Norfolk Community Health and Care NHS Trust

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Annual Report and Accounts 2012/13

Final version 31st May 2013

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1 Chair and Chief Executive's Foreword

Welcome to our review of the year 2012/13. This has been an excellent year for the Trust, with a strong performance in many areas. We should firstly start with patient care. We measure many indicators at the Trust Board to show how well we are serving patients. First and foremost amongst these is patient satisfaction and we are pleased to report that this has remained high throughout the year. We have implemented the new Friends and Family test and have consistently had high returns – amongst the highest in the country. At each Board meeting, we review actual comments that patients have made – many are positive, but where there are areas to be addressed that could have an adverse impact on patients or carers, the Board ensures we tackle these.

We have also made great progress on 'harm free care'. This has been of particular interest to the Board and we have driven down the rates of falls, catheter acquired infections, healthcare acquired infections and pressure ulcers. Our goal was to eliminate pressure ulcers and we have almost done that for our inpatient units. However, we have to report that there is more to do in the community, particularly in people's own homes and in care homes throughout the county. This will continue to be a priority for the coming year. The Trust struggled to meet targets in smoking cessation and staff sickness, and further concerted efforts are underway in these areas to improve performance.

At the same time, we have balanced our books. The financial challenges of the NHS continue to be high, but we are pleased to report that we met our efficiency targets, and indeed increased our surplus. Our thanks go to all staff who showed tremendous commitment and determination to deliver this great achievement.

We are also making good progress on integration with Adult Social Care run by Norfolk County Council. We had a report on our integrated care organisation pilots, which described the benefit of working more closely together. We have therefore brought services together in the west of the county under a single manager. In the coming year, we will explore whether this model will bring benefits across the rest of the county.

In respect of staff, we have worked hard to communicate with staff and engage clinically. At Board meetings, patients and staff come along to relay patient stories. These are usually the highlight of the Board meetings and set the tone for a focus on patient care throughout the meeting. The whole Board have taken time to get out and meet staff. This keeps us in touch with the frontline, but equally allows frontline staff to communicate their concerns directly to the Board. We have seen some evidence from our staff surveys that this is increasing staff morale and increasing the connectivity between the clinical and managerial areas of the Trust. Whilst much media attention has recently been focused on the things that go wrong in the health service after the Francis Inquiry, this constant connection with the Board means that our Board is in touch with patients and staff.

We would like to take this opportunity to acknowledge the hard work of our staff and the fact that so many of them go the extra mile. They don't allow themselves to

be unduly distracted by the many changes being experienced whilst the Trust modernises its services and strives to implement ever improving working practices.

We already do a great deal in partnership with our voluntary sector colleagues such as Voluntary Norfolk and Age UK Norfolk, but there is huge untapped potential for us to achieve more together. Norfolk has a vibrant voluntary sector and excellent health and care services. We look forward to working ever closer with our partner organisations as we see this as key to successfully responding to the challenges ahead.

This year has also seen progress on our Foundation Trust (FT) journey. We remain determined to become an FT although the timing of our achieving this may be influenced by factors beyond our immediate control.

Lastly, we must record the passing of NHS bodies. We developed very successful relationships with NHS Norfolk – the Primary Care Trust – and with the Strategic Health Authority in the east of England. Both these bodies have now gone. We are therefore working hard with our new local colleagues, in particular GPs in our clinical commissioning groups (CCG). We have already held a number of events to establish this relationship as we are keen to move forward in developing services. In addition, our locality clinical management structure is designed to ensure that our services wrap around the GP practice and the CCG in support of their aims. We look forward to another successful year working with these new partners.

Ken Applegate
Chair

Michael Scott
Chief Executive

The Trust's key locations

Did you know?

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

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

2 About the Trust

2.1 Our vision and values

The Trust's vision is to improve the quality of people's lives, in their homes and community, by providing the best in integrated health and social care. The starting point in describing our vision and our services is the patient – providing individualised care, focusing on appropriately keeping people out of hospital and maintaining their independence, for as long as possible. The Trust will achieve this by ensuring that quality of care is central to everything that it does. Services are structured around the patient, working closely with their GPs.

The Trust is committed to the values of:

- Home and community
- Personalised care
- Enabling our people
- Pioneering, innovative, creative and efficient.

2.2 Strategic objectives

The Trust's longer term strategic objectives are:

- **Improving quality for patients** and the public – as experts in community health and care, and by offering the best patient experience in the east of England;
- **Transforming services** – being the commissioners first choice provider and being the positive alternative to acute hospital care;
- **Building the organisation** – The Trust aims to be a clinically-led high performing organisation and the first choice employer for staff;
- **Building sustainability** – to deliver a long term financial model that demonstrates value for money, delivers innovative services and meets the requirements of the Trust's regulators;
- **Building reputation** – to play a leading role within the local health economy as the first choice for patients and GPs, with engaged and influential foundation trust Members and Governors.

The Trust will assess how effectively it is delivering its strategy by monitoring a number of aims, goals and targets:

- **Quality for patients** – key aims include contuing to improve patient satisfaction, attaining 100% referral within 18 weeks, minimising or eradicating the incidence of MRSA, C.diff, pressure ulcers and falls in care;
- **Compliance** – continue to meet standards of care, including no restrictions on CQC registration and a green governance rating from the Trust Development Authority and Monitor.
- **Staff** – goals include improved staff engagement and satisfaction, and reduced sickness absence.

- **GPs** – aim is to achieve high numbers of GPs who are satisfied with the Trust;
- **Finance** – targets include achieving a surplus, and liquidity to ensure financial stability and sustainability.

The business development strategy can be summarised as *defending* the Trust's market share and focusing on core business; *growing* the services we currently provide and *diversifying* the Trust's customer base and delivering new services so that our income is drawn from more sources.

2.3 What we do

The Trust's business units provide:

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

In summary, the Trust:

- Serves the population of Norfolk and Waveney;
- Provides services for a range of NHS and Local Authority commissioners;
- Employs 3,000 staff;
- Delivers care in people's homes, as well as from over 200 different locations, and through over 400 schools;
- Manages nine community hospitals;
- Shows results for the Trust's net promoter score consistently in the top quartile (71 or over);
- Has income forecast c.£125m.

The services provided by the Trust include:

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

CQC registration

The Trust is registered with the Care Quality Commission (CQC) to carry out the provision of legally regulated activities without any conditions on its registration. The CQC has not taken any enforcement action against the Trust during the year.

Norfolk

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

2.4 How we are organised

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

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

	Parent - Infant Mental Health Children's Community Nursing Children's Therapies Child Development Team Community Paediatrics Children's Short Breaks

For 2012/13 the Trust provided community drug and alcohol services and the integrated community equipment store. For 2013/4 these have transferred to other providers.

2.5 More about the Trust

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

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

In January 2011, the Trust launched its public consultation about its proposals to become a Foundation Trust. The consultation exercise was very successful and received positive feedback on the proposals. The Trust has been improving its governance arrangements with a view to becoming a Foundation Trust within the next year.

3 Improving quality and patient safety

3.1 Quality goals

The Trust achieved the following quality goals in 2012/13:

- Implementation of the Safety Thermometer data collection tool;
- Over 95% venous thromboembolism (VTE) assessments for inpatients by December 2012;
- Halved the number of catheter acquired urinary tract infections (CAUTI) by December 2012;
- Reduced the levels of injurious falls in our inpatient units to 4.0 per 1000 occupied bed days or less;
- Improved patient satisfaction to 70% 'very satisfied', with no area less than 50%;
- Implemented the patient experience net promoter score asking in-patients how likely they would be to recommend the service;
- Achieved "You're Welcome" accreditation in the school nursing service.

The Safety Thermometer is a measurement tool developed by the NHS to help frontline staff provide a 'temperature check' on areas of harm caused to patients and service users while under NHS care. It is also used to measure the proportion of patients that are 'harm free' during a working day; for example, at shift handover or during ward rounds. Trialled over the last year within a number of NHS trusts and now a Commissioning for Quality and Innovation target for all NHS trusts, its main purpose is to help us better analyse incidents and incident hot spots and improve the care we offer to our patients.

Implementing the United Nations Children's Fund (UNICEF) Baby Friendly best practice standards is a proven way of increasing breastfeeding rates. And, by adopting Baby Friendly practices, health professionals can give mothers the support, information and encouragement to continue their chosen method of feeding for as long as they wish. The Trust has achieved UNICEF Baby Friendly accreditation at level 1, and is striving to achieve level 2 in 2013/14.

The Trust is close to achieving the goal of achieving zero avoidable pressure ulcers in its community inpatient units.

In addition, the key quality activities undertaken during 2012/13 were:

- 40 pressure ulcer champions identified across the Trust;
- A quarter of our staff attended dedicated pressure ulcer prevention and management training events;
- We delivered 35% more pressure relieving equipment in October 2012, than we had done six months earlier;
- Transfer of care protocol agreed with our main acute partner;
- We continue to show steady progress in eradicating avoidable pressure ulcers in both our inpatient units and the community of which at least 50% occur in care homes;

- The Care Quality Commission inspected Benjamin Court, one of our community rehabilitation units, during 2012/13. The outcome of this inspection was that we were compliant in all five areas assessed. Our five joint learning disability services were also inspected with Norfolk County Council each receiving a fully compliant report.

3.2 Patient experience

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

The friends and family test

The friends and family test, also known as the net promoter score (NPS), is a measure of advocacy for a service as calculated on a rating scale by patients and service users. The Trust has made good progress in the use of the net promoter methodology during the year and will continue to develop this tool as a key indicator of patient satisfaction and service quality. NPS went live in all inpatient areas during May 2012. The results from the net promoter are as follows:

The NPS question is: "how likely is it that you would recommend this service to friends and family?". Patients are being given a feedback card on the day of discharge to rate their score between 1 and 10 and leave any comments as to why they gave that score. A minimum survey size of 10% of all inpatients discharged has been set and this has been achieved and exceeded every month to date.

Baseline results from May and June indicated an overall NPS for inpatients of 52. Results for the remainder of the year are as follows:-

Month	Responses	NPS score
July 2012	39	84
August	67	81
September	30	73
October	67	73
November	64	73
December	50	58
January 2013	27	74
February	64	73
March	56	75

These results remain in the top quartile of 71 or more (the target set for acute hospitals for 2012/13) with the exception of December.

3.3 Patient Environment Action Team (PEAT) Results

These are the 2012 results from the annual Patient Environment Action Team (PEAT) assessments undertaken by the Trust for its inpatient facilities. This assessment focuses on the environment in which care is provided and the quality of non-clinical services, such as food and privacy and dignity.

The Health and Social Care Information Centre publishes the results of all NHS and independent healthcare providers in respect of hospitals with 10 or more inpatient beds. The table below shows the Trust's ratings for 2012.

Site name	Environment score	Food score	Privacy & dignity score
Colman Hospital	Good	Good	Good
Norwich Community Hospital	Good	Excellent	Good
Dereham Hospital	Good	Excellent	Good
St Michaels Hospital	Acceptable	Good	Good
Kelling Hospital	Good	Good	Good
Swaffham Community Hospital	Good	Excellent	Good
Ogden Court, Wymondham	Good	Good	Good
Cranmer House, Fakenham	Good	Excellent	Excellent
Benjamin Court, Cromer	Good	Good	Good

The results of PEAT are published on the NHS Information Centre website www.hscic.nhs.uk and are also available to the public on www.data.gov.uk

From April 2013 the Trust has introduced a new national system for assessing the quality of the hospital environment. Patient-led assessments of the care environment (PLACE) has replaced PEAT inspections. PLACE assessments put patient views at the centre of the assessment process, and uses information gleaned directly from patient assessors to report how well a Trust is performing in the areas assessed – privacy and dignity, cleanliness, food and general building maintenance. The assessments are undertaken annually, and results will be reported publicly to help drive improvements in the care environment. The results will show how hospitals are performing nationally.

Most importantly, patients and their representatives make up at least 50 per cent of the assessment team, which will give them the opportunity to drive developments in the health services they receive locally.

4 Review of 2012/13

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

- Increased the number of health visitors by 29. This is an increase of 13% in line with our status as an early implementer site for a national roll out programme for new parents to receive more help and support from health visitors in their home and community;
- Successfully opened a new 24 bedded unit and outpatient facility in North Walsham to replace existing beds and those at Aylsham, improving the patient environment and sustainability;
- Increased the number of our Sure Start centres, from two to five as the result of a Norfolk County Council tender;
- Implemented a cross Norfolk CCGs-led specification for 24 hours, seven days a week community nursing and therapy services for the whole of our area;
- Met our sustainability targets for carbon reduction and were recognised as the "Most Sustainable Health Organisation" in the national Public Sector Sustainability Awards;
- Celebrated our award winning staff, four newly recognised Queen's Nurses, and an MBE for services to Children and Families.

4.1 Achievement of key performance indicators and performance targets

The Trust has a performance monitoring framework in place including integrated performance reporting to the Board. This allows routine scrutiny against a range of key performance indicators (KPIs) in key areas. KPIs are the nationally recognised method for calculating performance in the NHS and highlights are summarised in the table below. These include the national performance measures relevant to the Trust's services from the Operating Framework for the NHS in England 2012/13.

Infection control

Indicator	2011/12 performance	Target or annual threshold	2012/13 outturn	Status
Cases of clostridium difficile	8	9	3	Achieved
Cases of MRSA bacteraemia	0	1	2	Not achieved

Access

Indicator	2011/12 performance	Target or annual threshold	2012/13 outturn	Status
Percentage of beds occupied by patients whose discharge is delayed for non-medical reasons	4.1%	3.7%	5.4%	Not achieved
Percentage of patients treated within 18 weeks of referral	98.7%	95%	98.4%	Achieved
Percentage of equipment items delivered to patients within seven days of receipt of referral	99.4%	99%	98%	Not achieved

Public Health

Indicator	2011/12 performance	Target or annual threshold	2012/13 outturn	Status
Percentage of new birth visits made within 28 days of a birth	97%	95%	97.9%	Achieved
Percentage of women fully breastfeeding at six weeks	36%	21%	35.4%	Achieved
Number of smokers successfully quitting at four weeks	2,051	2,000	1,600 estimated	Not achieved
Human Papillomavirus vaccination uptake	Achieved	Contracted levels	Contract met	Achieved

Explanation of the performance targets

Infection control targets

The infection control indicators provide a measure of the number of Clostridium difficile (C.diff) cases and MRSA bacteraemia cases attributable to the Trust.

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

Cases of MRSA bacteraemia: is responsible for several difficult-to-treat infections. Many MRSA infections occur in hospitals and healthcare facilities, with a higher incidence rate in nursing homes or long-term care facilities. Hand-washing is essential to prevent cross infection. The Trust did not achieve the required threshold. By way of context, Monitor operates a proportionate, risk-based system of regulation, with a de minimis threshold of up to six hospital attributable cases applied. The Trust was within Monitor's de minimis threshold. The Trust continues to apply strict infection controls measures to aim for no cases of MRSA.

Access targets

Delayed transfers of care: provides a measure of the percentage of beds occupied by patients whose transfer is delayed for non-medical reasons. Delays result in patients staying in a hospital bed for longer than is medically necessary and is often a result of patients waiting for care assessments. This indicator is used as a measure as to how effectively a health and care system works, given these patients often have complex health and social care needs. The Trust did not achieve this target. The Trust continues to work closely with all local health and social care providers in its action planning to reduce delayed transfers of care.

Percentage of patients treated within 18 weeks of referral: monitors the level of compliance against the 18 week wait referral to treatment target for non-admitted patients, i.e. outpatients. It is calculated by the total number of definitive treatments which were not subject to an unnecessary breach divided by the total number of definitive treatments occurring in the reporting period, expressed as a percentage.

Community equipment store deliveries: monitors the percentage of community equipment store items delivered within seven days following the receipt of a referral. The calculation is the total number of items delivered within seven days, divided by the total number of items delivered, expressed as a percentage. The Trust narrowly missed this target. From April 2013, this service transferred to NRS Healthcare.

Public Health targets

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

Percentage of women fully breastfeeding at six weeks: is a locally agreed target with commissioners. This is aimed at increasing the number of mothers breastfeeding up to 6 weeks.

Smoking cessation: monitors the level of successful four week quits delivered by the Smokefree service against the contractual target agreed with the main commissioner. The Trust has agreed an annual target for patients who successfully quit after four weeks of setting a quit date. The Trust missed this target because it was unable to generate sufficient referrals to meet the contracted level. An action plan has been developed for 2013/14 to address this.

Human Papillomavirus (HPV) uptake: monitors the uptake of HPV vaccinations against the contractual target agreed with commissioners. Since September 2008 there has been a national programme to vaccinate girls aged 12 to 13 against the virus. This age-group is usually in year 8 at schools in England. The programme is delivered largely through secondary schools by the school nursing staff and consists of three injections.

4.2 Partnership working

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

4.3 Becoming a Foundation Trust (FT)

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

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

4.4 Foundation Trust Membership

The Trust has two categories of membership, in preparation for FT status. Public membership is open to anyone aged 14 years and over living in Norfolk and surrounding areas. Our strategy is to build a broad membership that is evenly spread geographically across the local area we serve and reflects the ages and diversity of our population. We have over 9,000 public members. The second category is staff membership. This is open to staff on permanent or fixed term contracts that run for 12 months or longer. Staff automatically become members, unless they opt out although few choose to do so. We have 3,000 staff members who are aligned to one of five constituencies according to their work base.

Members will:

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

In preparation for FT status, members will:

- be able to elect their representatives onto the Council of Governors;
- be able to stand as a Governor, if they are aged 16 and over, and meet certain basic criteria.

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

4.5 Managing our principal risks

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

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

- Improving quality for patients and the public: risks to patient safety, clinical effectiveness and patient experience;
- Transforming services: risks to operational performance, and risks arising from the changing commissioning landscape;

- Building the organisation: risks to clinical leadership, achieving Foundation Trust status, workforce assurance and human resources;
- Building sustainability: economic and demographic funding risks, and local organisational risks including the cost improvement programme, IM&T strategy implementation and the transfer of estates to the Trust;
- Building reputation: risks to providing appropriate alternative care to acute hospital admission, locally responsive services and competition risks.

4.6 Financial performance

2012/13 saw the Trust generate a £2.7m surplus for the year, exceeding its plan by £1.6m and thereby meeting its statutory duty to break even. The Trust also remained within its resource limits set by the Department of Health.

The Trust's financial plans for 2012/13 were ambitious and the achievement of these plans demonstrated the movement from an underlying deficit of £0.2m in 2011/12 to an underlying surplus, along with a significant Cost Improvement Programme (CIP) that helped underpin the Trust's financial strategy. Operational challenges that impacted on the financial performance included an orderly exit from a poorly performing commercial contract, moving fully to a locality based structure, preparing for the transfer of community estate from NHS Norfolk and Waveney (which took place on the 1st April 2013).

Significant efficiency savings were achieved through the Trust's Cost Improvement Programme (CIP) of £10.0m during the year (£6.1m in 2011/12) which was an overachievement against target of £1.1m. Much of this was achieved through the redesign and modernisation of clinical services, as well as non-clinical savings from procurement initiatives. Non-recurrent savings contributed £2.6m to the total.

The Trust is required to remain within its Capital Resource Limit (CRL) as set by the Department of Health. In 2012/13, the Trust underspent by £0.1m against its CRL of £2.8m, representing capital investment of 97% of plan. Key areas of investment during the year were IT infrastructure and clinical equipment to support the efficient delivery of patient care.

Working capital has been stable throughout the year. The Trust remains committed to prompt payment of suppliers by aiming to comply with the Confederation of British Industry (CBI) Better Payments Practice Code and is a signatory to the government's Prompt Payments Code. 2012/13 saw a slight reduction on the previous year's performance, with 86% of non-NHS trade payables being paid within 30 days (89% in 2010-11). 79% of NHS payables were paid within 30 days (74% in 2010-11). Details of compliance with the Better Payment Practice code are detailed in note 10.1 to the accounts.

Over the coming year the Trust will build on the strong financial position delivered in 2012/13 in line with its long-term financial strategy and annual plan (both of which are available on the Trust's website). Focus remains on strengthening the Trust's business platform as the basis for providing sustainable, high quality care to its patients. This will be achieved through the continued delivery of the Cost Improvement Programme, strengthening core business and developing new

service opportunities. A defining and exciting feature of the 2013/14 financial year will be the inward transfer of community estate with effect from 1st April 2013 (following the closure of NHS Norfolk and Waveney), which significantly increases the Trust's asset base by c£53m and gives the Trust more opportunities to make the best use of its estate.

Financial disclosures

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

- External audit fees

The Trust's external statutory audit for the 2012/13 financial year has been provided by Ernst & Young LLP at a cost to the Trust of £70,082 (inclusive of VAT). Ernst & Young LLP has not provided any other services to the Trust during this period.

- Critical accounting judgements

In preparing the 2012/13 accounts that accompany this report, critical judgements have been made in assessing the lease classification of estates rental charges from NHS Norfolk and Waveney. Department of Health guidance has been followed in applying IAS 17 Leases, with the resulting classification of the leases as operating leases.

- 'Off-payroll' arrangements

As part of the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, public sector organisations are required to disclose information in relation to any "off-payroll" arrangements that are, or have been, in place since 31 January 2012. The Trust has a policy that requires all employees to be paid through the Trust's payroll system, or through an agency contract in the case of temporary staff. Any engagements for the services of individuals that do not meet the criteria to be considered an employment contract are conducted on a commercial basis through a commercial contract for services. There have been no exceptions to this policy during the period in question and therefore the Trust has no "off-payroll" arrangements to disclose.

5 Our prospects for 2013/14 and beyond

5.1 Focus on quality

The Trust's Quality Goals are:

To continue embedding a culture of compassionate care and act on the learning from the Francis Report. This was published in February 2013 by Robert Francis QC following an extensive inquiry into failings at Mid-Staffordshire NHS Foundation Trust. Our approach to quality demonstrates that the Trust will:

- Treat all our patients with care and compassion;
- Ensure that every patient is treated with respect, privacy and dignity;
- Ensure the safety of patients / service users in our care;
- Raise the organisational visibility of all our vulnerable adults and children to improve their safety;
- Be open and transparent;
- Implement regular mortality reviews.

To develop and promote our approach to clinical effectiveness. This year the Trust will engage all clinicians across the Trust to develop a shared set of clinical effectiveness measures that can be used to demonstrate improved patient care. This will be achieved by focusing on:

- Reviewing the programme of clinical audit;
- Admission avoidance with community teams;
- Length of stay in community hospitals.

To meet our Commissioning for Quality and Innovation goals on:

- Friends and Family test;
- NHS Safety Thermometer;
- Dementia care;
- Venous Thromboembolism;
- System wide assurance processes for admission avoidance;
- Breastfeeding initiative;
- Lymphoedema;
- Neurology;
- Continuing healthcare.

5.2 Transformation programme

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

- Mobile working;
- Streamlined systems;

- Workforce and service planning;
- Supply chain management;
- Travel and estates rationalisation.

The ‘golden thread’ running through our plans for 2013/14 is that we will deliver transformation, in order to improve quality yet further.

The Trust will build on the strong relationships we have developed with Clinical Commissioning Groups and partner providers. In 2012/13 the Trust implemented a new CCG led specification for community nursing and therapy. The Trust will continue to be responsive to commissioner expectations, building integration within and across care pathways.

5.3 Clinical strategy

The key objectives of our clinical strategy are to:

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

The Trust has included a draft service development improvement plan within its contract with the main commissioner for 2013/14. The main elements of this are:

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

5.4 Patient experience in 2013/14

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

- Demonstrating improvements in patient experience using the net promoter score;
- Reviewing results from the community services survey and implementing actions as required;

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

5.5 Competition assessment

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

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

6 Our Staff

The Trust employs over 3,000 staff across the Trust, together with over 600 volunteers working within its services. Most volunteers are managed through a partnership with Voluntary Norfolk, a registered charity. Trust staff work from over 200 sites across Norfolk, in addition to providing services in over 400 schools and within people's homes. They include 10 community hospitals, GP surgeries and healthcare centres. The Trust also currently manages services from five Sure Start Children's Centres.

6.1 Staff engagement

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

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

The Workforce Strategy contains a number of objectives:

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

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

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

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

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

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

6.2 Sickness absence

Absence management in the Trust has continued to be a challenge against the backdrop of increasing demand, and an ageing workforce. We have increased the uptake of flu vaccinations in 2012/13 but will want to see further uptake in 2013/14. 25% of staff received flu vaccinations: an increase from 20% in 2011/12, whilst falling short of the internally agreed target of 50%.

The Trust set the sickness target at April 2012 to be 4.5%, decreasing to 4.0% by March 2013. Our actual rolling 12 month sickness rate for the Trust stands at 5.0% as at the end of December 2012 (based on data analysed by the NHS Information Centre as issued in May 2013). Total days lost in the period January 2012 to December 2012 were 25,584; equivalent to 2,261 staff years lost and equating to an average of 11.3 working days lost per person. We have focused on complex sickness cases in an effort to meet our target: long term sicknesses (eg musculo-skeletal conditions, stress, anxiety) account for approximately 60% of our current sickness.

6.3 Staff surveys

Staff opinion is regularly surveyed using both national and local questionnaires. The 2012 national staff survey was carried out from October to December 2012 and sent to a sample of 778 staff. Our 59% response rate was a 6% improvement on 2011 and is in line with the top national response rate of 60%;

Of the 21 community NHS trusts surveyed across England only two improved their engagement score more than the Trust and only three had a higher number of improved significant key findings compared to 2011. On these measures the Trust is in the top four fastest improving community NHS trusts in the country. However, there were also areas for improvement identified in comparison to other community NHS trusts. The high level results are summarised below:

Positive results

- 92% of staff stated they had an appraisal in the last 12 months (5% above average; 4.75% improvement on our 2011 results);
- 72% of staff feel able to contribute towards improvements at work (4.75% above average; 10.25% improvement on our 2011 results);
- 16% of staff stated they had experienced harassment, bullying or abuse from staff in the last 12 months (4% better than national average; this was a question);

- 5% of staff stated they had experienced discrimination at work in the last 12 months (4% better than national average; 7.5% improvement on our 2011 results);
- 23% staff stated they had felt pressure in the last three months to attend work when feeling unwell (4% better than national average; same as our 2011 results).

Areas for improvement in comparison to other community NHS trusts

- 69% of staff feel satisfied with the quality of work and patient care they are able to deliver (7.5% below national average; positive increase of 7% on our 2011 results);
- 33% of staff stated they have had a well-structured appraisal in the last 12 months (5% below national average; positive increase of 6% on our 2011 results);
- 52% stated hand washing materials are always available (5% below national average; score remained same as our 2011 results).

The Trust has implemented regular local staff surveys and action plans to address all areas requiring improvement in order to monitor progress.

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

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

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

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

6.5 The Trust's policy on equal opportunities.

The Board is committed to improving the equality performance of the Trust, making it part of its mainstream business and for all staff to meet the evidential requirements of the Equality Act, especially the public sector equality duty, and the statutory duty to consult and involve patients and communities and other local interests (Health and Social Care Act 2012 and Equality Act 2010). The Trust has published Equality Objectives under the following headings:

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

7 About the Trust Board

7.1 Board of Directors

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

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

Two Designate Non-Executive Directors have also been appointed during the year as part of our succession planning, to complement the skills of the Board, and to provide additional independent scrutiny and expertise at committee level. Derek Allwood has actuarial, accountancy and commercial strategy skills, and Professor Ian Harvey, Dean of the Faculty of Health and Medicine at the University of East Anglia has medical and public health expertise.

Ken Applegate Chair

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

Michael Scott Chief Executive

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

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

Dr Rosalyn Proops Medical Director

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

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

Anna Morgan Director of Nursing, Quality and Operations

Anna is a nurse with over 25 years experience which includes working in adults and older peoples' services. Anna has also worked within private care homes as well as managing homes specialising in care for older people, people with dementia and young people with physical disabilities.

Anna was the Service Director of an Essex-based healthcare provider and has vast experience in the modernisation of health services, and integration of teams. Most

recently she has fulfilled a secondment to the Department of Health and is currently developing health guidance for Safeguarding Adults.

Paul Cracknell Director of Strategy and Transformation

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

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

Roy Clarke Director of Finance

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

Non voting corporate Executive Director

Matt Colmer Director of Performance and Information

Previous to becoming Director of Performance and Information, Matt was Associate Director of Finance for NCH&C, fulfilling this role since the organisation was formed in 2008. Prior to the merger of five Norfolk PCTs into one to create

NHS Norfolk, Matt spent five years with South Norfolk PCT as Director of Finance. Immediately following the merger, he took on responsibility for the financial management of the provider element of NHS Norfolk, as Assistant Director of Finance (Provider).

Non-Executive Directors (NED)

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

Vivienne Clifford-Jackson

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

Neil Harrison

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

James Ross

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

Alex Robinson

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

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

Lisa Gamble

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

number of roles including the Chairman of the Norfolk Development Awards Panel, member of the Norfolk, Hertfordshire and Cambridge Boards.

Designate Non-Executive Directors

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

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

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

Derek Allwood

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

Professor Ian Harvey

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

Register of Directors

Name	Designation	Role
Ken Applegate	Non-Executive	Chair
Alex Robinson	Non-Executive	Deputy Chair
James Ross	Non-Executive	
Lisa Gamble	Non-Executive	
Patrick Harris	Non-Executive	Audit Chair until October 2012
Neil Harrison	Non-Executive	Audit Chair from November 2012
Vivienne Clifford-Jackson	Non-Executive	Senior Independent Director
Michael Scott	Executive	Chief Executive
Roy Clarke	Executive	Director of Finance
Anna Morgan	Executive	Director of Operations until August 2012 Director of Nursing, Quality and Operations from September 2012.
Dr Ian Mack	Executive	Medical Director until October 2012.
Dr Rosalyn Proops	Executive	Interim Medical Director From October 2012 to February 2013. Medical Director from February 2013.
Loyola Weeks	Executive	Executive Nurse and Director of Quality & Risk until August 2012.
Tracey Parkes	Executive (non voting)	Interim Director of Human Resources until April 2012.
Derek Allwood	Non-Executive (non voting)	Designate Non-Executive Director from January 2013
Professor Ian Harvey	Non-Executive (non voting)	Designate Non-Executive Director from January 2013
Matt Colmer	Executive (non voting)	Director of Organisational Performance until November 2012. Director of Performance

		and Information from November 2012.
Paul Cracknell	Executive	Interim Director of Business Development (non-voting) until May 2012. Director of Strategy and Transformation from May 2012.

Register of Directors' Interests

Name and Position	**Interest declared**	
Ken Applegate Chair	UNAT Direct Lowestoft College Lowestoft and Waveney Education Services Ltd	Non Executive Director Governor Director
Michael Scott Chief Executive	Barrowby Management Solutions Limited (No current NHS contracts)	Director
Derek Allwood Designate Non Executive Director	Abacus Management Consultants Limited	Owner (not Director)
Roy Clarke Director of Finance	None	
Vivienne Clifford-Jackson Non Executive Director	Residential landlord – small monthly rental income Clifford Consulting – training and communications Town Green Centre, Wymondham Methodist Church	 Layworker (staff member)
Matt Colmer Director of Performance and Information	City College, Norwich	Chair
Paul Cracknell Director of Strategy and Transformation	The Open Youth Trust	Trustee / Director of Charitable Company
Lisa Gamble Non Executive Director	Dream On – Community Interest Company	Company Director
Patrick Harris Non Executive Director	None	
Neil Harrison Non Executive Director	The Florida Group (Footwear)	Non Executive Director

	University of East Anglia	Lay member of Audit Committee
Professor Ian Harvey Designate Non Executive Director	Responsible for overseeing three UEA schools of NSC (School of Nursing Sciences), MED (Norwich Medical School) and AHP (School of Allied Health Professionals). Attendance at regular meetings of the Executive Team of which he is a member. Attendance at University meetings of Senate and UEA Council. Chairs regular meetings of the FMH Executive.	Executive Dean of the Faculty of Medicine and Health Sciences, University of East Anglia
Anna Morgan Director of Nursing, Quality and Operations	Publications review all articles that have Safeguarding/LD/Older People context.	Peer Reviewer for RCN
Dr Rosalyn Proops Medical Director	Ministry of Justice Committee Concerned with Children and Young People in the secure estate Spouse is Chair of Age UK, Norfolk	Member
Alex Robinson Non Executive Director	Millfield Primary School Alex Robinson Limited Ortoo Technologies Limited	Governor Director Director
James Ross Non Executive Director	Novartis Pharmaceuticals UK Ltd	Participation in focus groups and clinical trials
Dr Ian Mack Medical Director	Borough Council King's Lynn and West Norfolk Watlington Medical Centre Watlington Health Transitional Executive West Norfolk Shadow GPC	Elected Member Partner Director Member
Loyola Weeks Director of Quality and Risk/ Executive Nurse	University of East Anglia	Honorary Senior Lecturer 2012-2015

Tracey Parkes Interim Director of Human Resources	None	

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

Board attendance

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

	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
Ken Applegate	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓
Alex Robinson	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
Vivienne Clifford-Jackson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patrick Harris	✓	✓	✓	✓	X	✓	✓					
Neil Harrison							✓	✓	✓	✓	✓	✓
James Ross	✓	✓	✓	✓	✓	✓	X	✓	X	✓	✓	✓
Lisa Gamble	✓	X	X	✓	✓	✓	X	✓	✓	✓	X	✓
Derek Allwood										✓	✓	✓
Prof Ian Harvey										X	X	✓
Michael Scott	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Roy Clarke	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Ian Mack	✓	✓	✓	X	✓	✓	✓					
Dr Rosalyn Proops								✓	✓	✓	✓	✓
Loyola Weeks	✓	✓	✓	✓								
Anna Morgan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

In addition, the Board also met in closed session, where members of the public were excluded, on the following dates:

- 25 April 2012 (following meeting in public)
- 4 May 2012 (extra meeting)
- 30 May 2012 (following meeting in public)
- 27 June 2012 (following meeting in public)
- 18 July 2012 (extra meeting)
- 25 July 2012 (following meeting in public)
- 29 August 2012 (following meeting in public)
- 26 September 2012 (following meeting in public)
- 17 October 2012 (extra meeting)
- 31 October 2012 (following meeting in public)
- 28 November 2012 (following meeting in public)
- 19 December 2012 (following meeting in public)
- 30 January 2013 (following meeting in public)
- 27 February 2013 (following meeting in public)
- 27 March 2013 (following meeting in public)

7.2 Board Committees

Audit Committee

The Audit Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities, both clinical and non-clinical, that supports the achievement of the organisation's objectives.

Membership and attendance

The Committee's membership during the year was: Patrick Harris (PH), Non-Executive Director and Committee Chair until 1 November 2012 and Neil Harrison (NH), Non-Executive Director and Committee Chair from 1 November 2012, Vivienne Clifford-Jackson (VCJ), Non-Executive Director and Deputy Committee Chair, Lisa Gamble (LG), Non-Executive Director.

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

Date	PH	NH	VCJ	LG
18 May 2012	✓		✓	✓
8 June 2012	✓		✓	X
19 Sept 2012	✓		✓	✓
21 Dec 2012		✓	✓	✓
22 March 2013		✓	✓	✓

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

Quality and Risk Assurance Committee

The committee's role is to enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate clinical governance structures, quality assurance, clinical audit, and risk processes and controls are in place throughout the Trust to:

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

Membership and attendance

The Committee's membership during the year was: Alex Robinson (AR), Non-Executive Director and Committee Chair, Vivienne Clifford-Jackson (VCJ), Non-Executive Director and Deputy Committee Chair until the end of February 2013, Patrick Harris (PH), Non-Executive Director until November 2012 and Neil Harrison (NH) from November 2012, Professor Ian Harvey (IH), Designate Non-Executive Director and Deputy Chair from February 2013, Anna Morgan (AM), Director of Operations until September 2012 and Director of Nursing, Quality and Operations from September 2012, Dr Ian Mack (IM), Medical Director until October 2012, Dr Rosalyn Proops (RP), Medical Director from October 2012, and Loyola Weeks (LW) Director of Nursing, Quality and Risk until the end of August 2012.

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

Date	AR	VCJ	PH	IH	NH	AM	IM	RP	LW
11 April 2012	✓	✓	✓			X	✓		✓
2 May 2012	✓	✓	✓			✓	✓		✓
13 June 2012	✓	✓	✓			✓	✓		✓
18 July 2013	✓	✓	X			✓	✓		✓
5 September 2012	✓	✓	X			✓	✓		
17 October 2012	✓	✓	✓			✓		✓	
21 November 2012	✓	✓			✓	✓		✓	
21 January 2013	✓	✓		✓	X	✓		X	
18 February 2013	✓	✓		✓	✓	✓		✓	
18 March 2013	✓			✓	X	✓		X	

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

Finance and Performance Committee

The committee's role is to:

- Monitor, advise on and recommend to the Board matters relating to financial strategy and policies.
- Advise the Board on the effective and efficient use of resources
- Critically appraise annual budgets (revenue and capital) for the Board's approval.
- Consider the Cost Improvement Plans and QIPP plans for the Board's approval.
- Provide a forum for financial issues to be debated and recommendations made for potential resolution.
- Review performance reporting and support the development of appropriate performance measures and KPIs.
- Review in-year performance and any plans for corrective action.
- Oversee and evaluate the performance management strategy to ensure a framework is in place which allows the performance management against business plan.

Membership and attendance

The Committee's membership during the year was: James Ross (JR), Non-Executive Director and Committee Chair; Alex Robinson (AR), Non-Executive Director and Deputy Committee Chair; Derek Allwood (DA) from January 2013 (attended as an observer in November and December 2012), Designate Non-Executive Director; Roy Clarke (RC), Director of Finance; Anna Morgan (AM), Director of Operations until September 2012 and Director of Nursing, Quality and Operations from September 2012; Paul Cracknell (PC), Interim Director of Business Development until May 2012, and then Director of Strategy and Transformation, and Matt Colmer (MC), Director of Performance and Information (member from August 2012 when the Committee remit was extended to include performance).

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

Date	JR	AR	DA	RC	AM	PC	MC
23 April 2012	✓	✓		✓	✓	✓	
28 May 2012	✓	✓		✓	✓	✓	
25 June 2012	✓	✓		✓	✓	✓	
23 July 2012	✓	x		✓	✓	✓	
28 August 2012	✓	✓		✓	✓	x	✓
24 September 2012	✓	✓		✓	x	✓	✓
29 October 2012	x	✓		✓	✓	x	✓
26 November 2012	✓	✓	✓	✓	✓	✓	✓
17 December 2012	x	✓	✓	✓	x	x	✓
28 January 2012	✓	✓	✓	✓	✓	✓	x
25 February 2013	✓	✓	✓	✓	x	✓	✓
25 March 2013	✓	✓	✓	✓	✓	✓	✓

Charitable Funds Committee

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

Membership and attendance

The Committee's membership during the year was: Patrick Harris, Non-Executive Director and Chair until November 2012, Lisa Gamble Non-Executive Director and Chair from January 2013, Vivienne Clifford-Jackson, Non-Executive Director joined the Committee in April 2013, Roy Clarke, Director of Finance and Anna Morgan, Director of Nursing, Quality and Operations. Derek Allwood, Designate Non-Executive Director has attended the meeting from January 2013 in a non-voting consultancy capacity.

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

Date	PH	LG	RC	AM
11 April 2012	✓	✓	✓	X
3 August 2012	✓	✓	✓	✓
10 August 2012	✓	✓	✓	X
9 January 2013		✓	✓	✓

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

Remuneration and Nominations Committee

The committee's role is to:

- Ensure there is a fair and transparent procedure for developing and maintaining the policy on executive remuneration and for setting the remuneration packages of individual Directors.
- Decide on behalf of the Board on the appropriate remuneration and terms of service for the Chief Executive, Executive Directors and Very Senior Manager posts.
- Reach decisions taking account of best practice, national guidance, and Standing Orders.

- Be informed of the implementation of national pay arrangements for all medical and dental staff employed by the Trust, and be advised by the Trust as appropriate on any relevant matters.
- Ensure there is adequate succession planning in place.

Membership and attendance

All Non-Executive Directors, except the Audit Chair (from November 2012), and the Chair are members of the Remuneration and Nominations Committee which is chaired by Vivienne Clifford-Jackson. To avoid any possible conflicts of interest, and in accordance with good practice guidelines, the Audit Committee Chair is not a member of the Committee. The two Designate Non-Executive Directors may attend in a non-voting consultancy capacity.

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

Date	VCJ	KA	AR	JR	LG	PH
11 April 2012	✓	✓	✓	X	X	✓
13 August 2012	✓	X	✓	✓	X	✓
17 October 2012	✓	✓	✓	✓	✓	✓
9 January 2013	✓	✓	✓	✓	✓	

The Director of Strategy and Transformation and Head of HR attend as mandatory attendees, as required, to provide professional HR advice.

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

8 Emergency preparedness and resilience planning

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

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

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

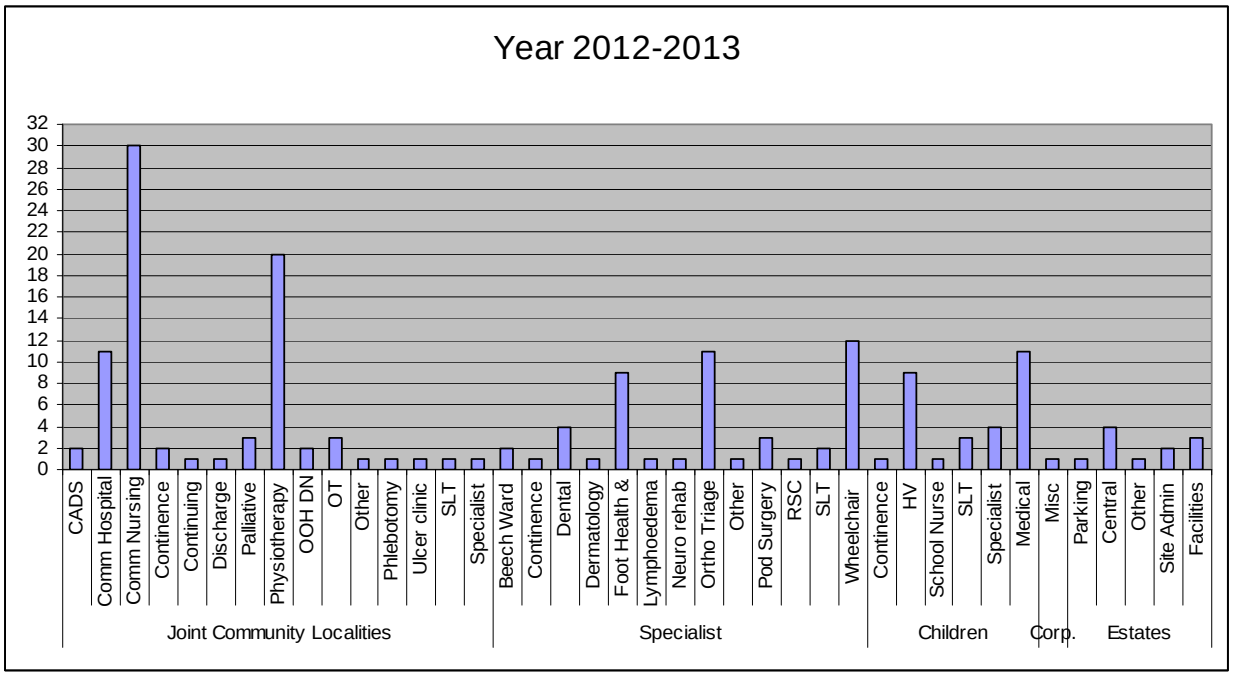
9 Complaints handling

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

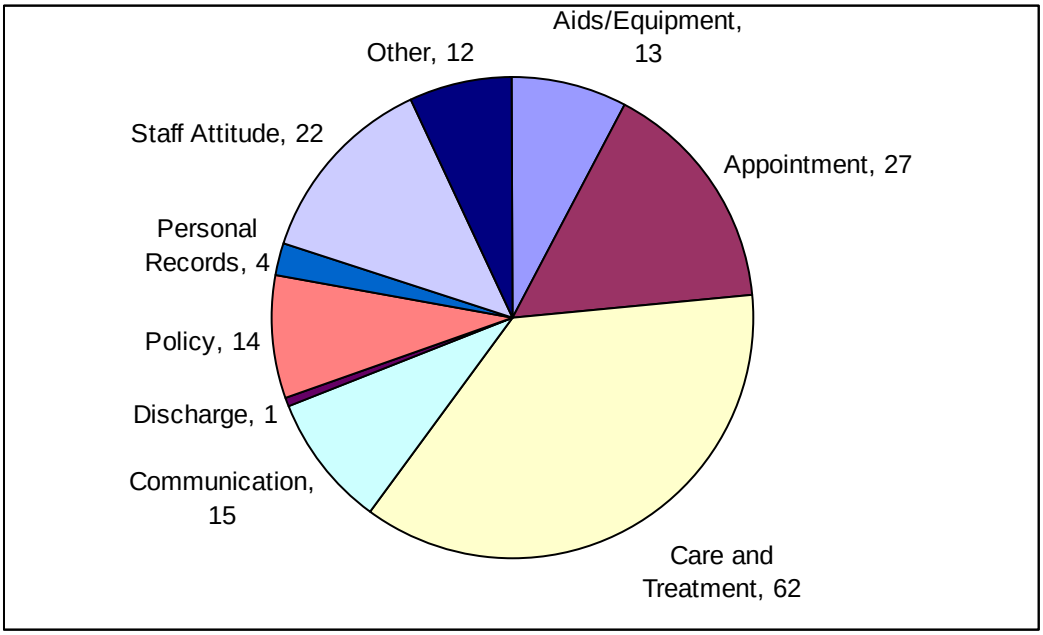
- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

The Trust received 170 complaints this year compared to 202 the year before. Complainants who are unhappy with the Trust's response may ask the Parliamentary and Health Service Ombudsman to review their case. We were notified of three such requests this year but after review the Ombudsman took no further action on these.

The table below shows the number of complaints received by service



The chart below shows the number of complaints by topic



A continual process of learning from complaints is in place and overseen by the Quality and Risk Assurance Committee. Lessons learned from complaints has led to specific improvements in, for example, clearer communication with patients and their families, the co-ordination of care across services and with partner organisations, and enhanced training for certain staff.

10 Sustainability report

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

10.1 Carbon Footprint

The Trust has successfully managed a sustainable development process for the last five years, taking a leading role in partnership with NHS Norfolk, before legal inception of the Trust in November 2010. The Trust has board level leadership with a nominated Executive Director lead for Sustainable Development.

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

The Trust has developed specific reduction targets for each year relating to the initial NHS target of 10% by 2015 e.g. 5% reduction in activity, carbon and cost by 2011/12. All others reductions are outlined below.

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

The Trust has completed carbon footprint assessments for each year between 2007 and 2011 and is about to evaluate its carbon footprint for 2012. The Trust now assesses on the basis of calendar year and actual Trust occupancy at each location. Performance against the Climate Change Act Targets is measured against this 2007 assessment – see figure 1.

GHG Emissions - CO2e		2007/8	2008/9	2009/10	2010/11	2011/12
Non Financial	Gas	2,345	2,212	2,056	1,964	1,988
	Oil	250	241	140	132	141
	Electricity	1,826	2,017	2,104	2,289	2,372
	Lease	905	915	922	1,021	862
	Grey Fleet	1,676	1,695	2,083	1,582	876
	Waste	1,155	1,167	1,177	1,189	1,200
	Water	41	42	44	48	36
	Supply Chain	3,081	3,689	2,166	2,838	2,798
	TOTAL	11,280	11,979	10,692	11,063	10,273
	TARGET	11,280	11,139	10,998	10,857	10,716
Financial	Gas	£255,254	£355,174	£272,142	£239,181	£287,916
	Oil	£32,701	£31,473	£18,341	£18,133	£25,136
	Electricity	£263,441	£299,189	£351,069	£380,484	£374,790
	Lease	£368,309	£372,396	£375,077	£353,907	£368,945
	Grey Fleet	£1,655,385	£643,506	£790,896	£2,109,119	£1,719,388
	Waste	£253,371	£256,183	£258,028	£260,718	£263,168
	Water	£93,425	£103,310	£108,498	£115,290	£118,201
	Supply Chain	£4,527,500	£5,794,531	£3,429,926	£4,347,173	£4,168,240
	TOTAL	£7,449,385	£7,855,762	£5,603,977	£7,824,005	£7,325,784
	TARGET	7,449,385	7,356,268	7,263,151	7,170,034	7,076,916
Avg Cost per tCO2e		£660.41	£655.81	£524.13	£707.25	£713.10

Graphical Analysis

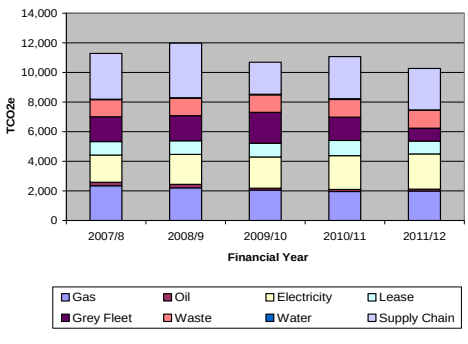


Figure 1. 2007 - 2011 Carbon Footprint Performance

Figure 1 demonstrates that the Trust has over achieved by 4% on its GHG emission target for 2011/12. The Trust has also achieved a 9% carbon footprint reduction against its 2007/08 baseline and are on track to achieve the interim NHS target of 10% by 2015. However, the average cost per equivalent ton of CO2 (TCO2e) has increased by 8% (£52.69) since the baseline year, demonstrating that as carbon usage increases, so does cost to the Trust of the utilities and drivers of carbon usage. There is a clear financial benefit to Trusts reducing its carbon footprint as well as the wider societal benefits.

Supply chain expenditure is the largest contributor to the Trust footprint for 2011/12. Ongoing cost improvement programmes aim to reduce expenditure through the rationalisation of product catalogues and greater spending control. The Procurement Department actively discusses spending activity and stock control with service users to identify product requirements and encourage better spending behaviour.

The Trust aims to include outstanding areas such as air and rail travel under the scope of passenger transport and refrigeration and air conditioning under the scope of energy within its carbon footprint evaluation for 2012/13. This will lead to a fully comprehensive carbon footprint measuring all areas required.

10.2 Sustainable Development Management Plan

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

Estates & Facilities

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

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

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

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

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

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

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

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

10.3 Good Corporate Citizenship

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

The Trust has completed GCC Assessments for each year between 2007 and 2011 and is currently evaluating its performance for 2012. Performance is measured against the Sustainable Development Unit's targets, the first being to score 37% or more in each section by 2012.

Figure 2 demonstrates areas for improvement in transport and community engagement. Good Corporate Citizenship actions are tracked by the Trust's sustainable development committee on a bi-monthly basis. Recent proposals include the development of a new travel policy and communication strategy.

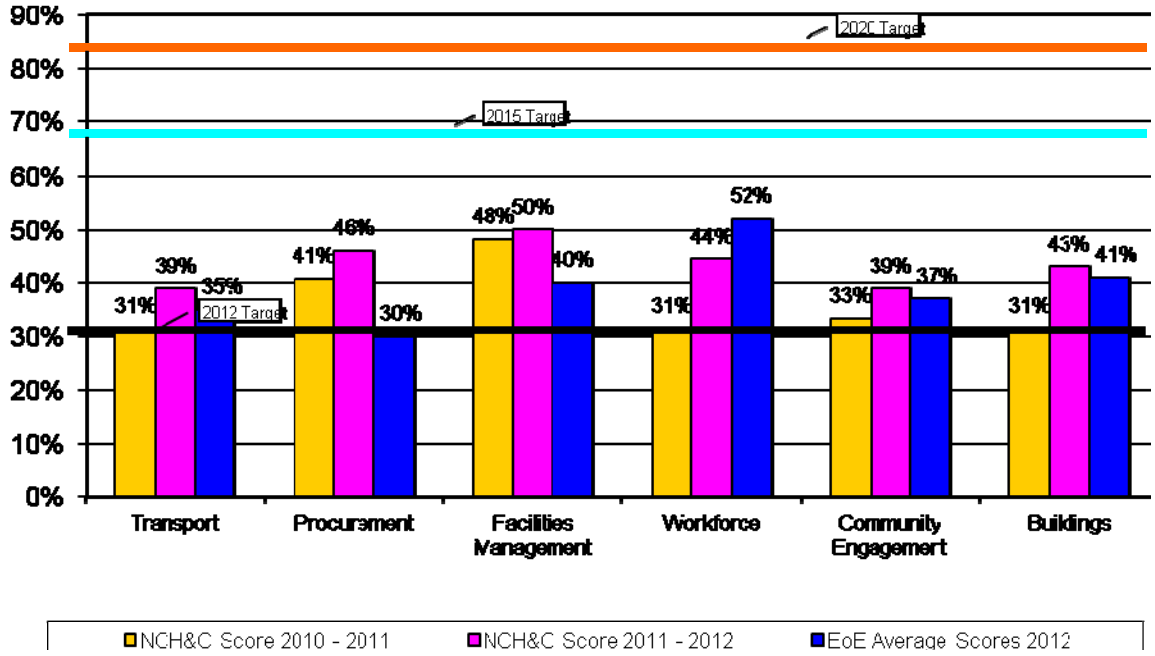


Figure 2. 2010/11 and 2011/12 GCCA performance

11. Serious incidents requiring investigation

The table below shows the number of serious incidents requiring investigation (SIRI). The Trust promotes a positive reporting culture and undertakes a root cause analysis on all SIRIs, ensuring that lessons are learned and acted upon across the full range of its services.

Table 1 shows the number of SIRIs from April 2012 to March 2013

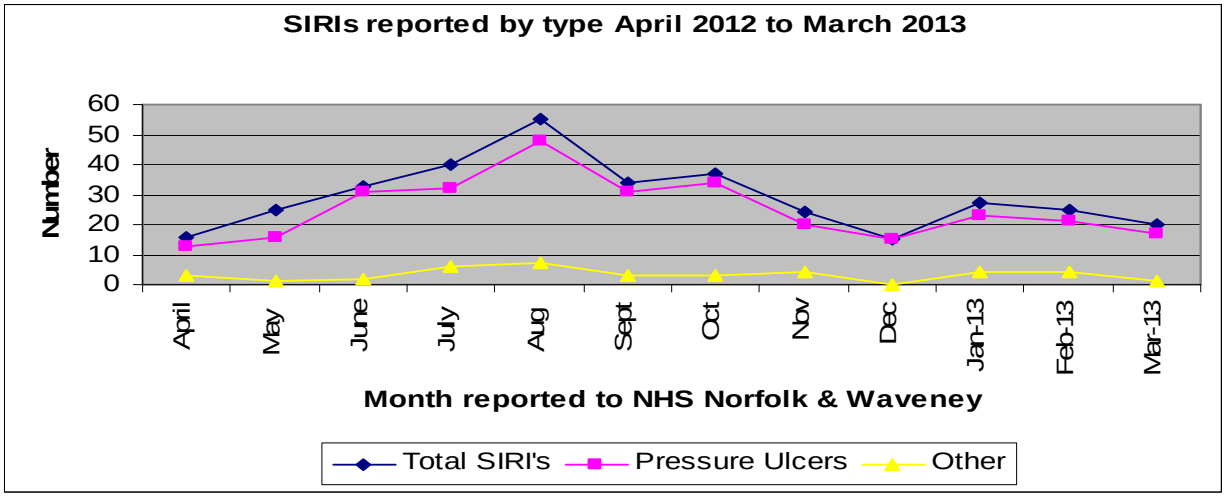


Table 2

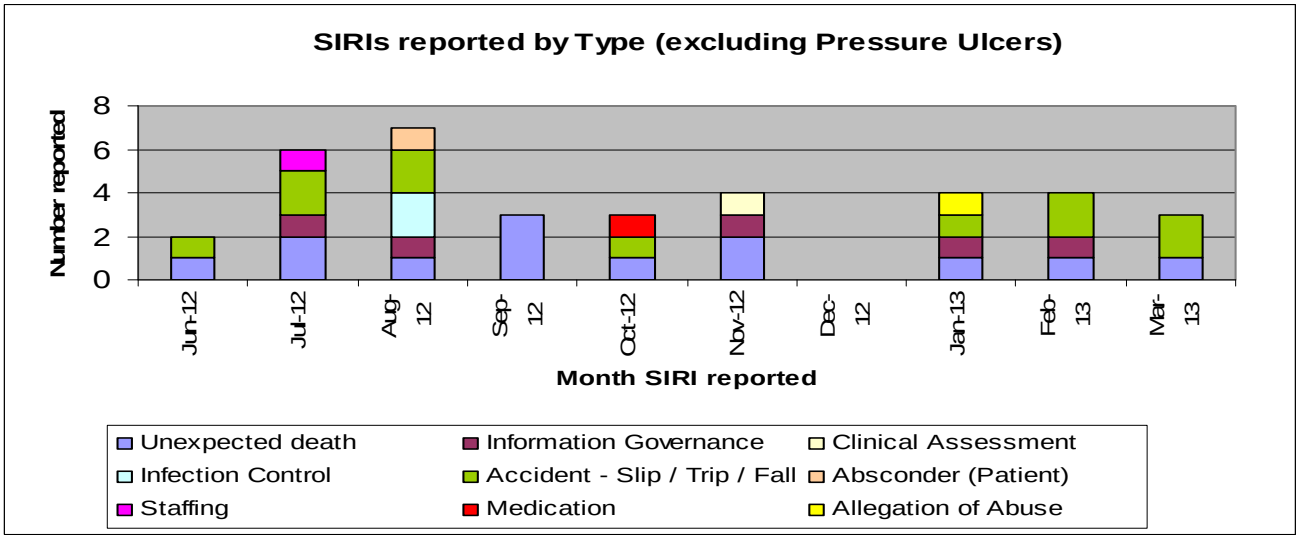


Table 2 shows the type of SIRI (excluding pressure ulcers) reported from June 2012 to March 2013.

Table 3

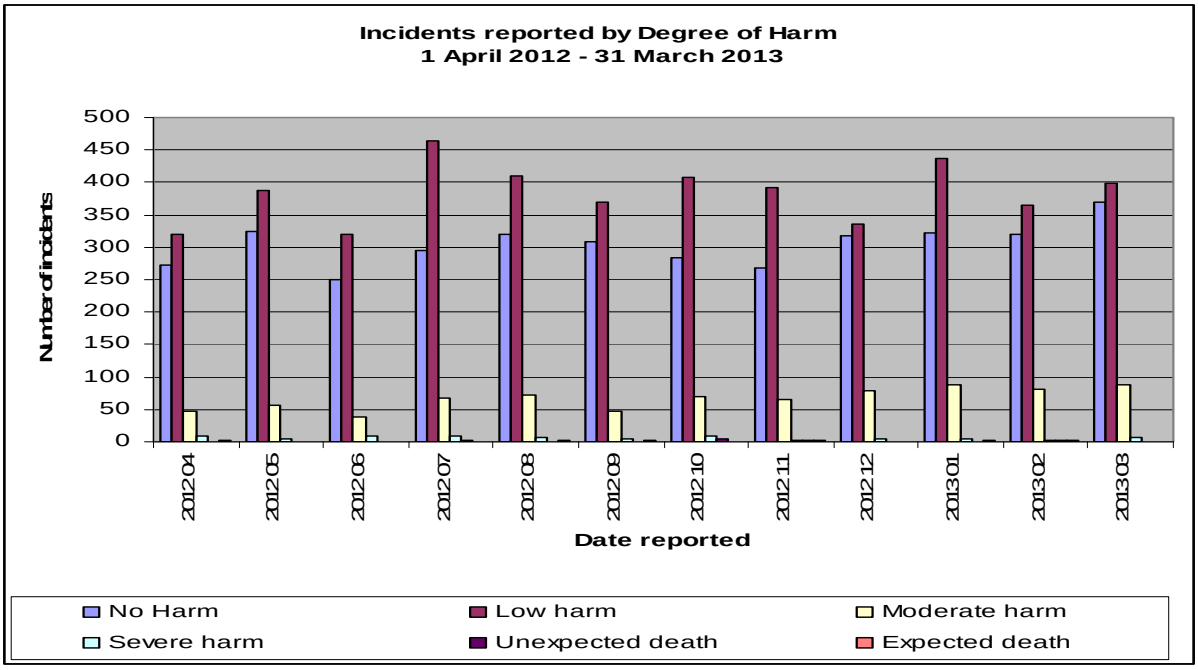


Table 3 shows all incidents reported for the year including no harm, low harm, moderate harm, severe harm, unexpected death and expected death.

Never Events

Never Events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The core list of Never Events published by the Department of Health are: wrong site surgery; retained instrument post-operation; wrong route administration of chemotherapy; misplaced naso or orogastric tube not detected prior to use; inpatient suicide using non-collapsible rails; escape from within the secure perimeter of medium or high secure mental health services by patients who are transferred prisoners; in-hospital maternal death from post-partum haemorrhage after elective caesarean section; intravenous administration of mis-selected concentrated potassium chloride. The Trust has not had any Never Events.

12. Data security

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

13. Charges for information

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

14. Remuneration Report

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

Remuneration Policy

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

In the case of the Chief Executive, a spot salary applies which is calculated on the basis of the weighted population of the County through the Very Senior Managers national framework.

For the other Executive Directors' remuneration, the Trust applies the mandatory guidance given by NHS Employers through the Agenda for Change framework for directors holding employment contracts. For part of the 2012/13 financial year, one of the Executive Directors was seconded from another NHS organisation for part of the year (details below).

Remuneration and Nomination Committee Membership:

Vivienne Clifford-Jackson, Non Executive Director (Committee Chair)
Kenneth Applegate, Trust Chair
James Ross, Non Executive Director
Lisa Gamble, Non Executive Director
Alex Robinson, Non Executive Director

Salaries and allowances

The salaries and other allowances of the senior managers who have been in office during the 2012/13 financial year are disclosed in the table below. Figures for staff appointed or leaving during the financial year are for the part of the year that the individual held the position.

Name	Title	2012-13				2011-12			
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in Kind (rounded to nearest £000)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in Kind (rounded to nearest £000)
		£000	£000	£000	£000	£000	£000	£000	£000
Kenneth Applegate	Chair	20-25	0	0	0	20-25	0	0	0
Michael Scott	Chief Executive	125-130	0	0	6	25-30	0	0	0
Dr. Ian Mack	Medical Director (from 01.04.12 to 05.10.12)	35-40	0	0	0	70-75	0	0	0
Dr. Rosalyn Proops	Interim Medical Director (from 06.10.12 to 05.02.13) Medical Director (from 06.02.13 to 31.03.13)	75-80	0	0	0	0	0	0	0
Loyola Weeks	Director of Quality & Risk (Executive Nurse) (from 01.04.12 to 24.08.12)	45-50	0	0	0	95-100	0	0	0
Anna Morgan	Director of Operations (from 01.04.12 to 31.08.13) Director of Nursing, Quality & Operations (from 01.09.12 to 31.03.13)	100-105	0	0	0	95-100	0	0	0
Matthew Colmer	Director of Organsational Performance (01.04.12 to 31.10.13) Director of Performance and Information (01.11.12 to 31.03.13)	95-100	0	0	0	95-100	0	0	0
Roy Clarke	Director of Finance	100-105	0	0	0	30-35	0	0	0
Paul Cracknell	Interim Director of Business Development (from 01.04.12 to 04.05.12) Director of Strategy and Transformation (from 05.05.12 to 31.03.13)	110-115	0	0	0	35-40	0	0	0
Tracey Parkes	Interim Director of Human Resources (from 01.04.12 to 30.04.12)	0	0	0	0	0	0	0	0
Derek Allwood	Designate Non Executive Director (from 01.01.13 to 31.03.13)	0-5	0	0	0	0	0	0	0
Vivienne Clifford-Jackson	Non Executive Director	5-10	0	0	0	5-10	0	0	0
Lisa Gamble	Non Executive Director	5-10	0	0	0	5-10	0	0	0
Patrick Harris	Non Executive Director (from 01.04.12 to 31.10.12)	0-5	0	0	0	5-10	0	0	0
Neil Harrison	Non Executive Director (from 01.11.12 to 31.03.13)	0-5	0	0	0	0	0	0	0
Prof. Ian Harvey	Designate Non Executive Director (from 01.01.13)	0-5	0	0	0	0	0	0	0
Alexander Robinson	Non Executive Director	5-10	0	0	0	5-10	0	0	0
James Ross	Non Executive Director	5-10	0	0	0	5-10	0	0	0

During the year, payments were made to third party NHS Norfolk and Waveney for the service of director Paul Cracknell for the period 1st April to 30th June 2012.

Pay Multiples

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

The banded remuneration of the highest paid director in the Trust in the financial year 2012-13 was £120-£125k (no change from 2011-12). This was 4.6 times (4.9 in 2011-12) the median remuneration of the workforce, which was £26,556 (£25,528 in 2011-12).

In 2012-13, 3 part-time (3 part-time in 2011-12) employees received remuneration in excess of the highest paid director, with salaries in the £130-135k band.

For the purposes of this calculation, 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.

Pension benefits

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The accounting treatment in relation to pension liabilities is detailed in note 9.5 to the accounts.

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

Name	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 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
Michael Scott	Chief Executive	(2.5-5)	(10-12.5)	50-55	150-155	1043	1036	-47	18
Ian Mack	Medical Director (from 01.04.12 to 05.10.12)	n/a	n/a	60-65	185-190	1251	n/a	n/a	112
Loyola Weeks	Director of Quality & Risk (Executive Nurse) (from 01.04.12 to 24.08.12)	0-2.5	0-2.5	25-30	75-80	0	552	-581	6
Anna Morgan	Director of Operations (from 01.04.12 to 31.08.13) Director of Nursing, Quality & Operations (from 01.09.12 to 31.03.13)	0-2.5	5-7.5	15-20	55-60	325	271	40	14
Matthew Colmer	Director of Organsational Performance (01.04.12 to 31.10.13) Director of Performance and Information (01.11.12 to 31.03.13)	0-2.5	0-2.5	25-30	75-80	395	359	17	14
Roy Clarke	Director of Finance	2.5-5	7.5-10	15-20	55-60	225	179	37	14
Paul Cracknell	Interim Director of Business Development (from 01.04.12 to 04.05.12) Director of Strategy and Transformation (from 05.05.12 to 31.03.13)	n/a	n/a	10-15	30-35	138	n/a	n/a	11

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

Norfolk Community Health and Care NHS Trust

Norfolk Community Health and Care NHS Trust

Annual Accounts 2012/13

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

The Chief Executive of the NHS has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

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

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

Michael Scott
Chief Executive
7th June 2013

Statement of Directors responsibilities in respect of the Accounts

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

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

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

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

By order of the Board

Michael Scott
Chief Executive
7th June 2013

Roy Clarke
Director of Finance
7th June 2013

Annual Governance Statement

1 Scope of responsibility

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

2 The governance framework of the Trust

Board committee structure

The Board comprises the Chair and five Non-Executives drawn from a variety of backgrounds, five voting and one non-voting Executive Directors who lead the clinical and corporate services that deliver quality care to patients and service users. The Board has also appointed two non-voting Designate Non-Executive Directors to strengthen its independent challenge, expertise and succession planning. The Board applies the principles of integrated governance to ensure that clinical services are consistently safe, effective and experience is good, and that resources are used and managed effectively. The Board operates to a forward agenda plan that covers quality, strategy, performance & planning and corporate governance matters. The Board monitors monthly integrated performance reports, quality assurance reports and finance reports covering operational performance, quality and finance, and the Board Assurance Framework. The appropriate committees monitor their areas in more detail, as described below.

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

The Board is supported in particular by Audit, Quality and Risk Assurance, and Finance and Performance Committees specialising in assuring the Board about the effective running of individual areas of the Trust. The Quality and Risk Assurance

Committee provides the leadership, supervision and monitoring of all serious incidents, complaints, claims and Coroner's inquests. This committee provides the overview, enquiry and challenge to ensure consistency; appropriate levels of investigation; root cause analysis and that key learning is delivered. Clear responsibilities and roles within the risk management process ensure that all actions and recommendations identified as part of the process are completed; and that there are effective interfaces between the Trust's directorates, to monitor ongoing compliance. The lessons learnt from these processes are communicated Trust-wide through clear lines of communication.

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

In all cases, the Board receives the approved minutes of each committee and a Chair's report is given of the committees' most recent meetings to communicate the issues the committee has reviewed, its principal findings, assurances and gaps and the direction it is giving on key issues. The Risk Management Strategy and the Board Assurance and Escalation Framework that are approved by the Board clearly outline the strategic intent and the committee structures that support the Board and provide the framework for risk control.

Assessment of Board effectiveness

The Board has undertaken a number of external reviews, observations and evaluations, internal whole Board and individual member self assessments and facilitated sessions. The learning points from the Board effectiveness activities have been taken forward and implemented throughout the year. The Board Development Programme for 2013/14 continues to embed the lessons learned from the activities undertaken during 2012/13, and a series of Board reviews and assessments will continue to take place throughout the coming year. The assessments confirm that the Board is effective and that key learning points are being taken forward. Each committee has also undertaken a self assessment on its effectiveness and performance against its delegated responsibilities as set out in the terms of reference. The committees have also produced annual assurance reports to the Board on how they have discharged their remit throughout the year. The attendance record of the Board and its committees is included in the Annual Report. All meetings have been quorate.

Board Committees have confirmed the following statements in their annual assurance reports to the Board:

The Quality and Risk Assurance Committee concludes that:

- The system of quality and risk assurance is adequate to identify risks and allows the Board to understand the appropriate management of those risks;

- The Board Assurance Framework and Corporate Risk Register are fit for purpose and the comprehensiveness of the assurances and the reliability and integrity of the sources of assurance are sufficient to support the Board's decision making and declarations;
- There are no areas of significant duplication or omission in the systems of governance that have come to the Committee's attention and not been resolved adequately.

The Finance and Performance Committee concludes that:

- The systems for monitoring, advising on and recommending to the Board matters relating to the organisation's financial and performance management strategies and in-year reporting are adequate;
- The systems for advising the Board on the effective and efficient uses of resources are adequate;
- The systems for appraising annual budgets, CIPs and QIPP plans and recommending them to Board are adequate;
- There are no areas of significant duplication or omission in the systems of governance that have come to the Committee's attention.

The Audit Committee concludes that:

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

The Operating Framework for the NHS in England 2012/13

The Trust has assessed its performance against the national priorities set out in the NHS Operating Framework 2012/13. The relevant national performance measures for the Trust, and the Trust's performance against these are described in the Annual Report. Most measures were achieved. The most significant area of under-performance was in smoking cessation, where the Trust was unable to generate sufficient referrals to meet the target. An action plan has been developed for 2013/14 to address this.

Compliance with the Corporate Governance Code

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

balance and independence, appointment and terms of office of directors, information, development and evaluation, director remuneration, accountability & audit, relationships with stakeholders, disclosure requirements, and the role of the Trust Secretary. Requirements in relation to Governors are incorporated into the Trust's Foundation Trust plans and the Trust's draft Foundation Trust Constitution. The Constitution was updated and approved by the Board in November 2012 to reflect changes in the Health and Social Care Act 2012 effected by the 1 October 2012 Commencement Order. The Constitution has been confirmed as being legally compliant, by the Trust's solicitors, with legislation relating to Foundation Trusts and the requirements of Monitor, the Independent Regulator of NHS Foundation Trusts.

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

3 Risk assessment

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

The Trust maintained level 1 against the NHS Litigation Authority (NHS LA) risk management standards. Most healthcare organisations providing NHS care, including independent sector organisations, are regularly assessed against the NHSLA's risk management standards which have been specifically developed to reflect issues which arise in the negligence claims reported to them. There is a set of risk management standards for each type of healthcare organisation incorporating organisational, clinical, and health and safety risks. The latest versions of these standards and the results of assessments are available on the NHSLA website at www.nhsla.com/riskmanagement.

All NHSLA standards are divided into three levels. Trusts that demonstrate compliance with the standards at assessment receive a discount on their contributions to the NHSLA schemes. The progression of organisations through the standards is logical and follows the development, implementation, monitoring and review of policies and procedures. Level 1 – Policy: the process for managing risks has been described and documented. Level 2 – Practice: the process for managing risks, as described in the approved documentation at Level 1 is in use. Level 3 – Performance: the process for managing risk, as described in the approved documentation at Level 1, is working across the entire organisation. Where deficiencies have been identified through monitoring, action plans must have been drawn up and changes made to reduce the risks. The NHSLA is changing its approach to the risk management standards and assessment process. From 1 April 2013 to 31 March 2014, the NHSLA will only undertake a limited assessment programme. Assessments will be undertaken in the following circumstances: (a) where a trust wants an assessment; (b) where a trust has failed an assessment in

2012/2013 and dropped to Level 0; or (c) for a trust for which the NHSLA have significant concerns. The Trust does not anticipate being assessed by the NHSLA in 2013/14.

The Risk Management Strategy covers risk identification, evaluation, recording, control, review and assurance. It also defines the structures for the management and ownership of risk and clearly identifies the Trust's attitude and appetite for risk and at what level a risk is tolerated, clearly defining processes for Board committee review and escalation through to the Board meeting. The Trust continues to use the National Patient Safety Agency (NPSA) risk matrix in order to assess the likelihood and severity of identified risks. Externally facilitated Board assurance sessions on key issues in risk management, such as the Bribery Act and the NHS Provider Licence, have been provided to all members of the Board. Risk management awareness has also been cascaded throughout the organisation.

The Trust maintains a Corporate Risk Register which is the aggregation of the local team and corporate department risk registers where the residual risk is rated as 12 and above. It includes any additional sources of risk such as external or internal reviews. It is maintained centrally by the Trust's Risk Manager and recorded on the incident reporting system. As such it identifies the source, describes the risk, scores and grades it and provides a summary of the action taken to control it. It includes a review date and a residual risk rating. The Corporate Risk Register is reviewed on a monthly basis at operational and corporate meetings in conjunction with the Board Assurance Framework to ensure that there are appropriate checks and balances between the two risk registers and that appropriate escalation and/or de-escalation occurs.

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

Each risk is linked to a Trust objective and has an executive lead, responsible for receiving assurance that the actions required to mitigate the risk are completed at either local, operational or strategic level. The Board Assurance Framework provides a vehicle for the Trust Board to be assured that the systems, policies and people in place are operating in a way that is effective and focused on the key risks which might prevent the Trust objectives being achieved.

The process for escalation and de-escalation of risks is described in the Board Assurance and Escalation Framework, which also describes the process for managing risks identified through completion of the Early Warning Trigger Tool

(EWTT). The EWTT is designed to capture and bring together all of the factors that could impact on the quality and safety of clinical services, to identify services that may be at risk, and to help prevent serious incidents and patient safety issues in the future. It is part of a package of measures being used to ensure that quality remains a key priority for the Trust. It was modified from a national tool developed by the National Patient Safety Agency and was tested in all business units prior to rollout.

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

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

Risks identified in 2012/13

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

- Delivery of the cost improvement programme plans (CIP);
- Future unfunded demographic pressures and the impact on finance and quality due to the nature of the block contract arrangements;
- Asset transfer;
- IM&T strategy infrastructure;
- Implementation of the administration and clerical review;
- Meeting the target performance for mandatory staff training.

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

Trust's risk profile

At the start of the year in April 2012, the Board Assurance Framework comprised three risks to the achievement of its strategic objectives, summarised as: meeting the pressure ulcers' performance target (rated as 20), cost improvement plans (20), and contract income (20). At the end of the year in March 2013 this had risen to eleven risks: asset transfer (16), CIP (20), demographic funding (20), IM&T

infrastructure (15), contract performance (16), pressure ulcers (12), staff training (16), IM&T information services (15), clinical waste (12), Norwich locality capacity issues (15), implementation of the administration and clerical review (16). Six high risks related to the strategic objective of building sustainability. One high risk related to the strategic objective of improving quality. Two high risks related to the strategic objective of building the organisation. Two risks on the BAF at year end were moderate amber rated risks and related to the strategic objective of improving quality.

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

The governance framework of the Trust is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2013 and up to the date of approval of the Annual Report and accounts.

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

Data security

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

Incidents reported to the ICO:

The Trust supplies the Registration Authority at NHS Norfolk and Waveney with details of staffing records of those starting and leaving the organisation

to ensure that only authorised staff are provided with NHS smart cards. The Trust supplied more information than was required for this purpose in error, and this was reported to the ICO. Measures have been taken to ensure that a similar error should not happen again. The Trust addressed all of the questions raised by the ICO and no further action was taken.

A health visitor had her diary stolen containing 12 months of non sensitive patient information relating to patient visits. This was reported to the ICO and at the time of writing their response is awaited.

Other serious information breaches

An out of hours unencrypted mobile phone was left in a pool car and found by another nurse the following day so patient information was not lost, but the use of unencrypted phones did raise concerns. A root cause analysis was undertaken and encrypted phones were recommended and are now in place.

A letter regarding adoption was sent to unsuccessful adoptee parents. The letter did contain sensitive personal information, in error, that was already known to them.

A member of staff offered their condolences to a person on the recent death of their father. However, the death was unknown to the person and was an accidental breach of confidentiality. After the incident, the team leader met with the family to inform them about the matter. Learning from this incident has been incorporated into staff training.

4 The risk and control framework

The overall responsibility for the management of risk lies with the Chief Executive as Accountable Officer. The Board, collectively and individually, ensures that robust systems of internal control and management are in place. This responsibility is supported through the assurance committees of the Board under the chairmanship of a Non-Executive Director, with appropriate membership or input from Executive Directors.

As part of the Board's continuing commitment to risk management, the Trust's management structure was reviewed during the year and the revised arrangements were further effected in 2012/13. The Director of Nursing, Quality and Operations provides the leadership and management for the risk management function within the Trust. The Medical Director is the Caldicott Guardian. The Director of Finance is the Senior Information Risk Owner (SIRO).

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

The Quality and Risk Assurance Committee receives minutes and exception reports from a number of sub-groups that monitor areas of quality and risk

including: Quality and Clinical Effectiveness, Infection Prevention and Control, multi-agency safeguarding, Risk, Health and Safety and Information Governance. All these meetings have a role to provide regular monitoring for best practice as well as to identify themes and trends for learning and sustained improvements.

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

Learning is promoted across the Trust through a series of training events commensurate with staff's duties and responsibilities. This includes risk management training for all new staff and regular involvement in risk management practices and awareness through risk reviews and individual appraisals, business unit and performance meetings.

Promoting awareness throughout the Trust arising from risk related issues, incidents, complaints, claims and significant events is key to maintaining the risk management culture within the Trust. Learning is acquired from a variety of sources, including:

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

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

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

All risk registers for the Trust have been brought together into a centrally maintained electronic system. This system is supported through regular risk review processes led by the Deputy Director of Quality Assurance; risk register reports are then scrutinised at service level and corporate meetings; newly established Risk

Group comprising Trust-wide risk leads, reporting to the Quality and Risk Assurance Committee. Risks that are not being successfully mitigated and controlled are escalated and discussed at executive directors' meetings in order to prioritise management action appropriately.

The Trust has implemented the NHS Information Risk Management Guidelines by establishing a register of key information assets, allocating each one to an information asset owner who reports to the Information Governance Group and Senior Information Risk Owner. Information risk management is reviewed and monitored by the Information Governance Committee. The Trust has implemented and rigorously enforced the Information Risk and Information Security Policy to control where personal information is stored and to protect personal information that is stored on all portable data storage devices from unauthorised access, through the encryption of all portable devices and remote access personal computers.

The Board is provided with assurance on the use of resources through a monthly report and the Finance and Performance Committee undertakes a review on a regular basis. Provider Management Regime reports are also submitted to the Strategic Health Authority on a monthly basis from which a risk rating is assigned. Any concerns on the Trust's performance are raised with the Strategic Health Authority and are acted upon. The NHS Trust Development Authority has now replaced the Strategic Health Authority in this role following its abolition.

5 Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the managers and clinical leads within the NHS Trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Account and other performance information available to me. My review is also informed by the Head of Internal Audit Opinion and comments made by the external auditors in their management letter and other reports.

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

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

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

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

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

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

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

- The design and operation of the Board Assurance Framework and associated processes – medium risk;
- Information governance – low risk;
- Care Quality Commission standards – no overall assurance opinion given;
- Clinical audit follow-up – critical friend review;
- Business continuity – medium risk;
- IM&T – medium risk;
- Corporate planning and performance – low risk;
- Data quality – medium risk;
- Mandatory training follow-up and personal development plans – medium risk;
- Charitable funds – low risk;
- Sure Start – critical friend review;
- Financial reporting and budgetary control – low risk;
- Key financial controls – low risk;
- Workforce planning – medium risk;
- Car lease scheme – critical friend review;
- Revalidation and criminal records bureau (CRB) checks – high risk.

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

- Board Governance Assurance Framework by Ernst and Young;
- Quality Governance Framework by KPMG;
- Historic Due Diligence by Deloitte;
- Annual financial statements by Ernst and Young.

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

In summary, during the year the Trust's assurance framework and governance processes identified high risks and gaps in control in the following areas:

- The design and operation of the Assurance Framework and associated processes;
- Care Quality Commission Standards;
- Clinical Audit Follow-up;
- Information Management and Technology;
- Data Quality;
- Mandatory Training Follow-up and Personal Development Plans;
- Workforce Planning;
- Recruitment of both Bank and permanent staff;
- Business Continuity.

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

The work of internal audit and executive managers

The annual Head of Internal Audit Opinion (HoIA) contributes to the assurance available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion in turn assists the Board in the completion of its Annual Governance Statement. The Opinion provides an overall opinion, the basis for the opinion, and a commentary. The overall opinion provided is 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.

However, some weaknesses in the design and / or inconsistent application of controls, puts the achievement of particular objectives at risk. Using the terminology set out in the Department of Health guidance to Heads of Internal Audit (gateway approval 15460), this opinion equated to "Significant Assurance". The opinion is based solely on internal audit's assessment of whether the controls in place support the achievement of management's objectives as set out in the Annual Internal Audit Risk Assessment and Plan and in individual Assignment Reports.

The basis for forming the opinion was as follows:

An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and an assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment took account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses. The commentary below provides the context for the opinion and, together with the opinion, should be read in its entirety.

Internal Audit identified a number of high risks through its reviews. These are detailed below, together with the associated actions that the Trust has taken to mitigate those risks.

The design and operation of the Assurance Framework and associated processes: Weaknesses were found in the completeness and quality of information in local and business unit risk registers.

> Actions arising: Risk leads undertake reviews of the quality of information and assurances in their team risk registers. Assistant Directors also undertake reviews of the quality of information on locality and business unit risk registers. The Corporate Risk Register is reviewed at the regular Trust-wide Risk Group meetings.

Care Quality Commission Standards: There is a need to apply a consistent and formalised self assessment framework for outcomes across the Trust, with central overview of compliance reported to the Trust's senior management. Due to lack of guidance or resource, not all services are performing self-assessments to assess their compliance with CQC outcomes and therefore action plans are not created to

address any areas of poor compliance. Where action plans are being created, these are not regularly monitored.

> Actions arising: a system-wide framework for CQC self-assessment has been established. A programme of unannounced visits to inpatient units to monitor compliance and ensure action plans are in place to address any gaps has been set up. Localities and business units now report compliance and progress against actions via the monthly performance meetings. The Quality and Risk Assurance Committee and Board receive regular reports on compliance.

Clinical Audit Follow-up: The central clinical audit resource has limited capacity.

> Actions arising: The resource has been strengthened through additional key appointments including quality assurance managers and co-ordinators and a Deputy Director of Nursing.

Information Management and Technology: The Trust does not have a complete register of all its IT assets, the IM&T department do not receive IT assets upon staff leaving the Trust, and there is a need to gain assurance over compliance with software licences relating to non Microsoft Office applications; and user accounts are not always disabled upon the staff leaving employment with the Trust.

> Actions arising: The Trust has completed an asset register of all IT assets. A process is in place to ensure staff return IT assets when they leave the Trust's employment. Assurance process is in place for compliance with software licences. More robust procedure is in place to ensure user accounts are disabled when staff leave.

Data Quality: There is no audit trail functionality present within the ICARUS information management system. Corporate level users have access to more patient identifiable data than is required for their role.

> Actions arising: The ICARUS redesign has enabled corporate staff to have a different set of dashboards to operational staff. A process is in place to audit the use of ICARUS by individual per dashboard. Issues of inappropriate access are escalated to line managers.

Mandatory Training Follow-up and Personal Development Plans: Trust employees are not in every case undertaking training in accordance with the Mandatory Training Policy; New joiners do not in every case complete the mandatory training within the required period of three months. Personal Development Plans are not always completed and provided to HR within the set timetables. The regular monitoring of the outstanding KPIs is not currently having any significant impact on the improvement of compliance rate.

> Actions arising: (1) Introducing the mandatory passport within the Bank Office to provide evidence of up to date and appropriate mandatory training (2) Line managers and staff have been reminded of their duties by the Head of HR to complete all mandatory training in accordance with the Trust's

Mandatory Training Policy through “Weekly Messages”, “The Exchange” and line management communication routes. (3) Mandatory training is monitored at Board to ensure appropriate action plans are in place to address areas of non-compliance and target areas for intervention. Detailed KPIs reviewed at Board and provided direct to line managers. For line managers this includes current attendance rates and individuals who were booked on and did not attend. (4) Departments are supported by HR by working with them to access different and various forms of mandatory training. (5) E-learning has also been expanded, with additional modules.

Mandatory training is now linked to induction within one month of joining. The requirement is included within part of appraisal paperwork and supporting records sent to line managers. Plans for first day inductions in place.

Managers and staff have been reminded of the timetable for PDPs, the appraisal document has been reviewed for ease of use and modified, and performance on PDPs is publicised through performance reports.

Workforce Planning: The booking process for agency staff forms are not always returned to the Bank Office; or in some cases where they are returned, the forms are not appropriately completed. For one sample the form could not be located.

Actions arising: The lead assistant director has written to all wards and community teams to remind them of the importance of completing all forms in a timely manner to the Bank Office. This process is audited every three months.

Recruitment permanent staff: Instances were noted where permanent employees started work at the Trust before the Criminal Record Bureau (CRB) disclosures were received and without the evidence of timely risk assessments being completed. Exceptions were noted in two out of 20 cases.

Actions arising: Managers have been reminded that CRB checks and risk assessments must be completed in line with Trust policy. A flagging system has been introduced to the current CRB monitoring system to identify outstanding CRBs, ensuring prompt action is taken, and refresh of risk assessments is undertaken where appropriate.

Recruitment Bank staff: Instances were noted where bank staff started work before the CRB disclosure results were received and before CRB risk assessments had been authorised. Exceptions were noted in two out of 20 cases.

Actions arising: to apply the process as described above for permanent staff and for bank staff also to record and monitor bank staff deployment ensuring CRB check is done or risk assessment is in place.

Business Continuity: a number of high risks were identified at the time of the audit fieldwork activity. Between the fieldwork being undertaken and the closing audit report, actions were taken by the Trust to reduce these risks as follows: a formal

programme of business continuity plans testing had yet to be devised at the time of the audit fieldwork (reduced to medium risk); At the date of audit fieldwork, the Trust had only partially completed the overarching business continuity spreadsheet and four business units had not documented their plans (reduced to medium risk); Issues were noted with the quality of some Service Continuity Plans and not all plans had been reviewed by the IM&T department to ensure the plans are practical and implementable in the event of a disaster, only six out of 33 had been reviewed (reduced to medium risk); At the time of the audit fieldwork, the Trust had not completed all required actions identified during a business continuity exercise undertaken in November 2011 during the period of industrial actions, 18 out of 24 actions remain outstanding (reduced to low risk).

Sure Start – critical friend review

Internal Audit undertook a critical friend review of the Trust's tender for Sure Start children's services. The review included the design and operating effectiveness of key controls in place relating to the project management, approval and submission of the bid and the effectiveness of issue resolution following the identification that the submitted bid was non compliant for certain lots. Internal Audit further reviewed the ongoing management of those lots that the Trust was successful in securing. The sub-processes and related control objectives were also included in the review. The audit was carried out as a value enhancement review, and therefore no overall risk rating was awarded. The review identified weaknesses in the Trust's arrangements for tendering and made a number of recommendations.

> Actions arising: The Trust is implementing an action plan that addresses all of the recommendations arising from the Internal Audit critical friend review, primarily through formalising the expected controls and processes in the form of a Tender Governance Manual, which in turn has been reviewed by Internal Audit, and further suggestions for improvement implemented.

6 Other significant issues to report

Kelling Hospital

Over the period June to September 2012 there were five deaths on Pineheath Ward, Kelling Hospital which were reported as 'unexpected'. Each of the five deaths resulted in a Serious Incident Requiring Investigation (SIRI) to be carried out and subsequent root cause analysis in line with the Trust's Incident Reporting Investigation and Management Policy. An interim report dated 1 October 2012 was submitted to both NHS Norfolk & Waveney and NHS Midlands & East, together with the individual root cause analysis investigations into each death, which had been completed in order to identify initial themes and trends. This resulted in the assurance that there were no untoward themes arising. A number of initial recommendations had already been implemented at this stage. A final report which included a clinical review of the five deaths was submitted to NHS Norfolk & Waveney and NHS Midlands and East at the end of November 2012. A clinical review was undertaken by two medical experts who reviewed each of the five

deaths and a summary of each case was provided in the report which identified key themes, learning and some notable practice.

The report also looked at clinical aspects around the admission process and the increasing acuity of patients being admitted with a review of the rehabilitation complexity scale and Barthel score (method used to measure performance in activities in daily living). An analysis of the workforce was included which looked at the potential impact of staff absence, turnover, training and appraisal levels and included the medical input.

The investigations into the deaths have confirmed that they do not represent a failure of service delivery nor of patient safety. However, the incidents have identified areas of service enhancement which can be improved. Eleven recommendations were made in the final report and are being implemented. A further related strategic review of rehabilitation services made recommendations to the Board, which are also being implemented.

7 Conclusion

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

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Accountable Officer: Michael Scott, Chief Executive
Organisation: Norfolk Community Health and Care NHS Trust

Date:

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

We have audited the financial statements of Norfolk Community Health and Care NHS Trust for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 28. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

- the table of salaries and allowances of senior manages on page 54;
- the table of pension benefits of senior managers and related narrative notes on pages 56 and 57; and
- the disclosure of pay multiples and related narrative notes on page 55.

This report is made solely to the Board of Directors of Norfolk Community Health and Care NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors and auditors

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 61, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Trust; 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 financial position of Norfolk Community Health and Care NHS Trust as at 31 March 2013 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998

We have nothing to report in these respects.

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

Respective responsibilities of the Trust and auditors

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

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

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

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

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in November 2012, as to whether the Trust has proper arrangements for:

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

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2013.

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

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in November 2012, we are satisfied that, in all significant respects, Norfolk Community Health and Care NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2013.

Certificate

We certify that we have completed the audit of the accounts of Norfolk Community Health and Care NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Neil A Harris

Audit Director

For and on behalf of Ernst & Young LLP
London
June 2013