position.

As a result of the audit, all relevant staff were reminded of their responsibility to be familiar with the guideline and to know the identity of the Named Nurse/Doctor for the Trust.

- GP Referrals to the Memory Clinic – Dr Anna King, Associate Specialist, won the Royal College of Psychiatrists' SAS Clinical Audit Prize 2011, which was open to all Staff and Associate Specialist (SAS) doctors in the UK. Dr King had become concerned

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

that poor, incomplete GP referrals were leading to service inefficiency and delays in patient care, and contributing to breaches of the 18-week referral to treatment target. The initial audit showed that only 8% of the referrals had all the required information. Subsequently, all GP surgeries were sent information about the Memory Clinic and a reminder of what information was required at referral. A re-audit showed a positive response, with 33% of referrals now having all the required information. All individual GPs were then sent an aide-memoire. Dr King has also embarked on a programme of surgery visits and formal presentations on dementia at educational meetings.

- An audit on the Mental Health Act Section 136* was inconclusive, owing to the correct record form not being used consistently across the Trust. The Section 136 suites were advised of the correct form to use and informed that all copies of other versions of the form had been removed. A second sample round of data collection took place in November 2011, inspecting the most recent 10 forms completed in the East (5) and West (5). This identified that the incorrect forms were still in use. Mental Health Act teams were contacted immediately by the Legal Services Manager and also in the East by the Locality Director to inform Section 136 suite staff about the correct form to be used, and to check, as forms are received, that the appropriate form is used. A re-audit has now taken place and correct forms were being used in both areas. A new joint protocol for Section 136 with all stakeholders in Suffolk will be finally agreed in year between the Trust, the Police and Social Services.
- The annual record-keeping (Electronic Records 2011) audit identified key areas for improvement including recording of veteran status, correct dating of entries made on Epex, signing and accurate timing of records.

Suicides and Service Related Deaths Audit

The report from the annual audit of Suicides and Service Related Deaths during 2010 identified key areas that require improvement.

Action planning is currently taking place to improve compliance against the National Patient Safety Agency (NPSA) 'Prevention of Suicide Toolkit' Standard Three – Post discharge prevention; Standard 4 – Family and Carer; and Standard 7 – Recording Support Post-Incident.

Future audits planned for 2012–13 include a continuation of suicide prevention, CPA, staff supervision, physical health and nutrition, planned discharge, additional observations, and topics specified by service users and carers.

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, this would be reported through the Norfolk and Suffolk Safeguarding Children's Board 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 Board, the Trust will take account of all recommendations arising from SCRs, even when Trust services were not involved.

The number of patients receiving NHS services provided or sub-contracted by the Trust from April 2011–2012 who were recruited (during that period) to participate in research approved by a research ethics committee was 690 in Norfolk (target 660) and 240 in Suffolk (target 205).

Participation in clinical research demonstrates the Trust's commitment to improving patient wellbeing and healthcare services. Research offers clinical staff the opportunity to stay 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 healthcare innovations and services.

The Trust was involved in conducting 56 clinical research studies in mental health during 2011–12, with 44 of these recruiting into UK Clinical Research Network National Portfolio studies. The Research and Development Department is in the process of developing key strategies aligned with National Institute of Health Research (NIHR) initiatives to increase the Trust's capacity to undertake high-quality research.

Some examples of where involvement in research has led to improvements in practice include participation in a number of studies which have informed the development and management of early intervention services with the Trust, including the therapies and medications offered (i.e. CBT, family interventions), validation of clinical scales used in practice and social recovery initiatives.

Involvement in the Health Improvement Profile (HIP) study, which looks at the use of a toolkit to assess physical health needs in patients with severe mental health problems, has led to staff undertaking additional training, implementing rigorous health checks as part of CPA reviews and being able to identify and treat symptoms that may have previously gone unnoticed.

** 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.*

Goals agreed with commissioners

A proportion of the Trust's income in 2011–12 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.

For the contract with NHS Norfolk and Waveney, a total of eight goals to improve quality were agreed as part of the main contract and a further three goals attributed to the contract to provide 'Improving Access to Psychological Therapies' (IAPT) services. 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 involved implementing the actions recommended from the external review as highlighted on page 20.

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 engagement by ensuring service users are given the opportunity to discuss and agree their care plan.	Compliance with this target increased from 55% to 76%. This will continue to be monitored and the audit repeated.	15%
Improve service user satisfaction by ensuring that changes in care coordinator are made in accordance with policy.	Compliance with this target was 97%. This will continue to be monitored and the audit will be repeated.	10%
Improve services for young people through working towards achievement of 'You're Welcome'. More information on this can be found at www.dh.gov.uk	A youth involvement group has been set up and activities in each locality implemented to involve marginal groups. Further work on achieving 'You're Welcome' will be included in the 2012–13 contract.	20%
Improve the safeguarding of children whose parents are active patients under CPA.	Compliance with this target increased from 59% to 70%. This will continue to be monitored and the audit repeated.	15%
Assess the physical wellbeing of service users admitted to inpatient wards.	The Trust was set a target of 70% to ensure that weight, height and body mass index were recorded on admission and a target of 85% to ensure that blood pressure, pulse and temperature were recorded on admission. The targets were exceeded in all cases except blood pressure.	10%
Improve the ongoing physical health of service users on discharge by the inclusion of a physical health summary in discharge documentation.	The discharge documentation was reviewed and audit identified that in all cases this was used. 82% of the letters contained a physical health summary. The discharge letter will now be available electronically to further improve compliance.	10%
Improve patient satisfaction by undertaking customer-focused training.	Customer service training was commissioned and 120 staff trained. This target will be rolled forward to 2012–13 to ensure all staff receive the training and that customer service is embedded in the organisation.	10%
Improve the implementation of the falls strategy and reduce falls for older adults by 7.5%.	Following a review of the falls strategy, the number of older people receiving a falls assessment rose from 54% to 87%. The number of falls was reduced by 23% between 1 April and 31 December 2011.	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 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
Increase GP understanding of NWS referrals and referral criteria.	Target 75%: achieved 64.7% This applied to Norfolk only	40%
Increase NWS self referrals for patients accessing psychological therapies (NWS).	Target 30%: Achieved 44.6% Norfolk; 29.2% Gt Yarmouth & Waveney	30%
Improve data collection on PC-MIS to 90%.	Target 95% on five items: this was achieved in one area in Norfolk and four areas in Gt Yarmouth & Waveney	30%

Data collection remains a priority for the Trust and an action plan will be put in place to continue to improve compliance.

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

Secure CQUIN 2011–12 summary

A total of six goals to improve quality were agreed nationally 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.

Title of quality improvement goal	Quality domain
Improve environment: The Essen Scale is a tool designed to assess the therapeutic climate within a care setting. It explores the degree to which service users feel safe and supported by both their peers and care staff. Evidence suggests that service users respond better and engage more in treatment (thus reducing length of stay) where they feel safe and comfortable. Service developments informed by feedback from this tool will enhance the therapeutic climate of care settings.	Quality
Service user involvement: The CQUIN promotes real partnership between service users and care staff so that service users can move through a shared pathway in a timely manner. It is assumed that in doing so, length of stay can be reduced and the experience of care improved.	Service user experience
25 hrs meaningful activity: Evidence suggests that boredom and reduced motivation result in poorer clinical outcomes for service users within secure care. The CQUIN promotes a balanced and structured day involving meaningful activity linked to service users' agreed care plans in order to promote recovery. Implementation of the CQUIN will enhance the experience of care and enhance clinical outcomes.	Service user experience
Recovery Planning: The CQUIN promotes real partnership between service users and care staff so that both can work to a shared understanding of recovery. It is assumed that in doing so length of stay can be reduced and the experience of care improved.	Innovation
Reduced lengths of stay: The CQUIN will assist in the delivery of the Specialised Commissioning Team's targets for reduced spending through quality and innovation.	Effectiveness
HoNOS*: HoNOS is a recognised clinical outcome measure. Data collected will demonstrate a service user's journey through their care pathway.	Effectiveness

The value of the scheme represents 1.5% of the total contract value and full compliance has been achieved in Norfolk and Suffolk.

** HoNOS, the Health of the Nation Outcome Scale, is an outcome measure to gauge the health and social functioning of people with severe mental illness.*

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 2011–12.

The Trust has not been eligible for any special reviews or investigations by the CQC during 2011–12.

Quality and Risk Profile (QRP)

The CQC publish a quality and risk profile. This document is a compilation of all the information known about the performance of the Trust. It 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 updated in March 2012.

The two main areas identified as of concern were the results of the Staff Survey and the results from the 2011 Patient Environment Action Team (PEAT*) inspections. In both cases, these surveys and inspections have been updated and the results are awaited. Action plans will be put in place to improve any areas of concern.

Data quality

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

- The Trust's Data Quality Strategy will be reviewed and updated to ensure that the principles are owned at all levels of the new organisation.
- The Data Quality Rating, introduced in 2011–12, will continue to be the main tool for assessing completeness, accuracy and timeliness of business information. The elements that make up the rating will be updated to reflect contemporary data quality issues.
- Abacus, the Trust's business intelligence reporting system, will continue to provide managers, clinicians and administrators with daily updates on data quality. This will be rolled out across the new organisation during the year.

Norfolk and Waveney Mental Health NHS Foundation Trust submitted records during 2011 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics. These are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.49% for admitted patient care
- Not applicable for outpatient care
- Not applicable for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 99.45% for admitted patient care
- Not applicable for outpatient care
- Not applicable for accident and emergency care.

Suffolk Mental Health Partnership NHS Trust submitted records during 2011 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics. These are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 98.97% for admitted patient care
- Not applicable for outpatient care
- Not applicable for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 98.97% for admitted patient care
- Not applicable for outpatient care
- Not applicable for accident and emergency care.

The Norfolk and Suffolk NHS Foundation Trust information governance assessment report score for 2011, submitted in October 2011, was as follows:

- Norfolk and Waveney Mental Health NHS Foundation Trust: 68%
- Suffolk Mental Health Partnership Trust: 78%
- Joint submission score submitted in March 2012: 69% (this was a merged submission with evidence provided from both pre- and post-merger).

** PEAT inspections are carried out annually involving service users to review the inpatient environment; they include a review of privacy and dignity, and of food. Further information can be found on page 34.*

Two requirements scored a level 0, and two requirements achieved a level 1. To be fully compliant all requirements must score a level 2 as a minimum. The overall level of compliance increased, with 10 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 2011–12 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 2011–12

Localities and services

The Trust encompasses eight geographical locations. The past year has seen a number of environmental improvements to services and new facilities. As well as the opening of Woodlands in July 2011 and Hammerton Court in March 2012, refurbishment work has taken place at Wedgwood House in Bury St Edmunds and Chatterton House in King's Lynn.

Many quality initiatives are in place across all localities but some are piloted in one area or are developed specifically to meet the needs of the locality.

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 that have high standards of organisation and patient care, and supports and enables others to achieve these.

In addition to the areas reported last year that have already attained accreditation – namely Churchill Ward, Glaven Ward, Waveney Ward, Great Yarmouth Acute Services and Waveney Acute Services – the Psychiatric Intensive Care Unit (PICU) in Norfolk is currently completing a self-assessment and hopes to be accredited in May 2012. In Suffolk, Northgate and Southgate Wards at Wedgwood House in Bury St Edmunds have accreditation and Poppy, Avocet and Lark Wards at Woodlands hope to commence the process in 2012–13.

Volunteers

The Volunteer Service was relaunched in Norfolk in June 2011 with the vision of giving service users, carers and members of the public the opportunity to give their time and skills to enhance the service provided by the Trust and benefit the wider community. Opportunities to volunteer in many activities have been identified and developed throughout the county. These include assisting with: activities on wards; gardening; mealtimes; art therapy groups; music groups; and group facilitation.

In Suffolk, volunteers have also been making a valuable contribution to teams across the county. The two county services are now coming together under single management.

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 ward level. It has been a welcome project support framework led by front-line clinical staff, which has allowed the systematic development of the clinical area. A number of initiatives have been developed, including an online forum in Suffolk for staff to share good practice and a project to increase efficiency in referral pathways within acute services in Norfolk. A pilot is due to start to extend a Productive Community Services framework in two crisis teams in Suffolk and a community team in Great Yarmouth. The funding has been approved to roll out the pilot with a view to embedding this initiative across other community mental health teams within the Trust.

The Trust has organised and taken part in a number of quality events throughout the year; this includes leading the Suffolk Health and Wellbeing Month in October 2011, and hosting the launch of a new national campaign, Triangle of Care – an initiative that emphasises the need for better involvement between healthcare staff, service users and their carers. Suffolk Wellbeing Month included a variety of events at which the public were informed about a range of mental health issues. There were also specific events aimed at improving wellbeing, such as singing and walking.

Locality-specific initiatives and innovations

The Child and Adolescent Mental Health Services (CAMHS) team in Great Yarmouth & Waveney has appointed a technical instructor to work with young people on nutrition and exercise. This is a joint project with the James Paget University Hospital. It involves helping young people who have poor mental health, low self-esteem or a diagnosis of anxiety or depression, and who are above their ideal weight or obese, to get more active and lead healthier lifestyles. Gym and swimming groups have been set up in various locations with morning and evening sessions to fit around school

hours, with half-term 'food and activity' days.

The South Norfolk locality is running a pilot during which community staff will receive training in fire risk assessment following a number of incidents involving service users in their own homes.

In King's Lynn, a six-month pilot of a Psychiatric Emergency Liaison Team (PELT) has commenced. The purpose of this dedicated team is to provide a 24hr assessment service to accident and emergency (A&E), medical assessment and Terrington short-stay wards within the Queen Elizabeth Hospital. The aim of the team is to provide timely assessments (within a target of 4hrs) to those who present with mental health problems in acute hospitals.

Another important role of the team is to provide education and support to front-line staff in A&E as well as the short-stay wards in managing people with mental health problems.

The Trust Alcohol and Drug Service (TADS) Open Assessment Clinic in Norwich commenced in June 2011 at the Weavers Centre, Hellesdon Hospital. This enables service users to directly access the service for an assessment. The assessment clinic runs from Monday to Friday from 10am to 3pm. Since TADS has commenced this pathway there has been no-one on a waiting list, and people have been enabled to commence their treatment within a week of assessment, ensuring targets are met, and also improving the experience for service users and other partner agencies.

Suffolk localities have been developing a personality disorder strategy to meet the needs of users, carers and staff, and to respond more effectively to people with personality disorders. The initial strategy document is focused on staff awareness training for all clinical, and some non-clinical, staff. The strategy also outlines a plan to provide interventions including the development of more effective therapeutic relationships, and user-led interventions based in the community rather than staff-led interventions in specialist mental healthcare. These interventions will reduce stigma and improve effectiveness.

Suffolk localities have been committed to the roll-out of a shared approach to, and system of, clinical supervision since the publication of the patient safety review in 2011. A variety of models have been used within a skills training programme to train upwards of 100 clinical supervisors. Approximately half of all staff have also been introduced to these models. The roll-out of the clinical supervision and management supervision is underway, and an ongoing evaluation of the impact of this system upon staff wellbeing and clinical effectiveness has started. Initial results suggest that the training and management supervision is very well received by staff, and that staff, as a result of clinical supervision, are adapting clinical work to better meet the needs of staff, service users and carers.

Suffolk Child and Adolescent Mental Health Services (CAMHS) has introduced a single point of referral for all CAMHS teams from January this year. The aim is to reduce the number of internal referrals and to simplify the process for external referrers. The service has also recently launched a telephone helpline for professionals who wish to discuss potential referrals with a professional; this is staffed from 10am to 3pm, Monday to Friday, by one of our Primary Mental Health Workers who can also advise on alternative services. Information about the referral process to CAMHS can be found on the website www.smhp.nhs.uk/youngpeople.

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.

The figures for 2010–11 are shown in brackets for comparison where available.

The target applies to both Norfolk and Suffolk unless indicated with (N); in these cases no target is reported for Suffolk.

Key Performance Indicator	NWMHFT position Apr–31 Dec 2011	SMHPT position 1 Apr–31 Dec 2011	NSFT 1 Jan–31st Mar 2012
Patient safety			
Seven-day follow up of service users following their discharge from inpatient services. Target 95%.	96.74% (96.17%)	96.27% (97%)	94.76%
Absconsions of detained patients from adult wards as a ratio of 100 detained patients. Target 4.1 (N).	4.09 (4.5)	9.65	4.87
Ratio of inpatient serious untoward incidents (e.g. suicide) per 10,000 occupied bed days. Target 3.8 (N).	2.78 (3.72)	16.54	6.18
Clinical effectiveness			
Access to crisis resolution and home treatment services. Target 90%.	99.87% (97.41%)	97.55% (99%)	95.89%
Delayed transfers of care relating to other support needs (like housing) following discharge from hospital. Target <7.5%.	Data includes social care 1.5%	Data includes social care 5.24%	Data includes social care 4.02%
Increased provision of cognitive behavioural therapy for people with a recent diagnosis of schizophrenia. Target >48% (N).	95% (68%)	Not measured	Not measured
Patient experience			
CPA patients having formal review within 12 months. Target 95%.	95.75% (94.87%)	95.99% (95%)	97.08%
Waiting times. The number of people waiting 18 weeks or longer.	11 (3)	18	20
Number of under 18-year-old admissions to adult acute ward.	5 (11)	1 (0)	6
Number of under 16-year-old patients admitted to adult acute wards. Target 0.	0	0	0

Variations in reporting between the former Norfolk and Waveney and Suffolk Trusts may account for some differences in the reported figures. Reporting across NSFT has now been standardised.

Evaluation of patient safety

The Trust continues to report all serious incidents on receipt of an initial report. This is reported as good practice by the National Patient Safety Agency (NPSA). Serious incidents are investigated using a process called root cause analysis, and this process leads to recommendations being made that are shared and implemented across the Trust to improve practice.

Infection Prevention and Control (IPAC) activities

Key activities during the year ranged from advising on the design and equipping of the new Dementia Intensive Care Unit, production of a video for Trust staff and annual update training through to all preliminary steps leading to the smooth implementation of IPAC services in the Suffolk area. In November 2011 the Trust successfully appointed an experienced and qualified IPAC nurse specialist as deputy director of infection prevention and control (DIPC) thus permitting extension of the 24-hour on-call cover for all of the merged Trust and management of day-to-day activities in the Suffolk area.

A novel approach to checking compliance with hand hygiene was implemented during 2011 in the Norfolk and Waveney area, which resulted in 197 trained hand hygiene assessors and the hand hygiene technique of 1,000 staff being individually checked. A similar campaign is planned for Suffolk in 2012.

Following the Chief Medical Officer's stated targets for increased uptake of 'flu vaccination amongst healthcare workers and 'at risk' service users, the Trust launched an energetic and successful campaign which doubled the uptake of that in previous years in the Norfolk and Waveney area.

The Trust has experienced a general reduction in the number of patients admitted with infections. There have been no cases of ESBL, MRSA or *Clostridium difficile* infections spreading to others whilst in our care, and no major outbreaks of infection. Seven wards had to be closed to admissions and transfers due to norovirus infection during the year. Closures amounted to 95 days in Norfolk and Waveney.

Evaluation of clinical effectiveness

The Trust has a clinical effectiveness policy which describes how clinical effectiveness is implemented and managed within the organisation.

The provision of Cognitive Behaviour Therapy (CBT) was a quality priority for Norfolk and Waveney in 2010–11 and a recent audit showed that the Trust has continued to improve with an increase from 68% to 95% of people newly diagnosed with schizophrenia who were offered or received CBT.

The provision of access to crisis resolution before a person is admitted to hospital is a national target and the Trust continues to report excellent compliance with the target.

Evaluation of patient experience

The licence for the patient experience tracker that had been used to gain service user feedback in Norfolk and Waveney expired during 2011. The Trust therefore decided to review the systems available and requests for tender have been made. The new system is expected to be operational across the Trust in May 2012. 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 Local Involvement Networks (LINks) in Norfolk and Suffolk and governors, who provide vital feedback.

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.

With the merger between Norfolk and Waveney Mental Health NHS Foundation Trust (NWMHFT) and Suffolk Mental Health Partnership NHS Trust (SMHPT) the figures are presented in three sections:

Norfolk and Waveney Mental Health NHS Foundation Trust

During April – December 2011 NWMHFT received 202 complaints. The majority of complaints related to 'all aspects of clinical care' (54%), followed by 'attitude of staff' (11%).

At the time of reporting, 193 complaints have been responded to. Of these complaints, 23% were upheld, 32% were partially upheld, and 33% were not upheld by the Trust, while 12% of complaints were stood down.

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

Suffolk Mental Health Partnership NHS Trust

During April – December 2011 SMHPT received 92 complaints. The majority of complaints related to 'all aspects of clinical care' (45%), followed by 'attitude of staff' (8%).

At the time of reporting, 89 complaints have been responded to. Of these complaints, 18% were upheld and 76% were not upheld by the Trust, while 6% of complaints were stood down.

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

Norfolk and Suffolk NHS Foundation Trust

Between January and March 2012, Norfolk and Suffolk NHS Foundation Trust received 74 complaints. The majority of complaints related to 'all aspects of clinical care' (43%), followed by 'attitude of staff' (18%).

At the time of reporting, 40 complaints have been responded to. Of these complaints, 32.5% were upheld, 25% were partially upheld, and 40% were not upheld by the Trust, while 2.5% of complaints were stood down.

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

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.

Learning from complaints

Quarterly 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. Wider learning has included review of ward activities, flexibility of visiting hours, completing relevant documentation following reviews of care and ensuring an individual's dignity is respected.

Serious incidents

The Trust continues to report all Serious Incidents (SIs) 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.

With the merger between Norfolk and Waveney Mental Health NHS Foundation Trust (NWMHFT) and Suffolk Mental Health Partnership NHS Trust (SMHPT) the figures are presented in three sections:

Norfolk and Waveney Mental Health NHS Foundation Trust

From 1 April to 31 December 2011, 80 SIs were reported by NWMHFT, of which 37 were unexpected deaths. At the time of reporting, nine deaths have been determined as being 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.

Suffolk Mental Health Partnership NHS Trust

From 1 April to 31 December 2011, 71 SIs were reported by SMHPT, of which 26 were unexpected deaths. At the time of reporting, two deaths have been determined as being due to a natural cause.

Norfolk and Suffolk NHS Foundation Trust

From 3 January to 31 March 2012, 52 SIs were reported, of which 26 were unexpected deaths. At the time of reporting, one death has been determined as being due to a natural cause.

In 2010–11 Norfolk and Waveney reported 115 SIs and Suffolk reported 53.

Serious Incidents are investigated using a nationally approved methodology called root cause analysis (RCA). A number of Trust staff are trained to facilitate this process.

A number of service improvement initiatives have arisen as a result of recommendations within the RCA reviews. These have followed themes including service-specific processes, policy development and engagement of carers with an individual's care.

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 National Patient Safety Agency (NPSA) requires each trust to undertake an assessment of each inpatient area on an annual basis, and issues guidance to be followed. The 2011 PEAT assessments were carried out across all inpatient areas of the Trust between January and March 2011. 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/

Site Name	Environment 2010	Environment 2011	Food 2010	Food 2011	Privacy and dignity 2010	Privacy and dignity 2011
Carlton Court	Good	Excellent	Good	Excellent	Good	Excellent
Chatterton House	Good	Excellent	Good	Excellent	Good	Good
Fermoy Unit	Good	Good	Good	Excellent	Good	Excellent
Hellesdon Hospital	Good	Good	Excellent	Excellent	Acceptable	Good
Julian Hospital	Good	Good	Good	Good	Excellent	Excellent
Meadowlands	Good	Good	Good	Excellent	Good	Excellent
Norvic Clinic	Good	Excellent	Good	Excellent	Good	Excellent
Northgate	Good	Excellent	Excellent	Excellent	Excellent	Excellent
St Clement's Hospital	Acceptable	Good	Acceptable	Good	Good	Good
Wedgwood House	Excellent	Good	Excellent	Good	Excellent	Good
Foxhall House	N/A	Excellent	N/A	Good	N/A	Excellent

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.

Service Users' Survey

The CQC conducts a national service user survey each year. In 2009, a survey of inpatient mental health services was carried out for the first time, and in 2011 the Trust participated in a survey of community services.

A response rate of 36% was achieved in Norfolk and 33% in Suffolk; the national response rate ranged from 26% to 42%.

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% nationally for the number of respondents who reported:

NWMHFT	SMHPT
Those who had received NHS talking therapies in the last 12 months found them helpful. Service users know who their care co-ordinator or lead professional is.	They were given information about medication in a way that was easy to understand. They were provided with a care plan which covered what to do in case of a crisis.
Had a care review meeting in the past 12 months. Were given the chance to express their views at the care review. NHS Services involved a family member or someone close to the service user.	Staff explained the purpose of medication.

The Trusts were in the bottom 20% nationally for:

NWMHFT	SMHPT
Treating service users with dignity and respect. Giving service users enough time to discuss their condition and treatment. Informing service users of possible side effects of medication.	Receiving help in finding and or keeping accommodation (the low response rate to this question may indicate that it was not applicable to many respondents).
Having a written copy of the care plan.	Those who considered NHS talking therapy received in the last 12 months to be helpful.
The last time you called the crisis care number did you get the help you wanted? Support with getting help with caring responsibilities.	Health and social care workers taking people's views into account.

The Trusts developed action plans to address these issues, and updates on progress have been reported quarterly to the Service Governance Sub-Committee. The survey is repeated each year and the results will demonstrate whether the action plans have been successful.

Staff Survey

The annual National NHS Staff Survey is a mandatory requirement for NHS organisations; its results are used by NSFT to understand staff views and to inform future work and improvements in the workforce arena.

The most recent survey took place from October to December 2011, before the creation of Norfolk and Suffolk NHS Foundation Trust. This means that this year, NSFT has two sets of results; one for NWMHFT and one for SMHPT.

The survey is structured around the four pledges to staff in the NHS Constitution, with additional themes on staff satisfaction and equality and diversity.

Analysis of the survey shows that the two trusts experienced similar results across all key indicators, and that indicators remained relatively constant compared with the previous year. Overall staff engagement scores were 3.54 for SMHPT and 3.60 for NWMHFT, against a national average of 3.61.

Out of 38 key findings, SMHPT achieved 10 scores that were either better than average or in the top 20% of trusts, while NWMHFT achieved three scores that were better than average.

Common areas for improvement across both counties include:

- People agreeing that their role makes a difference to patients
- Quality of job design
- Staff members participating in a well-structured appraisal, with a personal development plan, at least once every year
- Numbers of staff reporting that they have felt work-related stress during the preceding year

The Organisational Development and Workforce Committee, which will be a sub-committee of the Board, is being formed in recognition of the significance and complexity of NSFT's workforce challenges. The committee, which will be chaired by a non-executive director, will drive the strategic and wide-ranging workforce agenda, ensuring that staff engagement is included and integrated as a key thread running through all people processes, systems and programmes.

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

Looking forward

Looking forward to the Quality Account which will be published in 2013, the DoH and Monitor have reported some possible required changes that will strengthen the Quality Account.

This involves reporting against a core set of quality indicators.

The Trust is currently reporting or developing systems to report for the following domains:

- Ensuring that people have a positive experience of care

This will be achieved by: implementing the Net Promoter Score or a similar feedback mechanism; by using an electronic system to gather feedback; and by participating in the CQC annual survey.

- Treating and caring for people in a safe environment and protecting them from avoidable harm

This will be achieved by: reporting against the safety thermometer*; and by reporting all incidents and those resulting in severe harm or death.

The Trust is currently in the top quarter of reporters; the latest data are published up to the end of September 2011.

This reporting will be developed for inclusion in the next Quality Account.

** The safety thermometer is a tool for measuring care, looking at falls, pressure ulcers, catheter infections and venous thrombo-embolism.*

Statements from Local involvement Networks (LINks), Overview and Scrutiny Committees and NHS Norfolk

Suffolk Health Scrutiny Committee

The Suffolk Health Scrutiny Committee has been happy with the engagement of the NHS trusts in the work of the Committee over the past year, particularly in developing trust and dialogue at an early stage, in an ever-changing environment where the 'critical friend' role is becoming increasingly important.

The Committee is keen that these relationships should be developed to ensure the new health and social care architecture provides delivery of the best possible health services for the people of Suffolk.

The Suffolk Scrutiny Committee has decided not to comment individually on any of the Suffolk provider NHS trust's Quality Accounts again this year, and would like to stress that this should in no way be taken as a negative comment.

The Committee has taken the view that it is appropriate for Suffolk's Local Involvement Network (LINk) to consider the Quality Account and comment accordingly.

Councillor Anne Whybrow, Chairman of the Health and Scrutiny Committee on behalf of the Committee

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 0800 111 4452 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

Glossary of abbreviations

AIMS	Accreditation for Inpatient Mental Health Services
AOT	Assertive Outreach Team
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DIST	Dementia Intensive Support Team
DoH	Department of Health
HoNOS	Health of the Nation Outcome Scale
IAPT	Improving Access to Psychological Therapies
IPAC	Infection Prevention and Control
KPI	Key Performance Indicator
LINks	Local Involvement Networks
NCE	National Confidential Enquiry
NHSLA	NHS Litigation Authority.
NICE	National Institute of Clinical Excellence
NIHR	National Institute of Health Research
NPSA	National Patient Safety Agency.
PALS	Patients' Advice and Liaison Service
PCT	Primary Care Trust
PEAT	Patient Environment Action Team
PET	Patient Experience Tracker
PICU	Patient Intensive Care Unit
POMH	Prescribing Observatory for Mental Health
QIPP	Quality Innovation Prevention and Productivity
RCA	Root Cause Analysis
SCR	Serious Case Review
SI	Serious Incident
TADS	Trust Alcohol and Drug Service

Regulatory ratings

Performance and compliance

Performance reporting

Service performance and compliance with known national and locally determined targets and standards are monitored monthly by the Board of Directors through the business performance report and through a developing performance management structure with clearly defined levels of operational accountability and strategic leadership. The Performance Review Group receives an Integrated Performance Dashboard each month. Operational managers use this both to illustrate how the locality/service is meeting the current challenges and to ensure that best practice is acknowledged and shared.

During the year, work was started on a means of providing an overall assessment of Locality/Service performance, which when presented to the Finance and Performance Committee (Board of Directors Sub-Committee) would give committee members a clear indication of relative performance without having to look at a myriad of indicators. This development will continue during 2012–13.

Monitor's Compliance Framework

In the 2011–12 Compliance Framework, Monitor identified eight mental health targets and thresholds which informed the Governance rating assigned each quarter. Please note that the performance reported for the first three quarters of the year relates to Norfolk and Waveney Mental Health NHS Foundation Trust (NWMHFT). The fourth quarter position represents the Norfolk and Suffolk NHS Foundation Trust (NSFT) performance.

Target	Threshold	Qtr 1	Qtr 2	Qtr 3	Qtr 4
CPA patients receiving follow-up within seven days of discharge	95%	99.24%	96.48%	95.28%	94.76%
CPA patients having formal review within 12 months	95%	96.85%	95.29%	95.11%	97.08%
Minimising delayed transfers of care	<7.5%	2.02%	2.18%	1.95%	3%
Admissions to inpatient services had access to CRHT teams	90%	96.71%	97.11%	98.10%	95.89%
Meeting commitment to serve new psychosis cases by early intervention teams	95%	77.78%	101.85%	107.47%	109.64%
Data completeness: identifiers	99%	99.15%	99.13%	99.22%	99.57%
Data completeness: outcomes	50%	73.10%	67.87%	78.65%	77.69%
Self-certification against compliance regarding access to healthcare for people with a LD	6	6	6	6	6

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

The Governance ratings given by Monitor to foundation trusts include any issues identified by the Care Quality Commission (CQC) either at registration or associated with ongoing clinical governance reviews. Reports produced by the CQC have a real-time impact on Governance ratings. This means that, in theory, a rating given for the quarter is in fact only valid for the date of submission and could be updated by Monitor soon after the quarterly return.

This indeed occurred shortly after the first quarter return was submitted. A CQC Review of Compliance undertaken at the location Coastlands-Northgate in May 2011 identified two compliance actions. The impact of this report, received at the very end of June 2011, was seen in the immediate downgrading to an Amber/Red rating for the Trust. The CQC made a return visit in early July 2011 and, satisfied with progress, removed the compliance actions. A report was received by Monitor a few days later and the Governance risk rating was immediately re-classified to Green.

A similar situation arose at the beginning of quarter four when Norfolk and Waveney Mental Health NHS Foundation Trust merged with Suffolk Mental Health Partnership NHS Trust (SMHPT). Compliance actions received by SMHP prior to merger concerning Walker Close were assigned to the new organisation at the point of transfer, which immediately changed the risk rating from Green to Amber/Red.

Monitor gave the Trust the following risk ratings for Finance and Governance during 2011–12:

	Annual Plan 2011–12	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Finance	3	4	4	4	3
Governance	Green	Green	Green	Amber/Red	Amber/Green

Performance

Contract targets – NHS Norfolk and NHS Great Yarmouth & Waveney

The 'block' contracts with NHS Norfolk and NHS Great Yarmouth & Waveney for the provision of mental health services covering Child and Adolescent Mental Health Services (CAMHS), People of Working Age, Older People and Substance Misuse included a range of performance indicators jointly agreed as one of the initial steps towards the NHS Norfolk and Waveney cluster arrangement. Please see below for the performance outturn for both commissioners.

NHS Norfolk

Key Performance Indicator	2010–11 Outturn	2011–12 Target	2011–12 Actual
Percentage of adult patients with a valid MHCT assessment and a care cluster	42.47%	100%	95.85%
Percentage of older adult patients with a valid MHCT assessment and a care cluster	47.48%	100%	95.83%
Percentage of long-term (over 12 months) inpatients who have received an annual health check	50.00%	100%	76.92%
Percentage of substance misuse patients offered Hepatitis B vaccination	95.32%	99%	95.96%
Ratio of older people inpatient falls per 1000 occupied bed days	27.46	25.40	29.13
Percentage of referrals to CAMHS waiting eight weeks or less from referral to assessment	67.83%	70%	67.95%
Early Intervention in Psychosis total caseload	257	235	233
Assertive Outreach total caseload	148	153	153

NHS Great Yarmouth & Waveney

Key Performance Indicator	2010–11 Outturn	2011–12 Target	2011–12 Actual
Percentage of adult patients with a valid MHCT assessment and a care cluster	47.85%	100%	97.04%
Percentage of older adult patients with a valid MHCT assessment and a care cluster	78.77%	100%	96.76%
Percentage of long-term (over 12 months) inpatients who have received an annual health check	67.65%	99%	96.43%
Percentage of substance misuse patients offered Hepatitis B vaccination	96.83%	99%	92.93%
Ratio of older people inpatient falls per 1000 occupied bed days	14.86	13.75	17.00
Percentage of referrals to CAMHS waiting 8 weeks or less from referral to assessment	80.36%	80%	73.33%
Early Intervention in Psychosis total caseload	99	82	94
Assertive Outreach total caseload	54	53	54

Key to above	
Above upper threshold	
Within 2% of upper threshold	
Between thresholds ex 2% margin	
Within 2% of lower threshold	
Below lower threshold	

Contract target – Medium and Low Secure (East of England 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	2010–11 Outturn	2011–12 Target	2011–12 Outturn
Medium secure bed occupancy including leave days	86.82%	90%	89.80%
Low secure bed occupancy including leave days	79.14%	85%	89.19%

Contract targets – Norfolk County Council (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.

Performance Indicator	2010–11 Outturn	2011–12 Target	2011–12 Outturn
Social Care clients receiving Self Directed Support	436	559	371
Carers receiving assessment/review and specific service	280	400	325
Clients receiving a review	1795	1800	1384
Adults receiving secondary mental health services in settled accommodation	53.70%	55%	73.87%
Adults receiving secondary mental health services in employment	5.00%	6.80%	4.99%
Adults receiving secondary mental health services with accommodation recorded	63.03%	80%	84.37%
Adults receiving secondary mental health services with employment recorded	62.86%	80%	84.02%

During the year the Trust worked with Norfolk County Council to develop a means of allocating the Trust-wide target to individual Localities and Services. This work now enables the KPIs to be reported at a local level, which has led to a greater understanding of the KPIs and what needs to be done to improve performance.

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

Staff Survey

Employee feedback

The most recent annual National NHS Staff Survey took place during October to December 2011, before the creation of Norfolk and Suffolk NHS Foundation Trust. This means that this year, the Trust has two sets of results; one for Norfolk and Waveney Mental Health NHS Foundation Trust (NWMHFT) and one for Suffolk Mental Health Partnership NHS Trust (SMHPT).

The annual 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 future work and improvements in the workforce arena.

The survey is structured around the four pledges to staff in the NHS Constitution, with additional themes on staff satisfaction and equality and diversity.

The tables of results for the two trusts are shown within this section. A commentary on the results can be found within the Quality Account of this year's Annual Report and Accounts. In order to prevent duplication, the commentary is not repeated here.

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

NWMHT Staff Survey results

	2010–11		2011–12		
	NWMHFT	MH national average	NWMHFT	MH national average	Improvement or deterioration
Response rate	64%	54%	60%	54%	Deterioration 4%
Top 4 ranking scores 2011–12:					
KF21: Percentage of staff reporting errors, near misses or incidents witnessed in the last month	97%	97%	98%	97%	No significant change
KF30: Percentage of staff reporting good communication between senior management and staff	33%	31%	30%	29%	No significant change
KF11: Percentage of staff receiving job-relevant training, learning or development in last 12 months	82%	80%	81%	80%	No significant change
KF19: Percentage of staff saying hand washing materials are always available	59%	58%	61%	59%	No significant change
Bottom 4 ranking scores 2011–12:					
KF18: Percentage of staff suffering work-related stress in last 12 months	34%	31%	38%	33%	No significant change
KF4: Quality of job design (clear content, feedback and staff involvement)	3.31	3.42	3.32	3.42	No significant change
KF15: Support from immediate managers	3.75	3.80	3.70	3.79	No significant change
KF6: Effective team working	3.81	3.80	3.73	3.81	No significant change
Areas of most improvement 2011–12:					
There were no areas of improvement over 2010–11	n/a	n/a	n/a	n/a	n/a

Note

Improvement or Deterioration only shown if statistically significant at the 5% level.

SMHPT Staff Survey results

	2010–11		2011–12		
	SMHPT	MH national average	SMHPT	MH national average	Improvement or deterioration
Response rate	51%	54%	51%	54%	No change
Top 4 ranking scores 2011–12:					
KF36. Percentage of staff having equality and diversity training in last 12 months	72%	48%	78%	53%	Increase (better than 2010)
KF29. Percentage of staff feeling pressure in last three months to attend work when feeling unwell	19%	19%	16%	20%	No change
KF11. Percentage of staff receiving job-relevant training, learning or development in last 12 months	83%	80%	82%	80%	No change
KF16. Percentage of staff receiving health and safety training in last 12 months	90%	80%	90%	83%	No change
Bottom 4 ranking scores 2011–12:					
KF14. Percentage of staff appraised with personal development plans in last 12 months	61%	73%	52%	73%	Decrease (worse than 2010)
KF12. Percentage of staff appraised in last 12 months	71%	83%	63%	83%	No change
KF13. Percentage of staff having well structured appraisals in last 12 months	30%	40%	28%	39%	No change
KF30. Percentage of staff reporting good communication between senior management and staff	25%	31%	23%	29%	No change
Areas of most improvement 2011–12:					
KF36. Percentage of staff having equality and diversity training in last 12 months	72%	48%	78%	71%	Increase (better than 2010)

Trust governance

Demonstrating good corporate governance

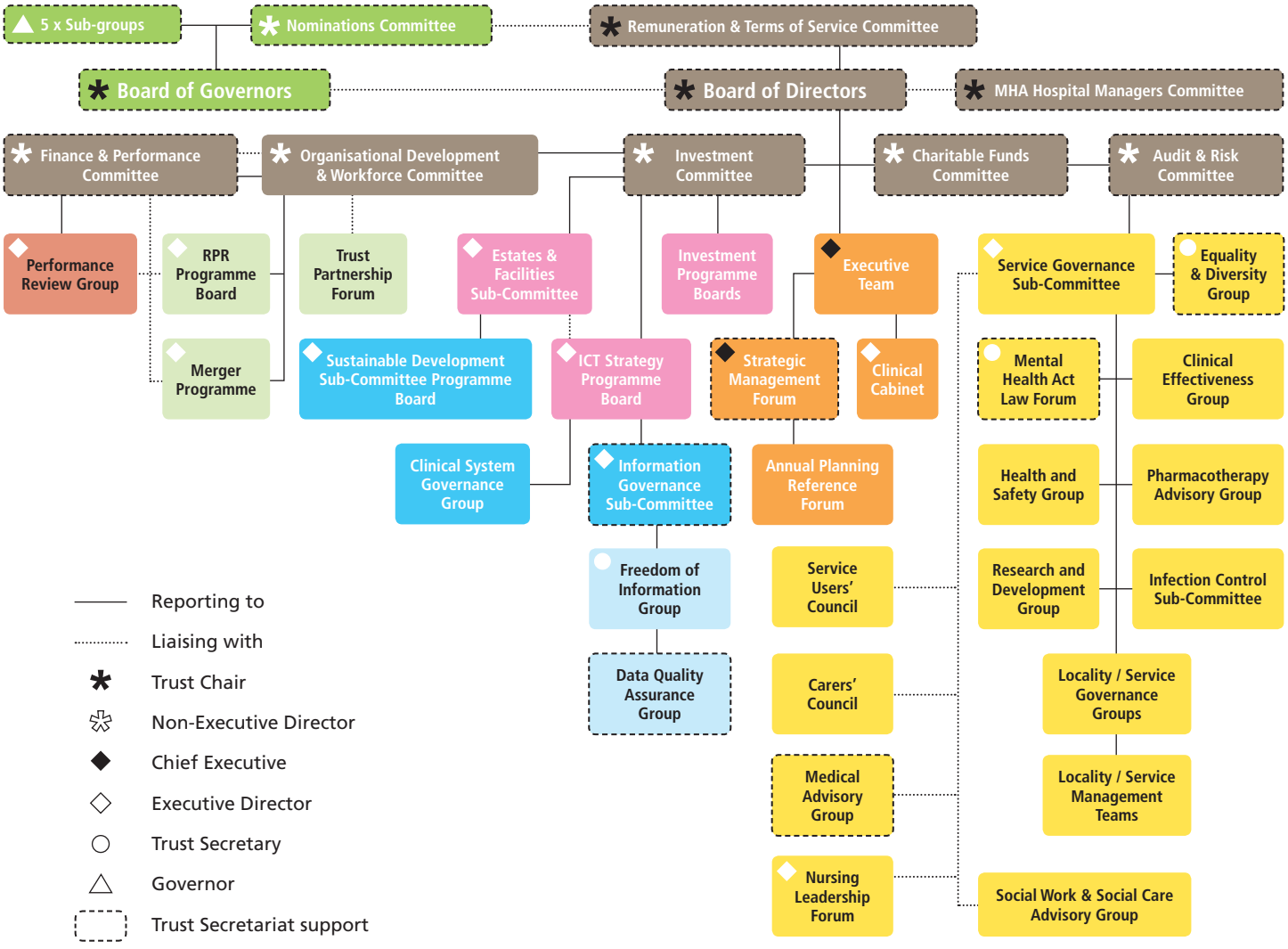
Compliance with the NHS Foundation Trust Code of Governance

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	Description	Commentary
C.2.1	Executive directors should be subject to re-appointment at intervals of no more than five years	Executive directors are appointed on substantive contracts. Remuneration & Terms of Service Committee chose not to change

Management structure

The management structure of the Trust including associated sub-committees is shown below.



The governors met formally as a Board on five occasions during the financial year. Five meetings were held in public. One meeting was held to consider the constitution for the Norfolk and Suffolk NHS Foundation Trust in detail, especially the composition of the NSFT Board of Governors and the transition from the current NWMHFT Board. In addition to the formal meetings, two informal meetings were also held. This allowed governors to discuss issues in more detail and agree items for future formal meetings for the Lead Governor to discuss with the Trust chair.

Elections to the Board of Governors of Norfolk and Suffolk NHS Foundation Trust were held after the new organisation came into being on 3 January 2012, with the results to be declared in April 2012 for two- or three-year terms starting from the publication of the unopposed or opposed elections. The following constituencies were elected to:

- Carer – Norfolk: no election required
- Carer – Suffolk: one new governor elected unopposed
- Public – Norfolk: one new governor and one governor re-elected, both unopposed
- Public – Suffolk: the results of the elections were not known during this reporting period
- Service User Female – Norfolk: no candidates; vacancy to be held to next election
- Service User Female – Suffolk: the results of the elections were not known during this reporting period
- Service User Male – Norfolk: the results of the elections were not known during this reporting period
- Service User Male – Suffolk: the results of the elections were not known during this reporting period
- Staff: one new governor and one re-elected governor, both unopposed, with one vacancy to be held to the next election

Due to the timing of the merger, the elections that would have been held in Autumn 2011 were held from January to April 2012: therefore the next set of elections will be held in Autumn 2012, with the vacancies held until then.

New partner governors from NHS Norfolk and Waveney, Broadland Meridian and the University of East Anglia were appointed during the financial year. NHS Great Yarmouth & Waveney and Norfolk County Council partner governors resigned in year, with their replacements to be appointed. Partner Governors-Designate were also appointed from Suffolk Constabulary, University Campus Suffolk, Suffolk Association of Voluntary Organisations and NHS Suffolk. These Governors will take office when the results of the elections are known; this was agreed to ensure that the number of elected governors was higher than that of appointed, partner governors.

Governors continued to work in sub-groups and the following outcomes were achieved by the whole Board and the sub-groups:

- Approved the appointment of the designate chief executive officer to the Board of Directors of the potential merged Trust
- Appointed two non-executive directors to the Board of Directors of the Trust (the Trust chair and two governors were on the interview panel)
- Appointed one designate non-executive director to the Board of Directors of the merged Trust (the Trust chair and two governors were on the interview panel)
- Attended Board of Directors' meetings held in public, bringing the governor and member views to the debates held
- Developed further the appraisal of the chair and non-executive directors
- Re-appointed one of the non-executive directors. The re-appointment of the Trust chair was also approved, which will allow for the recruitment of a Trust chair for the new organisation.
- An Annual Planning Reference Forum was set up with governors, members of the service users' and carers' councils, non-executive director and senior management attendees. Its purpose was to evaluate the previous year's annual plan and contribute to the production of the current annual plan. This forum reported back to the Board of Governors at each formal meeting.
- Involved in the evaluation of the previous year's Quality Account to identify learning for future years, and agreed which Quality Priority would be audited in the current year. This involvement has continued into the selection of the quality priorities for 2012–13, and the priority to be audited.
- Involved in the Equality Delivery Scheme and the development of equality priorities
- Continued links with the Trust's service users' and carers' councils, and received an annual report from the chairs of the councils of the work undertaken
- Continued representation at the Trust's charitable funds committee, including agreeing funding for both the service users' and carers' councils
- Held a joint meeting with the Audit and Risk Committee, where the annual plans and reports of the Trust's internal, external and clinical audit services, and counter-fraud service were discussed. All Governors received copies of the assessment of the committee itself, and the internal and external auditors.
- Held a joint meeting of the Nominations Committee and the Remuneration and Terms of Service Committee
- Reviewed the 'Meet your Governor' events to engage directly with the membership
- The performance subgroup of the Board of Governors was set up, working with the Audit and Risk Committee, in response to the Francis Report.

The subgroup has focused on the complaints process and patient safety indicators, particularly those for community services. A small number of governors volunteered to be involved in complaint cases and provide another view of the process and identification of lessons to be learned.

- Reviewed the Code of Conduct and role description for all governors
- The role of the Strategic Planning Sub-Group was amended to consider the merger
- Reviewed the role description for staff governors
- Reviewed the role description for the lead governor
- Received regular information on the merger with Suffolk Mental Health Partnership NHS Trust and the Trust's cost improvement programme, service standardisation and radical pathway redesign programme and the results of Care Quality Commission visits, making comments and asking questions about the implications
- Involved in the stakeholder events for the radical pathway redesign programme, and received updates at the Strategic Planning Sub-Group and the Board of Governors' meetings
- Considered the Care and Compassion report, and the implications for the Trust. Governors were invited to take part in the mock inspections with other local stakeholders.
- Received presentations from partner governors on their organisations and how they work with the Trust
- Reviewed the membership and remit of the subgroups of the Board of Governors and whether they were still fit for purpose

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 2010–11 annual accounts and the annual report were presented to the Board of Governors at the annual general meeting held on 27 September 2011.

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

NWMHFT and NSFT Board of Governors 2011–12 attendees

		NWMHFT				NSFT	
Board of Governors	**Constituency**	**6 Apr 2011**	**13 Jul 2011**	**31 Aug 2011**	**5 Oct 2011**	**11 Jan 2012**	
Mary Rose Roe	Carer	✓	✓	✓	✓	✓	Elected 1 Feb 2010 (unopposed)
Kate Pace	Carer	✓	✓	✓	A	✓	Elected 1 Feb 2011 (unopposed)
Robert Ashton	Public	A	A	A	A		Re-elected 1 Feb 2011 (unopposed)
Malcolm Bedingfield	Public	✓	✓	A	✓	✓	Re-elected 1 Feb 2009 (opposed)
Tony Betts	Public	A	✓	A	*	✓	Re-elected 1 Feb 2010 (opposed)
Pauline Elliott	Public	✓	✓	✓	✓	✓	Re-elected 1 Feb 2010 (opposed)
Tony Jackson	Public	✓	✓	✓	✓	✓	Re-elected 1 Feb 2010 (opposed)
Jacqueline Middleton	Public	A	✓	✓	A	✓	Re-elected 1 Feb 2010 (opposed)
Sheila Preston	Public	*	✓	✓	✓		Elected 1 Feb 2009 (opposed)
Maggie Prettyman	Public	✓	✓	A	A	✓	Re-elected 1 Feb 2011 (unopposed)
Pat Southgate	Public	✓	✓	A	A	✓	Elected 1 Feb 2010 (opposed)
Andy Street	Public	✓	✓	✓	✓	✓	Elected 1 Feb 2011 (unopposed)
Marion Swan	Public	✓	✓	A	A	✓	Re-elected 1 Feb 2011 (unopposed)
John Walker	Public	✓	✓	A	✓	✓	Elected 1 Feb 2010 (opposed)
Malcolm Blowers	Service User	A	✓	✓	✓	✓	Elected 1 Feb 2011 (unopposed)
Stephen Fletcher	Service User	✓	✓	A	✓	✓	Re-elected 1 Feb 2011 (unopposed)
Hilary Pegg	Service User	✓	A	✓	*	*	Elected 1 Feb 2011 (unopposed)
Neil Ashford	Staff	A	A	✓	*	✓	Re-elected 1 Feb 2011 (opposed)
Duncan Double	Staff	✓	A	A	✓	✓	Re-elected 1 Feb 2009 (unopposed)
Rebecca Horne	Staff	✓	✓	✓	A	✓	Re-elected 1 Feb 2011 (opposed)
Karen O'Sullivan	Staff	✓	✓	✓	✓	✓	Re-elected 1 Feb 2010 (opposed)
Kathleen Ben Rabha	Partner – SAVO					✓ (D)	Appointed in designate 1 Jan 2012
Cathy Craig	Partner – Suffolk County Council	✓	✓	A	A	A	Appointed Sept 2010 – Resigned Jan 2012
Pip Coker	Partner – Julian Housing Support Ltd	✓	✓	A	A	A	Appointed Mar 2008
Rosie Doy	Partner – UEA				A	✓	Appointed Sept 2011
David Edwards	Partner – NHS Great Yarmouth & Waveney	A	✓	A			Appointed Jun 2009 – Resigned Nov 2011
Dave Gooda	Partner – Broadland Meridian	✓	A	A	A		Appointed Dec 2010 – Resigned Dec 2011
Jeff Halliwell	Partner – NHS Norfolk		✓	✓	✓	✓	Appointed May 2011
Brian Hannah	Partner – Norfolk County Council	✓	✓	A	A	*	Appointed Mar 2011 – Resigned Jan 2012
David Harrison	Partner – Norfolk County Council						Appointed Mar 2012
Jenny Manser	Partner – Broadland Meridian					✓	Appointed Jan 2012
Paul Marshall	Partner – Suffolk Constabulary					✓ (D)	Appointed in designate 1 Jan 2012
Bob Payne	Partner – UCS					A (D)	Appointed in designate 1 Jan 2012
Martin Royal	Partner – NHS Suffolk					✓ (D)	Appointed in designate 1 Jan 2012
Mary Rudd	Partner – Suffolk County Council						Appointed Feb 2012
Kevin Wilkins	Partner – Norfolk Constabulary	✓	✓	✓	✓	✓	Appointed Apr 2007
Maggie Wheeler	Trust Chair	✓	✓	✓	✓	✓	

A = Apologies * Apologies not received D = Designate

NWMHFT and NSFT Board of Directors' attendees at Board of Governors' meetings

Directors attend to provide updates and reports to the Governors on developments and strategies, and to ensure a good working relationship between the two Boards

		NWMHFT				NSFT
	Constituency	6 Apr 2011	13 Jul 2011	31 Aug 2011	5 Oct 2011	11 Jan 2012
Graham Creelman	Senior Independent Director	A	✓	✓	✓	✓
Deborah Cadman	Non-Executive Director				✓	
Barry Capon	Non-Executive Director	✓	✓		✓	✓
John Brierley	Non-Executive Director			✓		
Aidan Thomas	Chief Executive					✓
Andrew Hopkins	Acting Chief Executive	✓	✓		✓	
Roz Brooks	Director of Nursing, Governance & Patient Safety	✓			✓	✓
Kathy Chapman	Director of Operations	✓			✓	

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 Trust 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 Trust's membership base has been maintained in 2011–12 via an ongoing telephone-based recruitment campaign, targeting groups of people who have previously been under-represented. The total number of members for Norfolk & Suffolk NHS Foundation Trust as of 31 March 2012 was 13,093. Members were also recruited via a series of 'meet your local mental health services' events across the Trust; stands at other related events; and the well-received 'Health, Happiness and Wellbeing' conference for service users.

Membership engagement for the year has included:

- 'Meet your local mental health services' events in locations across the Trust, including seminars and the opportunity to talk directly to the people who deliver our services
- Regular postal mailings of our Trust magazine *Insight*, and email briefings for those members who have provided an email address
- Quality Account consultation with all members via postal questionnaire
- Representation at a wide range of community events to promote membership including Black History Month, LGBT History Month, Norwich Pride, Ipswich Indian Mela festival

The Board of Directors formally reviewed the membership strategy in March 2011.

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

Membership Office
Norfolk & Suffolk NHS FT
Hellesdon Hospital
Drayton High Road
Norwich, NR6 5BE

If you wish to become a member, please call FREEPHONE 0800 111 4452.

Membership Report for Norfolk and Suffolk from 1 April 2011 to 31 March 2012

Public constituency	Last year (2011–12)	Population	Index
As at start (1 April 2011)	0		
New members	11,759		
Members leaving	139		
At year end (31 March 2012)	11,620	1491149	
Staff constituency			
As at start (1 April 2011)	0		
New members	4533		
Members leaving	0		
At year end (31 March 2012)	4533		
Patient constituency			
As at start (1 April 2011)	0		
New members	1,489		
Members leaving	16		
At year end (31 March 2012)	1,473		
Public constituency	Number of members		
0–16 years old	39	109201	4
17–21 years old	239	79299	38
22+ years old	9,454	1302649	93
Ethnicity			
White	10,943	1459859	96
Mixed	62	12079	65
Asian	142	6760	269
Black	95	6065	201
Other	17	5942	36
Socio-economic groupings			
ABC1	7,377	573028	165
C2	2,610	209853	159
D	683	198457	44
E	856	201182	54
Gender analysis			
Male	4,317	727532	76
Female	7,206	762663	121
Patient constituency			
0–16 years old	3		
17–21 years old	27		
22+ years old	1,246		

Board of Directors

The initial members of the Board of Directors were appointed on 1 February 2008, the date of authorisation as a Foundation Trust. The chair and non-executive directors were appointed for the unexpired period of their office as chair or non-executive directors of Norfolk and Waveney Mental Health Partnership NHS Trust. The following appointments have been made since authorisation:

- Graham Creelman and Stuart Smith were appointed as Non-Executive Directors from March 2008
- Aidan Thomas was appointed as Chief Executive on 1 October 2009, and appointed as Chief Executive of NSFT in April 2011
- Kathy Chapman was appointed as Operational Director – Norfolk & Waveney on 26 April 2010
- Leigh Fleming was appointed as Director of Commercial Development on 2 August 2010
- Roz Brooks was appointed as Director of Nursing, Governance & Patient Safety on 15 November 2010
- Debbie White was appointed as Operational Director – Suffolk in December 2011
- Andrew Hopkins was appointed Acting Chief Executive from March–December 2011
- Steve Ham was appointed Acting Director of Finance from March–December 2011
- Dr Luk Ho was appointed Acting Medical Director from March–December 2011
- Brian Parrott was appointed as a Non-Executive Director from January 2012
- Dr Peter Jefferys was appointed as a Non-Executive Director from September 2011
- Deborah Cadman was appointed as a Non-Executive Director from April–December 2011

The Board meets at least 12 times a year, with four meetings held in public at locations across the Trust's catchment area. The term of office of the Board members, along with their attendance at Board meetings, is set out opposite:

Name	NWMHFT														NSFT			
	28 Apr 2011	26 May 2011		ARA 3 Jun 2011	23 Jun 2011	28 July 2011	25 Aug 2011		22 Sept 2011	AGM 27 Sept 2011	27 Oct 2011	24 Nov 2011		15 Dec 2011	26 Jan 2012	23 Feb 2012		22 Mar 2012
		Public	Private				Public	Private				Public	Private			Public	Private	
Dr Hadrian Ball	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A
John Brierley	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓
Roz Brooks	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓
Deborah Cadman	✓	✓	✓	✓	✓	A	✓	✓	A	✓	✓	✓	✓	✓				
Barry Capon	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kathy Chapman	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Graham Creelman	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓
Barry Dennis	✓	✓	✓	✓	A	✓	✓	✓										
Leigh Fleming	A	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	A
Steve Ham	✓	✓	✓	✓	✓	✓	A	A	✓		✓	✓	✓	✓		✓	✓	
Dr Luk Ho	✓	A	A	✓	A	✓	✓	✓	✓		✓	✓	✓	✓				
Andrew Hopkins	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A	✓
Dr Peter Jefferys						D	D	D	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Brian Parrott		A	A	D	D	D	A	A	A	A	D	D	D	D	A	✓	✓	✓
Stuart Smith	✓	✓	✓	A	✓	✓	✓	A	✓	✓	✓	A	A	✓	✓	✓	✓	✓
Aidan Thomas	✓	✓	✓	A	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maggie Wheeler	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Debbie White															✓	✓	✓	✓
Dr Jon Wilson																		✓

A = Apologies D = Attended as Non-Executive Director Designate

Name	SMHPT																	
	27 Apr 11		25 May 11		22 Jun 11		27 Jul 11		24 Aug 11		28 Sep 11		26 Oct 11		23 Nov 11		14 Dec 11	
	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private
Lord Newton (Chair)	A	A	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A	✓	✓
Peter Collicott (NED)	✓	✓	A	A	✓	✓	✓	✓	✓	✓	A	A	✓	✓	✓	✓	✓	✓
Gary Norgate (NED)	✓	✓	✓	✓	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Anne Whitaker (NED)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A
John Hume (NED)	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A	✓	✓
Laurence Morgan (NED)	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Aidan Thomas (CEO)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A	A	A	✓	✓
Barbara McLean (Dir Nursing)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A	A	A
Hadrian Ball (Med. Dir.)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Keith Mansfield (Dir. Finance)			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sandra Cowie (Dir. Ops)	✓	✓	✓	✓	A	A	A	A	✓	✓	✓	✓	A	A	✓	✓	✓	✓
Daren Clark (Dir Spec. Svc.)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A	✓	✓
*David Farthing (Dep. Dir. Finance)	✓	✓																
*Mike Hurley (Dep. Dir Nursing)															✓	✓	✓	✓

A = Apologies * = Deputising for respective executive directors

The Board of Directors is satisfied that the non-executive directors who served on the Board for the period under review are independent. A summary of the background of each Board member, 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.

NWMHFT

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, the Norfolk Learning and Skills Council • Formerly Chief Executive, Local Training and Enterprise Council and city treasurer, Norwich City Council • Honorary Treasurer of local Mind	• Qualified accountant
Deborah Cadman: Apr–Dec 2011	• Chief Executive, Suffolk County Council (appointed Dec 2011) • Former Chief Executive, EEDA • Former Chief Executive, St Edmundsbury Borough Council • Lead Inspector: Audit Commission • Former Trustee, Suffolk Foundation • Director, University Campus Suffolk (UCS)	• BSc Social Administration • MA Economics • MSc Management Practice
Barry Capon	• Former Chief Executive, Norfolk County Council • Former Chair, Anglian Harbours NHS Trust • Former Commissioner of Criminal Cases Review Commission • Lay member, British Pharmacopoeia Commission	• Solicitor
Graham Creelman	• Consultant on creativity within organisations • Former Chair, City of Norwich Partnership • Chair of Governors, Norwich University College of the Arts • Former Chair, Living East (East of England Cultural Consortium) • Former Managing Director, Anglia Television • Former director of regional programming for ITV Network • Visiting Professor in Media, Norwich University College of the Arts • Vice-Chair, The Writers' Centre, Norwich	• Extensive experience in television production • OBE for services to broadcasting
Barry Dennis: left Aug 2011	• Independent businesses and media advisor • Non-Executive Director, Norfolk Chamber of Commerce • Non-Executive Director, Broadland Meridian • Chairman, Pike Textile Display Ltd • Previously Managing Director, Archant Ltd and Emap plc	• 35+ years in media business, originally a journalist • 2006 Prince Charles's Ambassador for Business In The Community's Eastern Region
Dr Peter Jefferys: appointed Sept 2011	• Consultant Old Age Psychiatrist and former Medical Director, 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
Brian Parrott: appointed Jan 2012	• 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	• Certificate of Qualification in Social Work (currently registered) • Extensive experience of social services management and partnership working with NHS

Director	Expertise	Qualifications
Stuart Smith	• Former director of business change programmes, 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
Aidan Thomas	• Two former Chief Executive posts at NHS PCTs • Former Executive Director roles at NHS Trusts	• MBA (Henley Management College) • Over 25 years' experience within the NHS • Cert. HSM, MHSM
Dr Hadrian Ball	• Consultant forensic psychiatrist since 1992	• Fellow Royal College of Psychiatrists • Doctor of Medicine • Diploma in Medical Jurisprudence • Health Foundation Leadership Fellow (2006–8)
Roz Brooks	• State Registered Nurse since October 1981; Registered Mental Health Nurse since Oct 1984 • Managed Trust Alcohol and Drugs Service (1997–2010)	• SRN/RMN • Diploma Healthcare Education, UEA, 2001 • BSc Nursing Practice, UEA, 2003
Dr Kathy Chapman	• 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	• Two previous director posts • Worked at Board level for 12 years • 28 years of NHS experience	• Certificate and Diploma in Management Studies • Significant professional development in all areas of responsibility
Steve Ham (Acting Director; Mar–Dec 2011)	• 20+ years' post-qualification experience, including eight years in commercial Director of Finance roles • Deputy Director of Finance of NWMHFT since 2010 • Completed NHS Strategic Financial Leadership Programme (2009)	• Member of the Chartered Institute of Accountants in England and Wales (ACA)
Dr Luk Ho (Acting Director; Mar–Dec 2011)	• Consultant Psychiatrist in General Psychiatry since 2001 • Clinical Lead in Mental Health/Lead Clinician 2004–11 • Completed NHS East of England Aspiring Directors' Development Programme 2009–10	• BA (Hons) Physiological Sciences, University of Oxford 1990 • Bachelor of Medicine & Surgery, University of Cambridge 1993 • Membership of the Royal College of Psychiatrists 1997 • MBA (Public Service), University of Birmingham 2006 • LLM (Legal Aspects of Medical Practice), Cardiff University 2009
Andrew Hopkins	• Former Director of Finance and Information, Huntingdonshire PCT • Former consultant and auditor, KPMG • Previous Chair, Eastern Branch of Healthcare Financial Management Association • Member, Eastern Region Collaborative Procurement Hub Board	• Member of the Chartered Institute of Public Finance and Accountancy (CIPFA)
Debbie White: appointed Dec 2011	• 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

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.

SMHPT

Director	Expertise	Qualifications
Lord Newton of Braintree	• Chair, Council on Tribunals/Administrative Justice from 1999 • Chair, Royal Brompton and Harefield NHS Trust, 2001–2008 • House of Lords from 1997 • Member of Parliament for Braintree, 1974–1997 • Parliamentary Under-Secretary of State 1982–1983 • Minister of State DHSS 1983–1986 • Minister of Health DHSS 1986–1988 • Chancellor of the Duchy of Lancaster DHSS 1988–1989 • Secretary of State for Social Security 1989–1992 • Lord President of the Council and Leader of the House of Commons 1992–1997	• BA Hons in Philosophy, Politics & Economics
Peter Collicott: appointed 2005, reappointed Dec 2009	• 32 years in Local Government in five authorities: Finance, IT, Housing, Social Services & Economic Regeneration • 14 years as Director of Finance for Suffolk Coastal District Council	• BSc (Hons) Mathematical Studies (1974) • CIPFA – Chartered Institute of Public Finance and Accountancy (1979)
Laurence Morgan: appointed Dec 2007	• Commercial Finance, Trinity Mirror, York International and Johnson Controls (2001 onwards) • Revenue Growth, Cost Management and Change Management (2001–2006) • Business Development, Johnson Controls, Morgan-Bell (2006 onwards) • Outsourcing Consultancy 2011	• Associate Member of Chartered Institute of Management Accountants (CIMA 2000) • Fellow CIMA (2007) • NHS Non-Executive Director Programme, CASS Business School (2009)
John Hume: appointed Dec 2007	• Senior Executive, General Management, Human Resources and Communication roles in Johnson and Johnson, SC Johnson, Glaxo, GlaxoWellcome and Group Human Resources Director at the London Group 1998–2007 • Chief Executive, EAR Ltd 1997–1998 • Non-Executive Director, Firstsite Gallery: Chair of Audit Committee, Member of Remuneration and Nominations Committees, from 2003 • Non-Executive Director, Stevenage Community Trust 1992–1997	• HND Business Studies 1966–1968 • Postgraduate Diploma in Industrial Administration, University of Bath (1969) • NHS Non-Executive Director Development Programme, CASS Business School (2009)
Anne Whitaker: appointed June 2010	• Global Chief Financial Officer/Chief Operating Officer for Risk Management at JP Morgan Investment Bank 2007–2009 • Regional Chief Operating Officer (Europe, Middle East, Africa and Asia-Pacific) for Risk Management at JP Morgan Investment Bank (2000–2007) • Trustee and Board Director at English National Ballet School 2007–2010	• HNC Financial Sector Studies (University South Glamorgan) 1977–1980 • Harvard Business School/Chase Manhattan Senior Leadership Programme 1996 • London Business School/JP Morgan Senior Leadership Programme 2000
Gary Norgate: appointed June 2010	• Senior Executive BT Group Plc: Strategy, Sales, Marketing and General Management roles in the provision of Global ICT solutions • Senior Vice President of Operations QOS Networks • Director – Interoute – operator of Europe's largest privately owned ICT infrastructure	• Master in Business Administration (1990) • Doctorate in Business Administration (2009)
Aidan Thomas	• 2 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	• MBA (Henley Management College) • Over 25 years' experience within the NHS • Cert. HSM, MHSM

Director	Expertise	Qualifications
Sandra Cowie	• 36 years in the NHS, 29 years in a range of Mental Health Services, including six years in reprovision of Friern Barnet Hospital • 16 years as Senior Manager, seven years at Board Level as Operational Director • Three years as Voluntary Director on specialist Mental Health Housing Boards, including the Dalco Rehabilitation Scheme and Metropolitan Housing Trust	• Registered Mental Nurse • Registered General Nurse • Diploma in Management Studies – Part 1
Daren Clark	• Extensive knowledge and experience of clinical and operational management at all levels of service delivery, supporting people with mental illness as well as individuals and families with complex needs • Successfully led multi-faceted, strategic change projects • Led significant transformational and cultural change projects	• NVQ Level 5 in Health & Social Care Management • Post-Graduate Diploma in Art Therapy • Post-Graduate Diploma in Health & Social Care Management • Registered Nurse for People with a Medical Illness – RMH • Registered Nurse for People with a Learning Disability – RNLD
Dr Hadrian Ball	• Consultant forensic psychiatrist since 1992	• Fellow Royal College of Psychiatrists • Doctor of Medicine • Diploma in Medical Jurisprudence • Health Foundation Leadership Fellow (2006–8)

During the transitional period from March 2011 to the date of the merger on 3 January 2012 the SMHPT executive team included interim appointments for the Director of Nursing (Barbara Mclean) and the Director of Finance (Keith Mansfield).

The Trust's standing orders, reservation and delegation of powers, and standing financial instructions set out the powers reserved for the Board of Directors, and the scheme of delegation for its other responsibilities.

- Regulation and control
- Appointment and dismissal of committees
- Strategy, business plans and budgets
- Policy determination
- Receipt and approval of the Trust's Annual Report and Accounts
- The monitoring and continuous appraisal of the Trust's affairs

Decisions delegated to management include policy implementation and operational management. The Trust's Strategic Management Forum meets monthly. This change reflected a change in the membership and a move to a wider strategic agenda. The Executive Directors and Trust Secretary meet regularly to deal with operational issues not dealt with elsewhere.

Based on the expertise and experience listed above, the Trust is confident that the necessary range of knowledge and skills exists within the Board of Directors, and that its balance, completeness and appropriateness to the requirements of the NHS Foundation Trust constitutes a high-performing Board.

A summary of how evaluation of the Board of Directors' performance has been conducted is included within this report.

Individual committees review their own performance. For example:

- The Audit and Risk Committee assessed itself against criteria contained in the NHS audit committee handbook
- The Investment Committee reviewed its terms of reference to ensure effectiveness and impact

NWMHFT and NSFT Audit and Risk Committee: 2011–12 attendance

	NWMHFT						NSFT
Name	13 Apr 2011	ARA 31 May 2011	8 Jun 2011	10 Aug 2011	12 Oct 2011	14 Dec 2011	8 Feb 2012
John Brierley	✓	✓	✓	✓	✓	✓	✓
Deborah Cadman				✓	✓	✓	
Barry Capon	✓	✓	✓				
Graham Creelman	✓	✓	✓	✓	✓	✓	✓
Barry Dennis	✓	A	✓	✓			
Peter Jefferys					A	✓	A

SMHPT Audit and Risk Committee 2011 attendance

Name	3 Jun 2011	8 Jun 2011	14 Sep 2011
Laurence Morgan	✓	✓	A
Anne Whitaker	A	A	A
Gary Norgate	✓	✓	✓
John Hume	✓	✓	✓
Peter Collicott	A	A	✓

Register of interests

At the time of their appointment, all directors are asked to declare any interests on the register of directors' interests. This register is reviewed on a regular basis and maintained by the Trust secretary. Declarations are checked at the beginning of every Board and subcommittee meeting.

The register is available for inspection by members of the public. Anyone who wishes to see the register of directors' interests should make enquiries to the Trust secretary at the following address:

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

Audit and Risk Committee

The Audit and Risk Committee incorporates the formal requirements of audit committees as required by the code of governance.

The committee has direct access to both external and internal auditors. The committee's role is to review the control and risk environments, including the Trust's financial systems and annual financial statements. It considers any matters concerning the external auditors, including their value for money reports, and also the adequacy of the Trust's internal audit and clinical governance arrangements. Membership of this committee comprises four non-executive directors, and attendance at meetings is set out above.

The Board of Governors appointed KPMG as the Trust's independent external auditors at its July 2009 meeting.

The Trust is responsible for preparing the annual report, the directors' remuneration report, and the financial statements in accordance with directions issued by the independent regulator of foundation trusts (Monitor) under the National Health Act 2006.

KPMG LLP's accompanying opinion on pages 4 and 5 of the financial statements is based on its audit conducted under the National Health Service Act 2006, and in accordance with Monitor's audit code for NHS foundation trusts, and international standards on auditing (UK and Ireland), and sets out its reporting responsibilities.

The Trust's external auditors may perform non-audit work where the work is clearly audit-related and the external auditors are best placed to do that work. For such assignments the audit and risk committee ensures that all such work is properly considered and that the correct protocols are observed. The processes in place ensure auditor objectivity is safeguarded. Further details of services provided within the year are found in this year's accounts.

NWMHFT and NSFT Nominations Committee: 2011–12 attendance

		NWMHFT					NSFT
Name	Constituency	25 May 2011	27 Jul 2011*	28 Sept 2011	23 Nov 2011	25 Jan 2012	28 Mar 2012
Malcolm Bedingfield	Public	✓	✓	✓	✓	✓	
Barry Capon	Acting Senior Independent Director	✓					
Stephen Fletcher	Service User	A	✓	A	✓	A	✓
Graham Creelman	Senior Independent Director	A	✓	✓	✓	✓	✓
Jacqueline Middleton	Public	✓	✓	✓	✓	✓	✓
Dr Karen O'Sullivan	Staff	✓	A	A	✓	✓	✓
Sheila Preston	Public	✓	✓	✓	A		
Mary Rose Roe	Carer	✓	✓	A	✓	A	A
ACC Kevin Wilkins	Partner	✓	✓	✓	✓	A	A
Maggie Wheeler	Trust Chair	✓	✓	✓	✓	✓	A
Aidan Thomas	Chief Executive	A	A			A	A
Andrew Hopkins	Acting Chief Executive			✓	A		
Tony Jackson	Lead Governor	✓	A	✓	✓	✓	A
Jane Marshall-Robb	Associate Director – Human Resources					A	A
Sarah Ball	Head of Human Resources	✓	✓	✓	A		

A = Apologies

** 27 July 2011 – Joint meeting with the Remuneration & Terms of Service Committee*

SMHPT Nominations Committee 2011 attendance

No nomination committee meetings were held in 2011.

Nominations Committee

The Nominations Committee is a sub-committee of the Board of Governors. Membership of this committee and attendance at meetings is set out above.

During the year the committee received the appraisal of the Chair and Non-Executive Directors and further refined the appraisal criteria and process. In light of the proposed merger with Suffolk Mental Health Partnership, the committee accepted that continuity and experience on the Board of Directors was important. To ensure this some of the Non-Executive Directors' terms of office were extended over the course of the year as circumstances required.

The committee held a joint meeting with the remuneration and terms of service committee in July 2011.

The committee commenced the recruitment of three Non-Executive Directors designate to the Board of Directors of the potential merged Trust and recommended the appointment of three Non-Executive Directors and the re-appointment of one Non-Executive Director, and the Trust Chair, to the Board of Governors for approval.

NWMHFT and NSFT non-executive directors: terms of office (April 2011)

Name	Original appointment	Reappointed	Reappointed	Reappointed	Current term ends	Total since 1 Feb 2008
John Brierley	10 Nov 2005 (for 4 years)	10 Nov 2009 (for 3 years)			9 Nov 2012	4 years 10 months
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 (for two years from date of merger)	4 years 2 months
Deborah Cadman	1 May 2011				16 Dec 2011	7.5 months
Graham Creelman	1 Mar 2008 (for 4 years)	1 Mar 2012 (for 3 years)			29 Feb 2015	4 years 1 month
Barry Dennis	31 Jul 2006 (for 4 years)	31 July 2010 (for 6 months)	31 Jan 2011 (for 4 months)	25 May 2011	31 Aug 2011	3 years 5 months
Dr Peter Jefferys	1 Sept 2011 (for 3 years)				31 Aug 2014	7 months
Brian Parrott	1 Jan 2012 (for 3 years)				31 Dec 2014	3 months
Stuart Smith	1 Mar 2008 (for 3 years)				28 Feb 2013	4 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 31 Dec 2013)	31 Dec 2013	5 years 11 months

SMHPT non-executive director appointments

Name	Appointed and reappointed	End date
Lord Tony Newton	1 Mar 2009 and 1 Mar 2011	28 Feb 2015
Peter Collicott	1 Dec 2005 and 1 Dec 2009	30 Nov 2013
John Hume	1 Nov 2008	31 Oct 2012
Laurence Morgan	1 Dec 2009	31 Nov 2012
Anne Whitaker	1 Jun 2010	31 May 2014
Gary Norgate	1 Jun 2010	31 May 2014

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 on pages 6 to 12 of the accounts.

Additional information

This Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

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 (headquarters),
Drayton High Road,
Norwich, NR6 5BE
Telephone: 01603 421421

Remuneration report

Benchmarking performance

The remuneration committee, comprising all the non-executive directors, sets the remuneration of executive directors. At their December 2010 and January 2011 meetings the committee considered the role and remuneration of the executive directors for the potential merged Trust Board of Directors, with information from benchmarking reports. The committee agreed to set salaries for 2011–12, and for the merged Trust, that were considered sustainable, fair and comparable within the NHS market at that time. There was no increase in the pay or performance element to the 2010–11 pay award for the executive directors. The members of the committee during the period, and their attendance at meetings, are set out below:

Remuneration & terms of service: 2011–12 attendance

Name		27 June 2011	27 July 2011*	5 Sept 2011	5 Dec 2011	5 Mar 2012
John Brierley	Non-Executive Director	✓	A	Stood Down	✓	Stood Down
Deborah Cadman	Non-Executive Director	A	A		✓	
Barry Capon	Non-Executive Director	✓	✓		✓	
Graham Creelman	Senior Independent Director	✓	✓		✓	
Barry Dennis	Non-Executive Director	✓	✓			
Andrew Hopkins	Acting Chief Executive	A	A		A	
Peter Jefferys	Non-Executive Director				✓	
Brian Parrott	Non-Executive Director					
Stuart Smith	Non-Executive Director	✓	A		✓	
Aidan Thomas	Chief Executive					
Maggie Wheeler	Trust Chair	✓	✓		✓	
Sarah Ball	Head of Human Resources	✓	✓		✓	

** 27 July 2011 – joint meeting with the Nominations Committee*

SMHPT Remuneration Committee 2011 attendance

Name	27 Apr 2011	11 May 2011	25 May 2011	22 Jun 2011	27 Jul 2011
Lord Newton	A	✓	A	Stood Down	✓
Laurence Morgan	A	✓	✓		✓
Anne Whitaker	✓	✓	✓		✓
Gary Norgate	✓	✓	✓		A
John Hume	A	✓	✓		✓
Peter Collicott	✓	✓	A		✓

A = Apologies

From March 2011 to the date of the merger, NWMHFT provided additional management support to SMHPT. Aidan Thomas and Hadrian Ball joined the SMHPT board as acting Chief Executive and Medical Director. Their roles were covered in NWMHFT by Andrew Hopkins (Acting Chief Executive) and Luk Ho (Acting Medical Director).

Directors' Remuneration report

Name and title	Year to 31 March 2012			Year to 31 March 2011		
	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind* (Rounded to the nearest £00)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind* (Rounded to the nearest £00)
Hadrian Ball Interim Medical Director (SMHPT) to Dec 2011Medical Director (NSFT) from Jan 2012	20 to 25	140 to 145	-	20 to 25	140 to 145	
John Brierley Non-Executive Director (NWMHFT) to Dec 2011 Non-Executive Director (NSFT) from Jan 2012	15 to 20	-	-	15 to 20	-	
Roz Brooks Director of Governance & Nursing (NWMHFT) to Dec 2011 Director of Nursing, Quality and Patient Safety (NSFT) from Jan 2012	95 to 100	-	-	30 to 35	-	-
Deborah Cadman Non-Executive Director (NWMFHT) Apr to Dec 2011	5 to 10	-	-	-	-	-
Barry Capon Non-Executive Director (NWMHFT) to Dec 2011 Non-Executive Director (NSFT) from Jan 2012	10 to 15	-	-	15 to 20	-	-
Kathy Chapman Operational Director (NWMHFT) to Dec 2011 Operational Director – Norfolk & Waveney (NSFT) from Jan 2012	95 to 100	-	2,400	85 to 90	-	400
Graham Creelman Non-Executive Director, Deputy Chair and Senior Independent Director (NWMHFT) to Dec 2011 Non-Executive Director, Deputy Chair and Senior Independent Director (NSFT) from Jan 2012	15 to 20	-	-	10 to 15	-	-
Barry Dennis Non-Executive Director (NWMHFT) to Aug 2011	0 to 5	-	-	10 to 15	-	-
Leigh Fleming Commercial Development Director (NWMHFT) to Dec 2012 Commercial Development Director (NSFT) from Jan 2012	95 to 100	-	400	60 to 65	-	5,000
Steve Ham Acting Director of Finance and Performance (NWMHFT) April to Dec 2011	60 to 65	-	-	-	-	-
Dr Luk Ho Acting Director of Medicine (NWMHFT) April to Dec 2011	5 to 10	85 to 90	-	-	-	-
Andrew Hopkins Acting Chief Executive (NWMHFT) Apr to Dec 2011 Director of Finance & Performance and Deputy Chief Executive (NSFT) from Jan 2012	115 to 120	-	2,400	105 to 110	-	2,100

Continued

Name and title	Year to 31 March 2012			Year to 31 March 2011		
	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind* (Rounded to the nearest £00)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind* (Rounded to the nearest £00)
Dr Peter Jeffreys Non-Executive Director (NWMHFT) from Sept 2011 to Dec 2011 Non-Executive Director (NSFT) from Jan 2012	5 to 10		-	-	-	-
Brian Parrot Non-Executive Director (NSFT) from Jan 2012	0 to 5	-	-	-	-	-
Stuart Smith Non-Executive Director (NWMHFT) to Dec 2011 Non-Executive Director (NSFT) from Jan 2012	10 to 15	-	-	10 to 15	-	-
Aidan Thomas Interim Chief Executive (SMHPT) Apr to Dec 2011 Chief Executive (NSFT) from Jan 2012	135 to 140	-	-	135 to 140	-	-
Maggie Wheeler Chair (NWMHFT) to Dec 2011 Chair (NSFT) from Jan 2012	40 to 45	-	-	40 to 45		-
Debbie White Director of Operations – Suffolk (NSFT) from Jan 2012	25 to 30	-	-	-	-	-
Lord Anthony Newton Chair (SMHPT) to Dec 2011	15 to 20	-	-	20 to 25	-	-
Peter Collicott Non-Executive Director (SMHPT) to Dec 2011	0 to 5	-	-	5 to 10	-	-
Laurence Morgan Non-Executive Director (SMHPT) to Dec 2011	5 to 10	-	-	5 to 10	-	-
John Hume Non-Executive Director (SMHPT) to Dec 2011	0 to 5	-	-	5 to 10	-	-
Gary Norgate Non-Executive (SMHPT) to Dec 2011	5 to 10	-	-	5 to 10	-	-
Anne Whitaker Non-Executive Director (SMHPT) to Dec 2011	5 to 10	-	-	5 to 10	-	-
Nick Gerrard Director of Finance (SMHPT) to May 2011	5 to 10	-	-	105 to 110	-	-
Robert Bolas Director of Nursing & Modernisation (SMHPT) to Jun 2011	40 to 45	-	-	90 to 95	-	-
Sandra Cowie Locality Director (SMHPT) to Dec 2011	55 to 60	-	-	85 to 90	-	-
Daren Clark Director of Specialist Services (SMHPT) to Dec 2011	60 to 65	-	-	85 to 90	-	900
Keith Mansfield Interim Director of Finance (SMHPT) from May 2011 to Dec 2011	0	150 to 155	-	-	-	-
Barbara McLean Interim Director of Quality and Nursing (SMHPT) from Apr to Dec 2011	70 to 75	-	-	-	-	-

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

Name and title	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 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2012 £000	Cash Equivalent Transfer Value at 31 March 2011 £000
Hadrian Ball Interim Medical Director (SMHPT) to Dec 2011 Medical Director (NSFT) from Jan 2012	5 to 7.5	15 to 17.5	65 to 70	195 to 200	1,220	1,023
Roz Brooks Director of Governance & Nursing (NWMHFT) to Dec 2011 Director of Nursing, Quality and Patient Safety (NSFT) from Jan 2012	5 to 7.5	17.5 to 20	30 to 35	90 to 95	582	432
Kathy Chapman Operational Director (NWMHFT) to Dec 2011 Operational Director - Norfolk & Waveney (NSFT) from Jan 2012	0 to 2.5	2.5 to 5	25 to 30	75 to 80	419	343
Leigh Fleming Commercial Development Director (NWMHFT) to Dec 2012 Commercial Development Director (NSFT) from Jan 2012	2.5 to 5	7.5 to 10	25 to 30	85 to 90	509	400
Steve Ham Acting Director of Finance & Performance (NWMHFT) April to Dec 2011	0 to 2.5	5 to 7.5	5 to 10	25 to 30	139	81
Dr Luk Ho Acting Director of Medicine (NWMHFT) April to Dec 2011	2.5 to 5	7.5 to 10	30 to 35	90 to 95	456	339
Andrew Hopkins Acting Chief Executive (NWMHFT) Apr to Dec 2011 Director of Finance& Performance and Deputy Chief Executive (NSFT) from Jan 2012	0 to 2.5	2.5 to 5	25 to 30	85 to 90	458	367
Aidan Thomas Interim Chief Executive (SMHPT) Apr to Dec 2011 Chief Executive (NSFT) from Jan 2012	0 to 2.5	5 to 7.5	50 to 55	150 to 155	967	861
Debbie White Director of Operations – Suffolk (NSFT) from Jan 2012	0 to 2.5	0 to 2.5	20 to 25	70 to 75	411	329

Name and title	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 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2012 £000	Cash Equivalent Transfer Value at 31 March 2011 £000
Nick Gerrard Director of Finance (Suffolk Mental Health) to May 2011	2.5 to 5	12.5 to 15	35 to 40	110 to 115	0	576
Robert Bolas Director of Nursing & Modernisation (Suffolk Mental Health) to Jun 2011	0 to 2.5	0 to 2.5	45 to 50	135 to 140	0	0
Sandra Cowie Locality Director (SMHPT) to Dec 2011	-	-	40 to 45	130 to 135	0	823
Daren Clark Director of Specialist Services (SMHPT) to Dec 2011	0 to 2.5	5 to 7.5	30 to 35	90 to 95	545	457
Barbara McLean Interim Director of Quality and Nursing (SMHPT) from Apr to Dec 2011	Not available	Not available	30 to 35	100 to 105	601	-

Where an individual was no longer an employee at 31 March 2012, CETV is disclosed as nil.

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. This requirement is new for 2011–12 and so comparative information has not been prepared.

The banded remuneration of the highest paid director in the Trust for 2011–12 was £165,000–£170,000. This was 6.3 times the median remuneration of the workforce, which was £26,557. In 2011–12 four clinical employees received annualised remuneration in excess of the highest paid director. Remuneration ranged from £169,334 to £194,011.

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.

	2011–12 £000
Band of highest paid director (full year effect)	165–170
Median total remuneration	£26,557
Ratio	6.3 times

Norfolk and Suffolk NHS Foundation Trust

Accounts for the year ended
31 March 2012

Norfolk and Suffolk NHS
NHS Foundation Trust

Accounts for the year ended 31 March 2012

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your wellbeing in mind

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 Officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("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 rust 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 Officers' Memorandum.

Aidan Thomas, Chief Executive

Date: 28 May 2012

Independent auditor's report to the Board of Governors of Norfolk & Suffolk NHS Foundation Trust

We have audited the financial statements of Norfolk & Suffolk NHS Foundation Trust for the year ended 31 March 2012 on pages 14 to 62. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

This report is made solely to the Board of Governors of Norfolk & 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

In our opinion the financial statements:

- give a true and fair view of the state of Norfolk & Suffolk NHS Foundation Trust's affairs as at 31 March 2012 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 2011–12.

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 & 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.

S Beavis

S Beavis for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
6 Lower Brook Street
Ipswich
Suffolk
IP4 1AP

28 May 2012

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 2012 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.

As regards the Trust's merger with Suffolk Mental Health NHS Partnership Trust (SMHPT) during 2011–12, the Trust identified a programme team to undertake the merger work reporting to the Director of Finance. This included project management and specialist advice, including transaction management, legal and financial.

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 monthly through the Trust's Service Governance Sub-committee and Audit and Risk committee.
- High risks (red) are reported monthly 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 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 undertook significant legal, property, governance and financial due diligence on the merger of Suffolk Mental Health NHS Partnership Trust (SMHPT) and Norfolk and Waveney Mental Health NHS Foundation Trust (NWMHFT) during 2011–12. This also included an assessment against the Quality Governance Framework using external assessors. In addition three members of the Trust's Senior Management Team including the Medical Director were seconded to SMHPT to effectively manage this Trust in the nine months prior to the date of merger, which enabled a full understanding of governance issues and risks within that Trust.

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 2011–12, which found the Trust to be fully compliant except for two reports where moderate concerns were raised, which were quickly addressed and currently the Trust has no 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 Trust has produced an Annual Quality Account for 2011–12. 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 will be developed.

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, 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 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).
- 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 2011 to 31 March 2012 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 2011–12 Quality Account at a Public Board Meeting in February 2011. The Quality Account for 2011–12 is subject to an external assurance review during 2012.

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.

Aidan Thomas, Chief Executive

Date: 28 May 2012

Foreword to the accounts

These accounts for the year ended 31 March 2012 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.

Aidan Thomas, Chief Executive

Date: 28 May 2012

Statement of Comprehensive Income for the year ended 31 March 2012

	Note	NWMHFT 1 Apr 2011 to 2 Jan 2012	SMHPT 1 Apr 2011 to 2 Jan 2012	Combined 3 months to 31 Mar 2012	Combined 12 months to 31 Mar 2012	Combined 12 months to 31 Mar 2011
		£000	£000	£000	£000	£000
Operating income	3	102,497	64,252	54,289	**221,038**	222,331
Operating expenses	4	(98,624)	(63,146)	(62,852)	**(224,622)**	(222,781)
Operating surplus/(defecit)		**3,873**	**1,106**	**(8,563)**	**(3,584)**	**(450)**
Finance costs						
Finance income	8	139	14	45	**198**	188
Finance expense – financial liabilities	9	(161)	(532)	(289)	**(982)**	(768)
Finance expense – unwinding of discount on provisions	22	(7)	(77)	(29)	**(113)**	(79)
PDC dividends payable		(1,975)	(788)	(712)	**(3,475)**	(3,629)
Net Finance Costs		**(2,004)**	**(1,383)**	**(985)**	**(4,372)**	**(4,288)**
SURPLUS/(DEFICIT) FOR THE YEAR		**1,869**	**(277)**	**(9,548)**	**(7,956)**	**(4,738)**
Other comprehensive income						
Impairments and reversals	11	(86)	(7)	(6,452)	**(6,545)**	(878)
Revaluation gains/(losses) on property plant and equipment	11	0	0	42	**42**	37
TOTAL COMPREHENSIVE INCOME/ (EXPENSE) FOR THE YEAR		**1,783**	**(284)**	**(15,958)**	**(14,459)**	**(5,579)**

The notes on pages 18 to 62 form part of these accounts.
All revenue and expenditure is derived from continuing operations.

Statement of Financial Position as at 31 March 2012

	Note	As at 31 March 2012 £000	As at 31 March 2011 £000
NON-CURRENT ASSETS:			
Intangible assets	10	**368**	370
Property plant and equipment	11	**144,893**	145,409
Trade and other receivables	13	**41**	44
Total non-current assets		**145,302**	145,823
CURRENT ASSETS:			
Inventories	12	**332**	232
Trade and other receivables	13	**5,347**	4,502
Non-current assets held for sale	14	**3,234**	0
Cash and cash equivalents	24	**20,075**	32,616
Total current assets		**28,988**	37,350
CURRENT LIABILITIES:			
Trade and other payables	15	**(23,375)**	(20,185)
Borrowings	18	**(1,189)**	(898)
Provisions	22	**(1,986)**	(2,129)
Tax payable	17	**(2,521)**	(2,561)
Other liabilities	16	**(3,357)**	(3,643)
Total current liabilities		**(32,428)**	(29,416)
TOTAL ASSETS LESS CURRENT LIABILITIES		**141,862**	153,757
NON-CURRENT LIABILITIES:			
Trade and other payables	15	**0**	(123)
Borrowings	18	**(19,570)**	(16,738)
Provisions	22	**(3,765)**	(4,005)
Other liabilities	16	**(478)**	(383)
Total non-current liabilities		**(23,813)**	(21,249)
TOTAL ASSETS EMPLOYED		**118,049**	**132,508**
FINANCED BY (TAXPAYERS' EQUITY):			
Public dividend capital		**80,588**	80,588
Revaluation reserve	23	**24,859**	31,837
Income and Expenditure reserve		**12,602**	20,083
TOTAL TAXPAYERS' EQUITY		**118,049**	**132,508**

The financial statements on pages 14 to 62 were approved by the Board on 28 May 2012 and signed on its behalf by:

Aidan Thomas, Chief Executive

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 2011	**132,508**	80,588	31,837	20,083
Total comprehensive income 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**
Taxpayers' Equity at 1 April 2010	**138,087**	80,588	33,151	24,348
Total comprehensive income for the year	**(4,738)**	0	0	(4,738)
Revaluations – property, plant and equipment	**37**	0	37	0
Transfers to the income and expenditure account in respect of assets held for sale	**0**	0	0	0
Impairments and reversals	**(878)**	0	(878)	0
Transfer of the excess of current cost depreciation of historical cost depreciation to the Income and Expenditure Reserve	**0**	0	(473)	473
Taxpayers' Equity at 31 March 2011	**132,508**	**80,588**	**31,837**	**20,083**

Statement of Cash Flows for the year ended 31 March 2012

	31 March 2012 £000	31 March 2011 £000
Cash flows from operating activities		
Operating surplus/(deficit)	**(3,584)**	(450)
Non-cash income and expense:		
Depreciation and amortisation	**6,039**	5,907
Impairments and reversals	**4,728**	6,910
(Increase)/decrease in trade and other receivables	**(788)**	85
(Increase)/decrease in inventories	**(100)**	56
Increase/(decrease) in trade and other payables	**4,152**	(522)
Increase/(decrease) in other liabilities	**(191)**	1,899
Increase/(decrease) in taxes payables	**(40)**	2
Increase/(decrease) in provisions	**(270)**	340
Other movements in operating cashflows	**175**	430
NET CASH GENERATED FROM OPERATIONS	**10,121**	**14,657**
Cash flows from investing activities		
Purchase of intangible assets	**(168)**	(75)
Purchase of property, plant and equipment	**(21,078)**	(17,333)
Net cash generated used in investing activities	**(21,246)**	**(17,408)**
Cash flows from financing activities		
Interest received	**198**	189
Loans received	**4,000**	9,200
Loans repaid	**(974)**	(509)
Interest paid	**(470)**	(284)
PDC dividends paid	**(3,561)**	(3,578)
Capital element of finance leases and PFI	**(97)**	(134)
Interest element of finance leases and PFI	**(512)**	(481)
Net cash (used in)/generated from financing activities	**(1,416)**	**4,403**
Increase/(decrease) in cash and cash equivalents	**(12,541)**	**1,652**
Cash and Cash equivalents at 1 April	**32,616**	30,964
Cash and Cash equivalents at 31 March	**20,075**	**32,616**

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 2011–12 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.

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 accrued 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 to 15
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".

Services Received

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

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.

PFI Liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It 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.

Lifecycle Replacement

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

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.

Internally generated intangible assets

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

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.

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

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.

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 HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.8% (2010–11: 2.9%) in real terms.

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

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 31 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 31, 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 from the Department of health are recognised at historical cost. Otherwise, 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:	**Financial year for which the change first applies**
IFRS 7 Financial Instruments: Disclosures – amendments Transfer of financial assets	Effective date of 2012–13 but this is not the year adopted by the EU
IFRS 9 Financial Instruments Financial assets Financial liabilities	Uncertain, dependant on the completion of the IASB financial instruments project
IFRS 10 Consolidated Financial Statements	Effective date of 2013–14 but not yet adopted by the EU.
IFRS 11 Joint Arrangements	Effective date of 2013–14 but not yet adopted by the EU.
IFRS 12 Disclosure of Interests in Other Entities	Effective date of 2013–14 but not yet adopted by the EU.
IFRS 13 Fair Value Measurement	Effective date of 2013–14 but not yet adopted by the EU.
IAS12 Income Taxes amendment	Effective date of 2012–13 but not the year adopted by the EU.
IAS 1 Presentation of financial statements, on other comprehensive income (OCI)	Effective date of 2013–14 but not yet adopted by the EU.
IAS 27 Separate Financial Statements	Effective date of 2013–14 but not yet adopted by the EU.
IAS 28 Associates and joint ventures.	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. The transaction represents the transfer of services between public sector bodies which are under common control and therefore is a "machinery of government change". The transaction falls outside the scope of IFRS3 "Business Combinations" as it meets the definition of a "Group Reconstruction". Consequently in accordance with the Foundation Trust Annual Reporting Manual, the principles of merger accounting have been applied to this transaction as set out in Financial Reporting Standard (FRS) 6 "Acquisitions and Mergers" issued by the United Kingdom Accounting Standards Board. As a result these accounts have been presented to include the prior year figures of the Trust to include the transactions and balances of both businesses, and also making necessary adjustment to align those figures to the accounting policies of the Trust.

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

	NWMHFT £000	SMHPT £000	Total £000
Operating Income	136,604	84,434	221,038
Operating Expenditure	(140,012)	(84,610)	(224,622)
	(3,408)	**(176)**	**3,584**

An analysis of the 2010–11 comparatives by predecessor organisation is set out below.

	NWMHFT for year to 31 March 2011	SMHPT for year to 31 March 2011	Combined year to 31 March 2011
Statement of Comprehensive Income	**£000**	**£000**	**£000**
Operating income	134,906	87,425	222,331
Operating expenses	(130,766)	(92,015)	(222,781)
Operating surplus/(deficit)	**4,140**	**(4,590)**	**(450)**
Net Finance Costs	**(2,505)**	**(1,783)**	**(4,288)**
SURPLUS/(DEFICIT) FOR THE YEAR	**1,635**	**(6,373)**	**(4,738)**
Impairments and reversals	0	(878)	**(878)**
Revaluation gains/(losses) on property plant and equipment	(9)	46	37
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**1,626**	**(7,205)**	**(5,579)**

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 2012 £000	Year ended 31 March 2011 £000
Block Contract income	**182,679**	179,859
Clinical Partnerships providing mandatory services (including S75 agreements)	**10,760**	14,087
Clinical income for the Secondary Commissioning of mandatory services	**5,329**	8,352
Other non-protected clinical income	**2,089**	2,426
	200,857	**204,724**

3.1.2 Source of income from patient care activities

	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
NHS Foundation Trusts	**47**	11
NHS Trusts	**95**	60
Strategic Health Authorities	**368**	654
Primary Care Trusts	**188,984**	189,103
Local Authorities	**10,895**	14,637
Non NHS Other	**468**	259
	200,857	**204,724**

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 2012 £000	Year ended 31 March 2011 £000
Mandatory Services	**198,768**	202,298
Non Mandatory Services	**2,089**	2,426
	200,857	**204,724**

3.1.4 Private patient income

Section 44 of the National Health Service Act 2006 as amended by the Health Act 2009 requires that the proportion of private patient income to the total patient related income of NHS Foundation Trusts should not exceed that proportion whilst the body was an NHS Trust in 2002–03 base year or 1.5% if greater. Private patient income was nil in both the current period and the base year.

3.2 Other operating income

	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Research and development	**1,950**	1,230
Education and training	**3,524**	3,454
Non-patient care services to other bodies	**10,683**	10,717
Other income	**4,024**	2,206
	20,181	**17,607**

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 2012 £000	Year ended 31 March 2011 £000
Services from NHS Foundation Trusts	**1,363**	1,598
Services from NHS Trusts	**1,135**	1,489
Services from other NHS bodies	**1,575**	1,440
Purchase of healthcare from non-NHS bodies	**5,133**	5,674
Employee Expenses – executive directors	**666**	617
Fees paid – non-executive directors	**168**	178
Employee Expenses – Staff	**164,168**	164,786
Drug costs	**3,489**	4,021
Supplies and services – clinical (excluding drug costs)	**564**	602
Supplies and services – general	**5,449**	5,373
Establishment	**4,016**	4,151
Research and development	**68**	49
Education and training	**1,247**	1,551
Transport	**4,353**	4,584
Premises	**8,745**	8,530
Increase/(Decrease) in provision for impairment of receivables	**256**	(70)
Inventory write downs	**0**	4
Depreciation and amortisation	**6,039**	5,907
Impairments	**4,728**	6,919
Audit fees – statutory audit	**133**	146
Other auditors remuneration – other services	**200**	116
Consultancy fees	**111**	261
Clinical negligence	**427**	433
Redundancy and reconfiguration costs	**8,308**	2,277
Loss on disposal of land and buildings	**0**	26
Loss on disposal of assets held for sale	**1**	0
Other	**2,280**	2,119
	224,622	**222,781**

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 £111k (2010–11 £146k). 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 (2011–12 £8k).

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 2012 £000	Year ended 31 March 2011 £000
Lease payments	**1,285**	2,018
Total	**1,285**	**2,018**

Total future minimum lease payments due	Year ended 31 March 2012	Year ended 31 March 2011
Payable:	**£000**	**£000**
Not later than one year	**1,681**	1,342
Between one and five years	**4,034**	4,140
After five years	**4,842**	5,073
Total	**10,557**	**10,555**

5.2 As lessor

Rental income

	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Rent recognised as income	**130**	128
Total income	**130**	**128**

Total future minimum lease payments due	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Receivable:		
Not later than one year	**69**	71
Between one and five years	**11**	14
After five years	**0**	0
Total	**80**	**85**

6 Employee costs and numbers

6.1 Employee costs

	Total year ended 31 March 2012 £000	Permanently Employed £000	Other £000	Total year ended 31 March 2011 £000
Salaries and wages	**139,480**	**122,231**	**17,249**	139,910
Social Security costs	**10,019**	**9,714**	**305**	10,049
Employers Contributions to NHS Pensions Authority	**15,482**	**15,298**	**184**	15,816
Other pension costs	**97**	**0**	**97**	(60)
Termination benefits	**8,308**	**8,308**	**0**	2,277
Total	**173,386**	**155,551**	**17,835**	**167,992**

The total employer pension contribution payable for the year to 31 March 2012 was £15,482k (31 March 2011 £15,816k). In addition to the above £244k (31 March 2011 £312k) of salaries of permanently employed staff was capitalised during the period.

6.1.1 Staff exit packages

Exit package cost band	Number of compulsory redundancies 2011–12	Number of other departures 2011–12	Number of compulsory redundancies 2010–11	Number of other departures 2010–11
<£10,000	**9**	**12**	7	8
£10,000–£25,000	**6**	**44**	8	9
£25,001–£50,000	**14**	**42**	7	1
£50,001–£100,000	**12**	**17**	1	8
£100,001–£150,000	**7**	**11**	0	4
£150,001–£200,000	**1**	**2**	0	0
£200,000+	**0**	**1**	0	0
Total number of exit packages by type	**49**	**129**	**23**	**30**
Total resource cost (£000)	**2,618**	**5,690**	**487**	**1,436**

6.2 Average number of persons employed

	Total year ended 31 March 2012 Number	Permanently Employed Number	Other Number	Year ended 31 March 2011 Number
Medical & dental	**222**	190	32	246
Administration & estates	**1,068**	969	99	975
Healthcare assistants & other support staff	**970**	880	90	1,066
Nursing, midwifery & health visiting staff	**1,324**	1,297	27	1,438
Scientific, therapeutic & technical staff	**310**	294	16	319
Social care staff	**112**	68	44	111
Total	**4,006**	**3,698**	**308**	**4,155**

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

6.3 Directors' emoluments

	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Directors' remuneration:		
Employee benefits and fees paid	**1,158**	1,478
Employer's Contributions to NHS Pensions	**185**	184
Total	**1,343**	**1,662**

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

The scheme is subject to a full actuarial valuation every four years by the Government Actuary (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) 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 to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contribution at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. The 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:

Note 6.4 continued

Annual Pensions
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".

Pensions Indexation
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.

Lump Sum Allowance
A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement
Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits
A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

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

Transfer between Funds
Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits
Where a scheme member ceases NHS Employment with more than two years' service, they can preserve their accrued pension for payment when they reach retirement age.

Compensation for Early Retirement
Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

6.5 Retirements due to ill-health

During 2011–12 there were 6 (2010–11 – 14) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £878k (2010–11 – £1,022k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority-Pensions Division.

7 Better payment practice code

7.1 Better payment practice code – measure of compliance

	Year ended 31 March 2012 Number	Year ended 31 March 2012 Value	Year ended 31 March 2011 Number	Year ended 31 March 2011 Value
Total Non-NHS trade invoices paid in the year	**38,421**	**70,215**	39,003	52,243
Total Non-NHS trade invoices paid within target	**36,698**	**66,966**	35,661	48,396
Percentage paid within target	**96%**	**95%**	**91%**	**93%**
Total NHS trade invoices paid in the year	**1,305**	**11,748**	1,607	17,636
Total NHS trade invoices paid within target	**1,173**	**10,755**	1,458	15,561
Percentage paid within target	**90%**	**92%**	**91%**	**88%**

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 2012 £000	Year ended 31 March 2011 £000
Interest on loans and receivables	**198**	188
	198	**188**

9 Finance costs

	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Interest on loans and overdrafts	**470**	290
Finance Costs in PFI obligations		
Main Finance Costs	**338**	342
Contingent Finance Costs	**174**	136
	982	768

10 Intangible assets

	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
Donated	0
Total at 31 March 2012	**368**
Asset financing	
Owned	368
Finance leased	0
Net book value 31 March 2012	**368**

Prior year:

	Software licences (purchased) £000
Cost or Valuation: At 1 April 2010	631
Additions purchased	75
Reclassifications	20
At 31 March 2011	**726**
Amortisation at 1 April 2010	159
Provided during the year	189
Reclassifications	8
Amortisation at 31 March 2011	**356**
Net book value at 31 March 2011	**370**
Purchased	370
Donated	0
Total at 31 March 2011	**370**
Asset financing	
Owned	370
Finance leased	0
Net book value 31 March 2011	**370**

11 Property, plant and equipment

	Land	Buildings, excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture and Fittings	Total
	Total £000	Total £000	Total £000	Total £000	Total £000	Total £000	Total £000	Total £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)**
Reclassified as 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 31 March 2012	**24,862**	**104,995**	**2,813**	**5,318**	**2,579**	**35**	**2,466**	**1,825**	**144,893**

Property, plant and equipment – prior year

	Land	Buildings, excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture and Fittings	Total
	Total £000	Total £000	Total £000	Total £000	Total £000	Total £000	Total £000	Total £000	Total £000
Cost or Valuation: At 1 April 2010	28,178	94,025	6,800	13,423	5,273	359	10,430	5,719	**164,207**
Additions purchased	496	103	11	16,638	110	0	258	234	**17,850**
Reclassifications	0	17,084	0	(17,822)	66	0	482	170	**(20)**
Impairments charged to revaluation reserve	(609)	(48)	(221)	0	0	0	0	0	**(878)**
Revaluation surpluses	0	37	0	0	0	0	0	0	**37**
Reclassified as held for sale	0	0	0	0	0	(28)	0	0	**(28)**
Disposals	0	0	0	0	(496)	0	(1,026)	(78)	**(1,600)**
At 31 March 2011	**28,065**	**111,201**	**6,590**	**12,239**	**4,953**	**331**	**10,144**	**6,045**	**179,568**
Depreciation at 1 April 2010	0	7,618	250	0	2,527	292	8,838	3,633	**23,158**
Charged during the year	0	3,506	197	0	387	32	1,244	352	**5,718**
Impairments charged to income and expenditure	69	209	281	6,354	0	0	0	6	**6,919**
Reclassifications	0	0	0	0	0	0	(8)	0	**(8)**
Disposals	0	0	0	0	(496)	0	(1,026)	(78)	**(1,600)**
Reclassified as held for sale	0	0	0	0	0	(28)	0	0	**(28)**
Depreciation at 31 March 2011	**69**	**11,333**	**728**	**6,354**	**2,418**	**296**	**9,048**	**3,913**	**34,159**
Net book value at 31 March 2011	**27,996**	**99,868**	**5,862**	**5,885**	**2,535**	**35**	**1,096**	**2,132**	**145,409**
Purchased	27,409	93,996	5,862	5,885	2,506	35	1,096	2,132	**138,921**
Finance Lease	587	3,679	0	0	29	0	0	0	**4,295**
On-balance sheet PFI contracts	0	2,193	0	0	0	0	0	0	**2,193**
Total at 31 March 2011	**27,996**	**99,868**	**5,862**	**5,885**	**2,535**	**35**	**1,096**	**2,132**	**145,409**
Freehold	27,409	93,996	5,862	5,885	2,506	35	1,096	2,132	**138,921**
Leasehold	587	5,872	0	0	29	0	0	0	**6,488**
Net book value 31 March 2011	**27,996**	**99,868**	**5,862**	**5,885**	**2,535**	**35**	**1,096**	**2,132**	**145,409**

Analysis of protected assets

	Land	Buildings, excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture and Fittings	Total
	Total £000	Total £000	Total £000	Total £000	Total £000	Total £000	Total £000	Total £000	Total £000
Net book value									
NBV – Protected assets at 31 March 2012	7,815	69,647	0	0	0	0	0	0	77,462
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**
Net book value									
NBV – Protected assets at 31 March 2011	15,788	64,008	0	0	0	0	0	0	79,796
NBV – Unprotected assets at 31 March 2011	12,208	35,860	5,862	5,885	2,535	35	1,096	2,132	65,613
Total at 31 March 2011	**27,996**	**99,868**	**5,862**	**5,885**	**2,535**	**35**	**1,096**	**2,132**	**145,409**

11. Property, plant and equipment continued

A full valuation of all land and buildings was undertaken as at 31 March 2010 on the basis set out in the accounting policies. A further valuation was undertaken at 31 March 2011 and 31 March 2012 of specific properties in Norfolk and Suffolk. 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 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 £11,273k have been recognised in the 2011–12 financial year, £4,728k 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 2012 £000	31 March 2011 £000
Drugs	280	186
Consumables	26	32
Energy	26	14
Total	**332**	**232**

13 Trade and other receivables

	31 March 2012 £000	31 March 2011 £000
Current		
NHS receivables	**1,853**	1,711
Other receivables from related parties	**350**	344
Provision for impaired receivables (note 13.1)	**(304)**	(38)
Prepayments	**1,447**	927
Accrued income	**0**	47
PDC receivable	**138**	52
Other receivables	**1,863**	1,459
Total current trade and other receivables	**5,347**	**4,502**
Non current		
Prepayments	**41**	44
Total non-current trade and other receivables	**41**	**44**
Total	**5,388**	**4,546**

13.1 Provision for impairment of receivables

	Total receivables £000
At 1 April 2011	**38**
Arising during the period	**353**
Utilised during the period	**(4)**
Unused amounts reversed	**(83)**
At 31 March 2012	**304**

13.2 Impaired debtors

	31 March 2012 £000	31 March 2011 £000
Current and up to three months past due	**226**	0
In three to six months	**35**	0
Over six months	**43**	38
Total	**304**	**38**

13.3 Non-impaired debtors

	31 March 2012 £000	31 March 2011 £000
Current and up to three months past due	**2,946**	3,014
In three to six months	**72**	145
Over six months	**0**	142
Total	**3,018**	**3,301**

14 Non-current assets held for sale and assets in disposal groups

	2012 £000	2011 £000
Net Book Value at 1 April	**0**	430
Assets classified as avialable for sale in the year	**3,495**	0
Assets sold in year	**(175)**	(430)
Impairments of assets held for sale	**(86)**	0
Net Book Value at 31 March	**3,234**	**0**

15 Trade and other payables

	31 March 2012 £000	31 March 2011 £000
Current		
NHS payables	**586**	855
Amounts due to other related parties	**724**	806
Trade payables – capital	**2,534**	3,619
Other trade payables	**1,107**	3,801
Other payables	**1,969**	2,140
Accruals	**16,455**	8,964
Total current trade and other payables	**23,375**	**20,185**
Non current Assets		
Accruals	**0**	123
Total non-current trade and other payables	**0**	**123**
	23,375	**20,308**

Other payables include £1,266k outstanding pension contributions as at 31 March 2012 (31 March 2011 £1,275k).

16 Other liabilities

	31 March 2012 £000	31 March 2011 £000
Current		
Lease incentives	**43**	13
Deferred income	**3,314**	3,630
	3,357	**3,643**
Non current		
Lease incentives	**478**	383
	478	**383**
	3,835	**4,026**

17 Taxes payable

	31 March 2012 £000	31 March 2011 £000
Current		
Taxes payable	**2,521**	2,561
	2,521	**2,561**

Taxes payable include PAYE and national insurance contributions.

18 Borrowings

	31 March 2012 £000	31 March 2011 £000
Current		
Loans from Department of Health	**534**	534
Loans from Foundation Trust Financing Facility	**522**	243
Private Finance Initiative liabilities	**106**	98
Finance lease liabilities	**27**	23
Total current borrowings	**1,189**	**898**
Non-current		
Loans from Foundation Trust Financing Facility	**8,673**	5,194
Other loans	**6,665**	7,199
Obligations under finance leases	**21**	29
Obligations under Private Finance Initiative contracts	**4,211**	4,316
Total non-current borrowings	**19,570**	**16,738**
	20,759	**17,636**

Timing of loan repayments

Amounts falling due:	31 March 2012 £000	31 March 2011 £000
In one year or less	**1,056**	777
Between one and two years	**1,056**	839
Between two and five years	**3,170**	2,586
Over five years	**11,112**	8,968
Total	**16,394**	**13,170**
Of which:		
– wholly repayable within five years	**5,282**	4,202
– wholly repayable after five years, by instalments	**11,112**	8,968
	16,394	**13,170**

The Trust has two loans with the Foundation Trust Financing Facility. Both loans are an unsecured loan 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.

Total obligations for on-statement of financial position PFI contracts due:

	31 March 2012 £000	31 March 2011 £000
Not later than one year	**627**	593
Later than one year, not later than five years	**2,667**	2,526
Later than five years	**12,715**	12,798
	16,009	15,917
Less interest element	**(11,692)**	(11,503)
Net PFI obligations	**4,317**	**4,414**

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 on-statement of financial position PFI contracts was £1,005k (2011 £955k) The Trust is committed to the following charges:

	31 March 2012 £000	31 March 2011 £000
Not later than one year	**1,046**	990
Later than one year, not later than five years	**4,450**	4,214
Later than five years	**21,212**	21,710
	26,708	**26,914**

19.4 Imputed finance lease obligations under PFI commitments

Commitments in respect of the lease rentals of the PFI comprise

	31 March 2012 £000	31 March 2011 £000
Rentals due within one year	**627**	593
Rentals due within 2nd to 5th years (inclusive)	**2,667**	2,526
Rentals due later than five years	**12,715**	12,798
Sub total rentals due	**16,009**	15,917
less interest element	**(11,692)**	(11,503)
Total	**4,317**	**4,414**

20 Finance Lease obligations

	Minimum lease payments 31 March 2012	Present value of minimum lease payments 31 March 2012	Minimum lease payments 31 March 2011	Present value of minimum lease payments 31 March 2011
	£000	£000	£000	£000
Within one year	27	27	23	23
Between one and five years	21	21	29	29
After five years	0	0	0	0
Less future finance charges	0	0	0	0
Present value of minimum lease payments	**48**	**48**	**52**	**52**
Included in:				
Current borrowings		43		23
Non current borrowings		5		29
		48		**52**

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 £16.4m loans outstanding at 31 March 2012 (2011 – £13.2m). Further details can be found at note 18.

Monitor has given the Trust a prudential borrowing limit of £28.5m for the year ended 31 March 2012 (2011 – £28m), 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 £14.9m (2011 – £8.4m).

The Trust has not used its working capital facility in either 2011–12 or 2010–11.

The Trust has successfully passed the four ratio tests set out in Monitor's Prudential Borrowing Code.

Financial ratio	Actual ratio 2011/12	Approved PBL ratios 2011/12
Minimum dividend cover	2.1x	>1x
Minimum interest cover	16.3x	>3x
Minimum debt service cover	5.3x	>2x
Maximum debt service cover	0.7%	<2.5%

22 Provisions for liabilities and charges

	Current		Non-current	
	31 March 2012	31 March 2011	31 March 2012	31 March 2011
	£000	£000	£000	£000
Pensions relating to former staff	**265**	259	**2,340**	2,693
Legal claims	**500**	262	**0**	0
Restructurings	**0**	0	**0**	0
Redundancy	**0**	768	**0**	0
Other	**1,221**	840	**1,425**	1,312
Total	**1,986**	**2,129**	**3,765**	**4,005**

Current year

	Total	Pensions relating to former staff	Legal claims	Restructuring	Redundancy	Other
	£000	£000	£000	£000	£000	£000
At 1 April 2011	**6,134**	2,716	262	0	768	2,388
Arising during the period	**1,421**	75	366	0	0	980
Utilised during the period	**(1,392)**	(265)	(115)	0	(528)	(484)
Reversed unused	**(525)**	0	(13)	0	(240)	(272)
Change in discount rate	**0**	0	0	0	0	0
Unwinding of discount	**113**	79	0	0	0	34
At 31 March 2012	**5,751**	**2,605**	**500**	**0**	**0**	**2,646**

Prior year	Total	Pensions relating to former staff	Legal claims	Restructuring	Redundancy	Other
	£000	£000	£000	£000	£000	£000
At 1 April 2010	**5,721**	2,918	227	465	544	1,567
Arising during the period	**1,954**	71	198	99	382	1,204
Utilised during the period	**(1,345)**	(244)	(84)	(564)	(158)	(295)
Reversed unused	**(128)**	0	(79)	0	0	(49)
Change in discount rate	**58**	59	0	0	0	(1)
Unwinding of discount	**(126)**	(88)	0	0	0	(38)
At 31 March 2011	**6,134**	**2,716**	**262**	**0**	**768**	**2,388**

Expected timing of cash flow at 31 March 2012

	£000
Within one year	1,986
One to two years	340
Two to five years	1,020
Over five years	2,405
Total	**5,751**

The pensions provision relating to former 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 £1,518k in respect of Injury Benefits awards. 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. Other provisions also included £1,107k for additional costs relating to TUPE transferred staff.

£1,342k is included in the provision of the NHS Litigation Authority as at 31 March 2012 in respect of clinical negligence liabilities of the Trust (31 March 2011 £289k).

23 Revaluation Reserve

	Property plant and equipment £000
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**
Revaluation reserve at 1 April 2010	**33,151**
Revaluation and impairment losses on property plant and equipment	**(878)**
Net gain on revaluation of property plant and equipment	**37**
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and Expenditure Reserve	**(473)**
Other recognised gains and losses	**0**
Revaluation reserve at 31 March 2011	**31,837**

24 Cash and cash equivalents

	2012 £000	2011 £000
At 1 April	**32,616**	30,964
Net change in year	**(12,541)**	1,652
At 31 March	**20,075**	**32,616**
Broken down into:		
Cash at commercial banks and in hand	**472**	393
Cash with the Government Banking Service	**19,603**	32,223
Cash and cash equivalents as in Statement of Financial Position	**20,075**	**32,616**
Cash and cash equivalents as on Statement of Cash Flows	**20,075**	**32,616**

25 Third party assets

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 2012 the cash held on behalf of third parties was £356k (31 March 2011 – £395k).

26 Capital commitments

As at 31 March 2012, the Trust has entered into contracts to purchase property plant and equipment for £2,915k (31 March 2011 – £14,467k). These commitments are expected to be settled in the following financial year.

27 Subsequent events

Subsequent to the Statement of Financial Position date, no events which would require adjustments to the accounts or disclosure have occurred.

28 Contingencies

The Trust has no contingent liabilities or assets at 31 March 2012 (31 March 2011 – £nil)

29 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 (2010–11 – £nil).

	Income £000	Expenditure £000
Department of Health	**1**	**0**
East of England Strategic Health Authority	**3,854**	**4**
NHS Norfolk	**78,810**	**1,543**
South East Essex PCT	**19,057**	**0**
Suffolk PCT	**70,184**	**78**
Ipswich Hospital NHS Trust	**4**	**981**
Other NHS Bodies	**34,462**	**5,161**
Other	**11,262**	**49,927**
Total value of transactions with related parties in 2011–12	**217,634**	**57,694**
	26	0
Department of Health	4,305	15
East of England Strategic Health Authority	77,228	1,369
NHS Norfolk	19,175	0
South East Essex PCT	68,591	75
Suffolk PCT	7	618
Ipswich Hospital NHS Trust	35,607	5,749
Other NHS Bodies	15,064	30,410
Other	**220,003**	**38,236**
Total value of transactions with related parties in 2010–11		

	Receivables £000	Payables £000
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2012	**0**	**0**
Department of Health	**0**	**710**
East of England Strategic Health Authority	**8**	**120**
NHS Norfolk	**458**	**788**
South East Essex PCT	**119**	**0**
Suffolk PCT	**1,060**	**61**
Ipswich Hospital NHS Trust	**0**	**152**
Other NHS Bodies	**208**	**1,013**
Other	**769**	**2,096**
Total balances with related parties at 31 March 2012	**2,622**	**4,940**
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2011	13	0
Department of Health	29	0
East of England Strategic Health Authority	(50)	0
NHS Norfolk	692	0
South East Essex PCT	(51)	0
Suffolk PCT	78	118
Ipswich Hospital NHS Trust	1	74
Other NHS Bodies	1,011	959
Other	888	1,470
Total balances with related parties at 31 March 2011	**2,611**	**2,621**

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 £7,449k of expenditure with NHS Professionals for temporary staff costs (2010: £6,096k). 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 Mental Health NHS Foundation Trust Charitable Fund (Charity Number: 1050441) and Suffolk Mental Health Partnership Trust Charitable Fund (Charity Number: 1103563). 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.

30 Losses and special payments

There were 84 cases of losses and special payments totalling £175k approved during the year to 31 March 2012 (94 cases and £114k in the year to 31 March 2011). 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 2011).

31 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, BNP Paribas, Citibank, Credit Agricole, HSBC Bank, 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 15 "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".

31.1 Financial assets by category

	31 March 2012 £000	31 March 2011 £000
Assets as per balance sheet		
NHS receivables (net of provision for impairment of receivables)	**728**	2,551
Other receivables (net of provision for impairment of receivables)	**916**	349
Non current assets held for sale	**3,234**	0
Cash at bank and in hand	**20,075**	32,616
Total	**24,953**	**35,516**

31.2 Financial liabilities by category

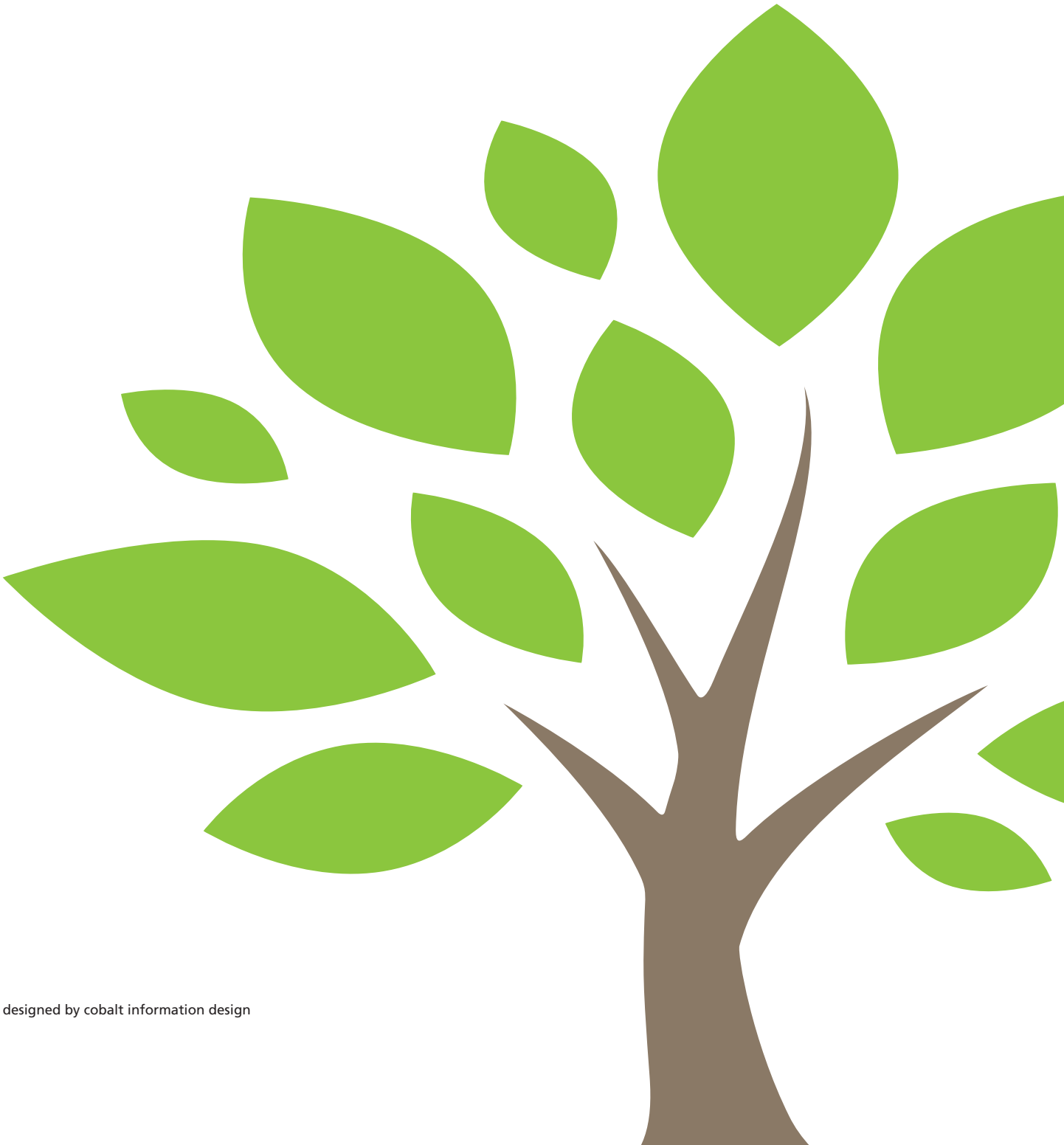
	31 March 2012 £000	31 March 2011 £000
Liabilities as per balance sheet		
NHS payables	**586**	12,553
Loans	**16,394**	13,170
Other payables	**20,748**	3,089
Capital payables	**2,534**	3,619
Obligations under finance leases	**48**	52
PFI and finance lease obligations	**4,317**	4,414
Total	**44,627**	**36,897**

32 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.

32.1 Maturity of financial liabilities

	31 March 2012 £000	31 March 2011 £000
Maturity of financial liabilities:		
Less than one year	**25,058**	20,159
In more than one year but not more than two years	**1,191**	974
In more than two years but not more than five years	**3,568**	2,956
In more than five years	**14,810**	12,808
	44,627	**36,897**



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