Norfolk Community Health and Care NHS Trust

Annual Report & Accounts 2011/2012

Looking after you locally

Getting better together

Contents

In your words…

Here, we have highlighted a selection of the written thanks and compliments we have received from our patients and their carers in the past few months – these comments represent the end-of-life care we provide, the support we provide to enable patients to lead an active life and to recover from major operations.

We hope the quotes give a sense of the lasting impression made not just by what our staff do, but how they do it.

"I am writing to express my grateful thanks for the proactive help and care I continue to receive from the staff. Knowing that the team will, and often do, go out of their way, is very reassuring…"

"The nurse was clear, explained everything and she has made my life so much better as I was beginning to be very distressed…"

"Just a short note to thank you for the wonderful care you took of our Dad. His last couple of weeks were made easier by your kindness and thoughtfulness. Dad often mentioned how respectful and kind you all were…"

"The care I received from you all was very professional, but just as importantly so kind and reassuring…"

"The exercise regime proved to be a challenge and at a certain point I felt like giving up but your staff's enthusiasm saw me through this period…"

"With their constant support, I have been able to cope and feel more positive about my operation…"

"It is a great consolation to us that with your nurses' support we were able to care for mum at home until she died, which is exactly what she wanted…"

1. Foreword

It is our pleasure to introduce this Annual Report. It has been a year of change and achievement, both in the structure of our organisation and our services.

In terms of our services, we have continued to provide high quality local services throughout Norfolk. Firstly, in Adult Services we continue to support local GPs in their practices and with patients in their own homes. This means keeping people healthy for longer, avoiding unnecessary hospital admissions and supporting them with chronic conditions. Our Specialist Services continue to offer high quality palliative care, neuro-rehabilitation and dental services. Our Children's Services work very closely with Norfolk County Council, supporting vulnerable families and children and safeguarding those most in need. Our Learning Disabilities Services work with some of the most vulnerable in society, caring and supporting them to an independent future. We have many further services that work with marginalised and vulnerable adults across the city of Norwich and the county.

This has been a successful year in many respects. Financially we have balanced the books and returned a healthy surplus for reinvestment next year.

In terms of quality, we hit a number of our major quality targets. This included a rise in patient satisfaction, a decrease in acquired infections, a decrease in falls and more venous embolism assessments.

Our Board is stronger in this year, with a new Chief Executive, a new Finance Director and new Trust Secretary. Equally, we have modified our operational management. A major change this year has been the creation of Clinical Commissioning Groups (CCGs), run by local GPs. We have realigned our services to match their boundaries. This locality management means that we can work even more closely with our local GPs in partnership as fellow providers and commissioners.

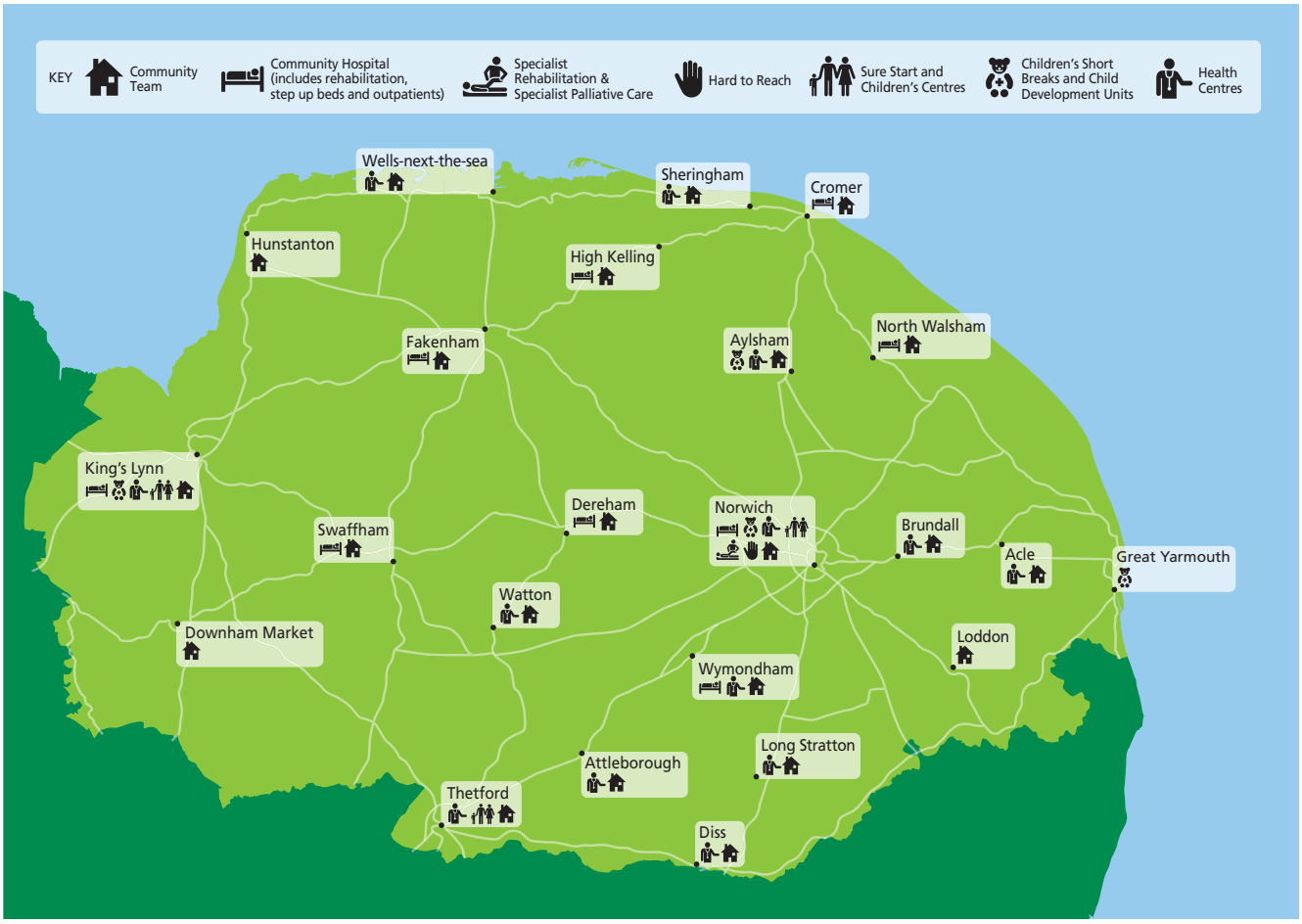
So, in many respects this has been a successful year. We believe by becoming a stronger and better governed organisation, this takes us well down the road to Foundation Trust status (FT). This status enables us to deliver even more high quality services for local people and rightly protects and sustains community services. As we look forward to another busy year, we have set ourselves increasingly challenging goals. This includes a high level of financial surplus (£1m); more challenging quality goals, particularly around the reduction in preventable pressure sores and further reductions in falls and other harms.

All of this means that we are responding to local needs and reinvesting for the benefit of the local community. As we look forward to this new year, we will be particularly focussing on even better links with our community. We will particularly be looking to build on the relationship with our new Community Members and establishing our Council of Governors. These will be the lifeblood of the new Foundation Trust and therefore, if you are interested in joining us, then please do get in touch.

Ken Applegate
Chair

Michael Scott
Chief Executive

Some of our key locations



Did you know?

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

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

2. About Norfolk Community Health and Care

2.1 Our values

The Trust is committed to the following values:

Home and community

We exist to improve the lives of our patients, whenever and wherever they need us. We are proud to be trusted to enter their homes and be part of their communities. We aim to deliver care equally for all, locally.

Personalised care

We strive to understand each individual patient's total needs, and energetically join up their health and care requirements across different providers. We aim to prevent as well as treat problems. We are committed to safe, excellent care. Above all, it has to be the right care for the individual.

Enabling our people

At our heart is the incredible personal motivation of our staff. We value and develop their expertise and commitment. We balance empowerment and accountability. We communicate clearly and concisely, and like to keep things simple. We are one team.

Pioneering

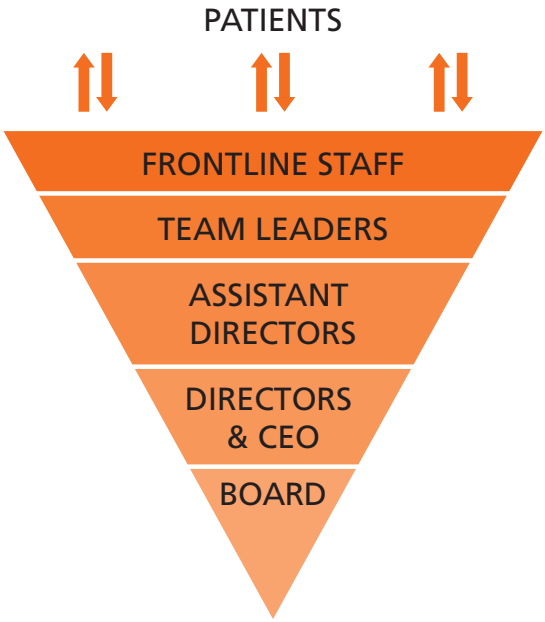
We are hungry for innovative and more efficient ways of delivering care to patients. We make it easy for creativity and leadership to flourish. We are determined to break down all barriers to improve care and value for money.

Our vision

The Trust's vision is to improve the quality of people's lives, in their homes and community through the best in integrated health and social care. We often sum this up as 'Looking after you locally'.

The starting point for the Trust is the patient: this means that quality is at the heart of everything the Trust does. The Trust's services are built up around the patient, working closely with GPs as partners whether as commissioners, customers or fellow providers, and wherever possible they are delivered in an integrated way with social care. Seeing ourselves as an 'inverted organisation' (see diagram below) also supports this.

The diagram demonstrates that patients come first and that front-line staff are most important in our interaction with them. The role of managers is to support staff to enable them to deliver.



Our vision is supported by the way the Trust structures its services. The Trust's activities are structured through three business units: Localities, Children's Services and Specialist Services.

The Trust's vision will be delivered through the achievement of a number of longer term, strategic objectives. These are set for the next five years and described in our Integrated Business Plan which also includes our business development strategy.

The Trust's longer term corporate objectives are:

- **Improving quality** – for patients and the public and 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 wants to be the first choice employer for staff and be a clinically led, high performing organisation
- **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 be the first choice for patients and GPs and to play a leading role within the local health economy

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.

2.2 What we do

We are amongst the largest dedicated providers of community based health and care services in the NHS. We offer a wide range of general and specialist services to patients throughout their life, delivering care in, or near to, people's homes according to their level of need. Our ambition is to expand outwards from our base in Norfolk and we are pursuing tendering opportunities to grow our business.

Our home county of Norfolk, excluding the district of Great Yarmouth, is predominantly rural with pockets of urban deprivation. Its population of 767,000 is more elderly than the England average, and is growing faster in numbers than the England average. In serving our population, we have developed an expertise in delivering care to hard-to-reach and vulnerable groups, as well as to frail and elderly and geographically dispersed populations.

Several of our services are recognised regionally or nationally, including:

1. Early Implementer Site for the national health visiting programme
2. Integrated Care Organisations
3. Early Supported Discharge service
4. Specialist neurological rehabilitation services
5. Matrix – our pioneering service to sex industry workers
6. Palliative care services, including Priscilla Bacon Lodge and Rowan Day Centre
7. Family Nurse Partnership

The Trust operates from around 200 sites across the county, including ten community hospitals. The Trust has a strong track record of community service delivery as well as an established infrastructure; however the community setting is over a large dispersed area in which the Trust reflects commissioning patterns in that it does not have uniformity of service provision.

The services currently 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

Norfolk is one of the largest of England's shire counties with one of the lowest levels of population density and has, by any measure, a poor transport infrastructure. At over 5,000 square kilometres, Norfolk is roughly 50% larger than either Cambridgeshire or Suffolk, but has a population density similar to Lincolnshire. It is predominantly rural with pockets of rural deprivation. Less than 40% of the population lives in the three major built-up areas of Norwich, Great Yarmouth and King's Lynn. Long distance transport links are poor, with no motorways, limited dual carriageways and an underdeveloped public transport network. The long distances and travel times to the acute hospitals make the development of a comprehensive range of community-based healthcare services essential for improving the quality of life and healthcare outcomes locally. The Trust has developed expertise in managing dispersed rural community services.

2.3 How we are organised

The table below sets out the main services provided by the Trust within each locality/ business unit:

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
Alcohol and Drugs Service
Smoking Cessation
Dental Service
Adult Community Learning Disability

Community Children's Services
Health Visiting
School Nursing
Contraceptive and Sexual Health Service
Sure Start Children's Centres
Looked after Children
Parent - Infant Mental Health
Children's Community Nursing
Children's Therapies
Child Development Team
Community Paediatrics
Children's Short Breaks
Other
Clinical Support Services
Prison Health*

*Prison healthcare will no longer be provided from 2012/13.

2.4 More about the Trust

The Trust 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 Arm's Length Trading Organisation, or provider arm, at the end of 2008 as part of its 'Moving Forward' programme. This allowed the Trust to develop independent commercial and governance operations. The Trust became a separate NHS Trust on 1 November 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 NHS Norfolk, 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 we received positive feedback to our proposals. The Trust has been improving its governance arrangements with a view to becoming a Foundation Trust by a revised date of 31 March 2013.

3. Improving quality and patient safety

The Trust builds its services around the patient, and quality is our essential priority.

3.1 Patient experience

Patient experience is a main pillar of the Trust's strategy to keep the patient at the centre of all that we do. The following patient and carer experience survey work has taken place as part of the delivery of the Trust's Patient Experience and Involvement Strategy.

Picker inpatient survey results

The Trust commissioned the Picker Institute Europe to conduct a survey among inpatients staying in the Trust's community hospitals. Face-to-face interviews were conducted in 13 community hospitals by professional market research interviewers during February 2011. A total of 48% of patients from participating hospitals took part in the survey which is an excellent response rate.

The overall ratings were as follows:

- 97% of respondents rated care as excellent, very good or good (39% excellent, 45% very good, 13% good)
- 97% said they would recommend the hospital to others (83% said definitely, while 14% said probably)
- 90% of respondents felt they were always treated with respect and dignity by hospital staff
- Almost nine out of ten patients (86%) felt that the nurses caring for them were always responsive to their needs
- 90% felt they were involved in decisions about their care and treatment (67% definitely and 23% to some extent)

The Trust has taken a number of actions as a result of recommendations. Healthy food options are always available and nutritional booklets are utilised with the patient. This supports them in selecting healthy food options. The catering satisfaction survey has been updated to include a question about healthy food options being available.

The provision of ward information on admission and a general patient information booklet has been developed and agreed. Unit specific detailed information is currently being developed based on an agreed template.

Local patient experience surveys

Adult services

3,551 local surveys were completed to gather feedback and subsequently improve patient experience focusing attention on adult services at Norwich Community Hospital and St James, King's Lynn; Orthopaedic Triage, Physiotherapy, Podiatry and Biomechanics. The methodology used to collect data was through the patient experience software system Meridian, where information is collected in a variety of ways, for example, electronically through email, through a touch-screen kiosk or paper surveys. There were three key themes for the survey: information/involvement, environment and communication as well as 'general' covering overall satisfaction and recommendation of the service. All surveys went live on 1 July 2011 and continued until end February 2012. The key results are shown below.

Survey Theme	Overall satisfaction rating
General	96%
Information/Involvement	95%
Environment	100%
Communication	98%

Even though the results were extremely positive, the comments received resulted in a number of actions. For example:

- Improved service specific information has been developed including information on what to expect at first appointment. Patient Information leaflets have been produced for all four services and are sent with appointment letters
- Improved directions and parking information at Norwich Community Hospital is now issued; a new site map has been produced giving clearer details on parking and directions to the site and once on site
- Improved signage at Norwich Community Hospital has been put up from the car park to main reception for clinics and clearer signage once inside the main building for clinic areas has been added
- Improved Biomechanics and Orthopaedic Triage waiting areas at Norwich Community Hospital through both areas being de-cluttered, clear notices now being displayed in Biomechanics welcoming patients to the service and the Reception staffed regularly. Notice board displays have been updated in Orthopaedic Triage. This work is in progress currently.

Children's services

A programme to gather and improve information to be used to improve children and families experience, focusing attention on clinics provided at Upton Road Children's Centre, Norwich, was delivered during 2011/12, using the same methodology.

The results of this survey are shown below

Survey Theme	Overall satisfaction rating
General	92%
Information/Involvement	91%
Environment	99%
Communication	96%

The comments received resulted in a number of actions:

- Existing Patient Information leaflets have all been updated to include additional information requested prior to first appointment
- Improved waiting area for children of all ages; additional toys acquired
- A more accessible version of the survey was developed via an easy-read format

Local carers' experience surveys

Within the Trust a holistic approach to care is championed, and carer and family feedback is of significant importance to us in measuring overall performance. Two surveys were delivered in 2011/12 with this group specifically in mind.

A carer's satisfaction survey was carried out focusing on interactions with Case Managers and in the Trust's residential short breaks service for children.

The methodology used in both surveys was a system called 'health feedback' consisting of a very simple A5 size survey card completed manually, online or via a free phone number. The surveys commenced in July 2011 and ran to December 2011.

In addition to the survey questions respondents were also asked for their comments. The findings were as follows:

Adult services

- 100% felt they were always or usually treated with respect by staff
- 99% of carers felt they were involved as they wanted to be
- 99% felt the information they were given had been very or fairly helpful
- 95% felt very satisfied with the overall experience, 5% fairly satisfied
- 91% felt they were very satisfied with the way staff communicated with them

As a result of this survey, the following key actions have been taken:

- Improved information leaflets have been drafted and will be personalised to each area
- Commitment has been taken to ensure a change of Community Matron will be well communicated and explained to carers
- A Carer's focus group took place to discuss survey results, actions and future recommendations

Children's services

- 96% parents/carers felt very or fairly involved in the planning of care for their child
- 65% said there had been no changes to their booking, with 35% saying it had been changed only once or twice
- 55% said they were very satisfied with the booking change, 25% fairly, 15% neither satisfied nor dissatisfied
- 74% felt their child had always been treated with respect, with 26% saying usually
- 52% felt very confident their child's individual needs had been met, 43% fairly
- 70% said staff had been very helpful, with 30% saying fairly helpful
- 70% were very satisfied with their overall experience of the service and 30% were fairly satisfied

As a result of this survey, the following key actions have been taken:

- Improved involvement of parent/carers in the planning of care for the child; each child will have a full review of their short breaks care package six monthly
- Named member of staff responsible for organising the booking with Parents/carers contacted by phone if their booking needs to be amended giving them as much notice as possible
- A privacy and dignity action plan is being written for each unit. To maintain this during personal care "stop" and "go" signs have been placed on toilet and bathroom doors. Each child will also have a name plate and a photograph on their room during each stay to identify personal space
- Increased communication is aided through a newsletter which has been developed to improve communication between parents/carers and the units

Community services survey

The Trust took part in a community services survey, co-ordinated by Hounslow and Richmond Community Healthcare for all community trusts. Patient Perspective has been commissioned to conduct the survey and provide analysis and reporting to each participating trust. The survey focused on Podiatric Surgery, Continence, Paediatric Speech and Language Therapy (SALT), Adult SALT and Wheelchair Services. This will be the first opportunity for the Trust to receive comprehensive and benchmarked data on patient opinion and experience.

Patient stories

A key objective within the Trust Patient Experience and Involvement Strategy April 2011 to March 2013 is to "embed patient stories as an in-depth qualitative methodology in the Trust". The Trust has made a number of service improvements as a result of this work.

Sure Start Children's Centre at Bowthorpe, West Earlham and Costessey has increased communication within GP surgeries, local libraries and schools about services offered at the Centre. The content of a "Stay and Play" session had been altered to meet the requested needs of parents attending with their children. The centre was assessed in 2011 as "outstanding" and commended on their use of parent stories, requesting more were conducted.

Starfish Learning Disability and Behaviour team have a new service leaflet designed for parents/carers and have improved the referral process from Paediatricians into the service.

Colman Centre for Specialist Rehabilitation Services has involved patients more in the discharge planning process and has improved transition processes from in-patients to outpatient services.

Advocacy – net promoter

The net promoter score is a measure of advocacy for a service or brand, 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 in 2011/12 and will continue to develop this tool as a key indicator of patient satisfaction and service quality. The results from 2011/12 specifically relating to net promoter are as follows:

From the Picker Institute survey 2011

97% said they would recommend the hospital to others (83% said definitely while 14% said probably). 3% said they would not.

From the adult services survey 2011/12

94.5% said they would recommend the service to a friend or relative if they needed similar treatment, care or advice (85.5% very likely while 9% said fairly likely). Just under 1% were very or fairly unlikely to recommend.

From the children's services survey 2011/12

95% said they would recommend the service to a friend or relative if they needed similar treatment, care or advice (79.5% very likely while 15.5% said fairly likely). 3% were very or fairly unlikely to recommend.

Survey results from 2011/12 show a significant improvement compared to the results of the Ipsos MORI Patient Experience Survey in 2010 where 68% of patients were very likely to recommend and 58% of parent/guardians.

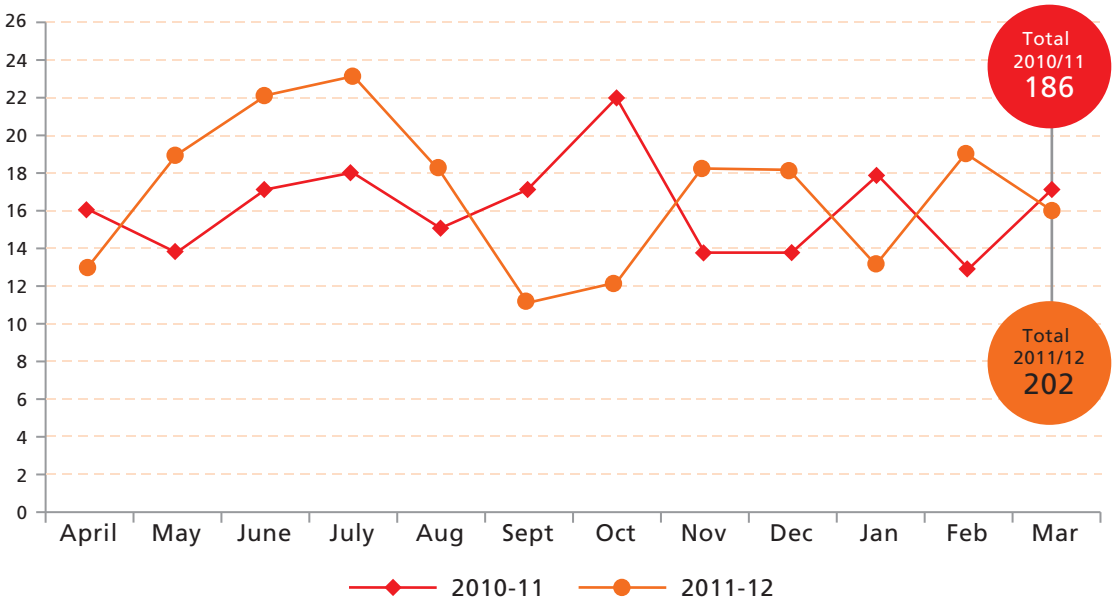
3.2 Complaints and compliments

The Trust received 202 complaints, in comparison to 186 for the full year 2010/11. The Trust continues to use the number of complaints as a clear indicator of patient satisfaction alongside the patient experience programme. Two main themes arising from analysis of complaints include the single point of referral, which is under review, and attitude of staff, which is also receiving attention from the internal training team. New courses are under development focusing on customer care and professional behaviours.

Patient compliments are also measured and this year the Trust has received 335 compliments. The dedication and commitment of frontline staff is a recurring theme of the compliments received.

Learning from complaints is collated from the Service Managers following an investigation, and communicated across the organisation via the Quality and Risk monthly report (seen at Quality & Risk Assurance Committee and the Trust Board) which is published on the Trust's website and through the monthly staff briefing exchange. Themes from complaints are taken to the senior Clinical Management Team (CMT) for discussion and forward planning.

Complaints received compared to previous year's results



3.3 Patient Environment Action Team (PEAT) results

The National Patient Safety Agency has confirmed the Trust's PEAT results for environment, food and privacy and dignity for each hospital within our organisation as follows:

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

Site Name	Environment Score	Food Score	Privacy & Dignity Score
Colman Hospital	Good	Good	Good
Norwich Community Hospital	Good	Good	Good
Dereham Hospital	Acceptable	Excellent	Good
North Walsham Hospital	Acceptable	Good	Good
St Michaels Hospital	Good	Good	Excellent
Kelling Hospital	Acceptable	Good	Good
Swaffham Community Hospital	Acceptable	Excellent	Good
Ogden Court, Wymondham	Good	Good	Excellent
Cranmer House, Fakenham	Good	Excellent	Excellent
Benjamin Court, Cromer	Good	Good	Excellent

4 Review of 2011/12

The Trust is proud of its many achievements over the last year. Building on its values, the Trust has delivered exciting and challenging projects and celebrated growth in recognised services. The Trust was proud to be designated as an Early Implementer Site for the national health visiting programme. This designation recognised the high quality of current services and the Trust's ability to innovate within the field of service redesign.

Throughout the year, the Trust continued to deliver significant capital development projects in partnership with commissioners and local communities. New building projects began at both North Walsham and Aylsham that will bring a range of services closer to these communities.

One of the Trust's school nurses received an award for innovation from Anglia Ruskin University for his invention that is designed to help children taking their medication for asthma. The Trust's Falls Service also received a runner up commendation from NHS East of England as part of their Celebrating Success Awards.

4.1 Achievement of KPIs and Performance targets

The Trust has a robust 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.

Indicator	Target or annual threshold	2011/12 outturn
Infection control		
Cases of Clostridium difficile	9	8
Cases of MRSA bacteraemia	1	0
Access		
Percentage of beds occupied by patients whose discharge is delayed for non-medical reasons	6%	4.1%
Percentage of patients treated within 18 weeks of referral	100%	98.7%
Urgent District Nurse response within 24 hours	100%	100%
Non-urgent District Nurse response within 48 hours	100%	100%
Percentage of equipment items delivered to patients within seven days of receipt of referral	99%	99.4%
Public Health		
New birth visits made within 28 days of a birth	95%	97%
Percentage of women fully breast feeding at six weeks	21%	36%
Number of smokers successfully quitting at four weeks	2700	2100 (estimated)
Human Papilloma Vaccination uptake	Contract with PCT	Achieved

Infection control targets

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

Cases of Clostridium difficile

Clostridium difficile (C.diff) 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. The organism is now endemic (continuously present) not only in hospitals but also in nursing homes and other facilities for long term care. Patients taking antibiotics are at risk of becoming infected with C.diff. Antibiotics disrupt the normal bacteria of the bowel, allowing C.diff bacteria to become established in the colon. The chief risk factor for the disease is prior exposure to antibiotics. A prolonged course of antibiotics or the use of two or more antibiotics in combination increases the risk of C.diff diarrhoea. The treatment of C.diff diarrhoea includes rehydration and administration of an antibiotic to which the bacteria are sensitive, whilst maintaining strong infection control measures. Only cases that occur more than 48 hours after admission to the hospital are attributable to the Trust due to the time it takes for the infection to develop.

Cases of MRSA bacteraemia

Methicillin-resistant Staphylococcus Aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. Staphylococcus aureus most commonly colonizes the anterior nares (the nostrils), although the rest of the respiratory tract, open wounds, intravenous catheters, and urinary tract are also potential sites for infection. Healthy individuals may carry MRSA asymptomatically for periods ranging from a few weeks to many years. Many MRSA infections occur in hospitals and healthcare facilities, with a higher incidence rate in nursing homes or long-term care facilities. Rates of MRSA infection are also increased in hospitalised patients who are treated with quinolones, a family of synthetic broad-spectrum antibiotics. Healthcare provider-to-patient transfer is common, especially when healthcare providers move from patient to patient without performing necessary hand-washing techniques between patients. In 2010/11 the Trust experienced nine cases of Clostridium difficile. For 2011/12, the Trust had a ceiling of no more than nine cases for this and one for MRSA bacteraemias. In 2011/12, there were eight reported cases of C.diff, and no MRSA bacteraemias. All reported cases have been subject to Root Cause Analysis to review lessons learned.

Access targets

Delayed transfers of care

This indicator provides a measure of the percentage of beds occupied by patients whose transfer is delayed for non-medical reasons. The number of beds occupied by patients whose discharge is delayed for non-medical reasons, divided by the total number of occupied bed days in the reporting period, expressed as a percentage. Delayed transfers of care result in patients staying in a hospital bed longer than is medically necessary. Often these patients are waiting for health or social care assessments and delays in these processes result in patients' discharges being delayed. During this time patients may become acutely unwell, and as such are no longer classed as medically fit for discharge. The patient is also occupying a bed that could be used by another patient awaiting discharge from an acute hospital. This KPI is a good indicator as to how effectively a health and care system works, given these patients often have complex health and social care needs. Throughout the year, and in line with the previous year, the Trust maintained low levels of delayed transfers of care. On average, patients whose discharge was delayed for non-medical reasons occupied only 4.1% of beds, compared to 4.4% the previous year. There are no contractual targets in place for this measure. This improvement in the discharge process is as a result of the implementation of the 'Productive Ward' across the Trust's community hospitals.

Percentage of patients terated within 18 weeks of referral

This indicator monitors the level of compliance against the 18 week wait Referral to Treatment Target (RTT) for non-admitted patients, i.e. outpatients. 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. The achievement of a maximum wait of 18 weeks from referral to treatment for admitted patients (90% compliance) and non-admitted patients (95% compliance) was a previous NHS Operating Framework requirement. Although the measure for 18 weeks changed following the publication of a revised Operating Framework in June 2011, NHS Norfolk still require the Trust to achieve a local target of 100%, allowing for legitimate exceptions, such as patient choice and clinical complexity. Throughout the year, the Trust made significant improvements with most services either achieving the target on a consistent basis, or being close to 100%.

District Nurse response times

This indicator provides assurance that all referrals to the community nursing teams are actioned and contact made (either face-to-face or by telephone) within 24 or 48 hours depending on the urgency of the referral.

Community equipment store deliveries

This indicator 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 demands made on community equipment services result from:

- equipment, such as a perch stool, walking frame or wheelchair is often required to facilitate hospital discharge by supporting home nursing
- providing equipment and adaptations helps to prevent accidents, such as trips or falls, in the home
- equipment can be a necessary part of continuing care and community care, and often provides a better solution than other forms of (more costly) care
- timely supply of equipment in the community may prevent hospitalisation

By providing equipment in a timely manner following receipt of a referral, ensures the above issues can be addressed promptly. Where a patient chooses to receive their equipment after 7 days, they are excluded from the calculation. The Trust delivered in excess of 23,600 items from its Central Equipment Store.

Public Health targets

New birth visit made within 28 days of birth

The Health Visitor target for all postnatal women to receive a new birth visit by day 28 has been developed in line with the integrated pathway of maternal antenatal /postnatal care jointly delivered by the midwifery and health visiting service. This is in line with national policy including the Healthy Child Programme (DH 2009) and NICE guidance.

The new birth visit provided by the Health Visitor is offered between days 10 to 14 to ensure the provision of on-going postnatal care and advice to mothers as they are discharged by the midwifery service.

The new birth contact is important as it:

- Promotes sensitive parenting
- Enables assessment of mental health
- Promotes and supports continuation of breast feeding
- Addresses sudden infant death through appropriate advice
- Providing relevant advice re health start / smoking cessation
- Promotes advice on home safety
- Promotes advice on safeguarding
- Promotes immunisation uptake

Percentage of women fully breast feeding at six weeks

The indicator is a locally agreed target with NHS Norfolk in line with the NHS Norfolk Breast Feeding Strategic Plan. This is aimed at increasing numbers of mothers breast feeding up to 6 weeks and is in line with the UNICEF baby friendly initiative (1995).

The benefits of mothers continuing breast feeding are extensive and the target is important for children's long term outcomes in terms of:

- Reducing childhood obesity
- Improving infant / maternal attachment
- Reducing cardiovascular disease
- Improving immunity and reducing childhood illnesses, eg, gastro-intestinal upsets, otitis media
- Improving cognitive development / visual acuity

Smoking cessation

This indicator 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 data is reported in arrears because the quit date set by the patient only relates to a successful quit four weeks after that date. Therefore successful quits are reported in the month the successful quit date took place, rather than the reporting month. The Smoking Cessation service agreed an annual target for 2011/12 with NHS Norfolk of 2,700 quits. Despite a comprehensive restructure of the service to deliver the quit target, achieving the necessary level of referrals supported by a strong conversion rate proved challenging. It became apparent during the year that the Trust was starting to deviate from its trajectory and a number of actions were established to improve referrals rates. However, the subsequent referrals generated were not sufficient to recover the level of quits required, and as such the Trust failed this target. For 2012/13, the Trust will work in partnership with NHS Norfolk and Waveney to understand the demographic context of the targets and look at new ways of working with partner organisations to improve quit rates and referrals. A target of 2000 quits has been agreed for 2012/13 with our commissioners.

Human Papillomavirus (HPV) uptake

This indicator monitors the uptake of HPV vaccinations (all doses) against the monthly contractual target agreed with NHS Norfolk. Since September 2008 there has been a national programme to vaccinate girls aged 12 to 13 against the Human Papilloma virus (HPV). 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 that should ideally be given over a period of six months, although they can all be given over a period of 12 months.

Third party investigations and Never Events

From April 2011 to October 2011 the Trust was registered with the Care Quality Commission with conditions on its registration, all of which have been met. The Care Quality Commission has not taken any enforcement action against the Trust during the period April 2011 to March 2012. The Trust did not experience any Never Events during 2011/2012.

Staff Sickness

The rate of staff sickness for the Trust in 2011/12 was 4.79%. (previous year was 5.03%).

4.2 Partnership working

Through close partnership working between our clinicians, Clinical Commissioning Groups and the PCT, the Trust was awarded an additional £1.5m investment to provide an enhanced Community Nursing and Therapy service across the county. This means more staff delivering more services that patients and GPs want. Patients will see the benefit of the new service immediately as the new specification for the service launches this month, with more improvements and expanded services coming online over the coming months. Our community nursing and therapy teams currently have, on average, 108,000 face to face contacts with local patients every month. The new specification has an even stronger focus on keeping these patients stable and out of acute hospitals. It will do this by delivering more equitable access to services through strong integrated frontline teams, using the successful Case Managers model, and increasing the levels of general care and support, right across the county.

Some of the enhanced services will include:

- An expanded and Trust delivered Out of Hours Community Nursing service with a team based within each locality from November 2012 (the West locality will continue with their existing service)
- Care at Home teams - currently only provided in the south - providing supervised, non-qualified, healthcare support to patients in their own homes right across our patch from November 2012
- A dedicated 'named link nurse' working with each GP practice, acting as a direct clinical link between the practice and the Trust and helping our service respond to the needs of patients. Further enhancements to our community-based long term conditions services which are currently under discussion

The new specification will see additional recruitment to support not only the enhanced services but the expanded core services, such as delivering a Rapid Response Team within each locality.

4.3 Foundation Trust Membership

Becoming a foundation trust is an exciting opportunity for the Trust. It means becoming a truly effective public organisation that is accountable to our Members. The Trust will actively engage its Members in developing the services provided, and will be accountable to its Members for those services. The Trust is committed to guaranteeing its Members become central to the way it works as an FT. The Trust wants to become an organisation that is recognised as being at the heart of the community, and to achieve this it needs the community at the heart of its organisation.

The Trust will strive to empower its Members to have a real influence in the direction of the Trust and its services. Having a strong membership will:

- Ensure patients' experiences are listened to and are an integral part of service development
- Empower staff by giving greater control (and therefore ownership) over services and their delivery
- Enable the Trust to maintain and develop the highest levels of safe, quality care
- Improve the Trust's ability to forge strong and diverse partnerships with the community and partners
- Allow the Trust to support the health needs of our community more closely

Over 9,000 members of the public have already signed up to be Members of the future foundation trust, together with over 3,000 members of staff.

4.4 Financial Performance

2011/12 represented the first full financial year of trading for Norfolk Community Health and Care, following establishment as an NHS Trust during the previous financial year as part of the government's Transforming Community Services agenda. The Trust met its statutory duty to break even and remained within its resource limits set by the Department of Health. A £545k surplus for the year was achieved which was an improvement on the previous year's £528k.

Significant efficiency savings were achieved through the Trust's Cost Improvement Programme (CIP) of £6.1m during the year (£4.6m in 2010/11). Much of this was achieved through the redesign and modernisation of services, as well as non-clinical savings from procurement initiatives and travel costs. Shortfall in delivery of the Trust's £7.3m planned efficiency savings coupled with unplanned cost pressures contributed to the £455k underachievement against the planned surplus of £1m for the year. During the first half of the year the Trust put in place a financial recovery plan to address a projected £1.7m deficit. This revised budgets across the organisation and required additional in-year savings to be found. This, along with non-recurrent income received by the Trust, enabled the Trust to deliver a surplus position.

The Trust is required to remain within its Capital Resource Limit (CRL) as set by the Department of Health. For 2011/12, the Trust underspent by £2.0m against its CRL of £7.8m. During the year the Trust's asset base increased as a result of additional Public Dividend Capital of £3.9m being issued by the Department of Health to support the 2011/12 capital expenditure programme. The Trust is currently investing in two key local developments; a new community hospital in North Walsham and a new healthcare complex in Aylsham, both of which are expected to complete early in 2012/13.

Working capital has been stable throughout the year. The Trust remains committed to prompt payment of suppliers and aims to comply with the Confederation of British Industry (CBI) Better Payments Practice code and is a signatory to the government's Prompt Payments Code. 2011/12 saw an improvement on the previous year's performance, with 89% of non-NHS trade payables being paid within 30 days (84% in 2010/11). 74% of NHS payables were paid within 30 days (70% in 2010/11). Details of compliance with the Better Payment Practice code are detailed in note 10.1 to the accounts.

The Trust's closing cash position of £14.5m included £5.7m owed to NHS Norfolk in respect of 2011/12 estate rental payments which was paid over in April 2012.

In preparing the 2011/12 accounts, critical judgements have been made in assessing the lease classification of estates rental charges from NHS Norfolk. Department of Health guidance has been followed in applying IAS 17 Leases, with the resulting classification of the leases as operating leases.

The Trust's external statutory audit for the 2011/12 financial year has been provided by the Audit Commission at a cost to the Trust of £107,467 (inclusive of VAT). The Audit Commission has not provided any other services to the Trust during this period.

Over the coming year the Trust will continue to focus on strengthening the Trust's business platform and long-term sustainability through the delivery of its Cost Improvement Programme, strengthening the core business and developing new service opportunities. The Trust also expects to take ownership of a large proportion of the estate from which it operates during 2012/13, which will increase the Trust's asset base by c£50m.

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. Despite mitigation the following risks remained as high rated risks at the year end:

- Delivery of Cost Improvement Plans
- The impact of pressure ulcers on patient care
- Future unfunded demographic pressures and the impact on finance and quality due to the nature of block contract arrangements

Future risks are categorized as: organisational, clinical quality, workforce, estates, IM&T and finance. The Trust's policy is to manage risk to a reasonable level and for the governance framework to provide reasonable assurance of effectiveness.

5. Our prospects for 2012/13 and beyond

5.1 Annual objectives

The Trust has chosen its annual objectives having drawn together the enabling strategies and service developments and focused on what will be needed to deliver the Trust's vision and values.

Seven priority areas have been identified for 2012/13:

1. To improve the quality of the Trust's services

Quality has to be at the heart of everything we do and we have a range of patient-centred quality measures. These will be measured in part through the implementation of the new Safety Thermometer, which will measure the number of Pressure Ulcers, Falls, Catheter Acquired Infections and the incidence of Venous Thromboembolisms.

Building on our successes last year, we also aim to achieve Level 2 'Baby Friendly' accreditation, as well as the 'You're Welcome' accreditation within our School Nursing Service. We are also aiming to further improve our patient satisfaction scores, which is something every member of staff can play a role in.

2. To deliver excellent services and delight our customers

By demonstrating and delivering services which provide a genuine alternative to hospital care, we plan to reduce avoidable admissions to acute hospitals which will help patients retain their independence and save the local NHS money. We also plan to further increase our stakeholders' understanding of our role within the local area and work with our partners to deliver more integrated services. An excellent example of this can be found in the new Community Nursing and Therapy (CN&T) specification. Tangibly, we expect to see a further increase in the number of GPs reporting their satisfaction with our Trust's services, up to 65% by this time next year. We will also work to further promote good health by early intervention, for example our Family Nurse Partnership Service, while developing our specialist services.

3. To truly inspire our staff

Staff are at the heart of everything we do. We want our Trust's engagement with staff to further improve over the coming months, which will enable staff to make a difference and ensure they have a shared understanding of our goals. Clearly, cascading this information will be a first step to achieving this. As we continue to work towards becoming a Foundation Trust, there will be further opportunities for staff to be involved in the decisions that affect them and the services they provide, including surveys and Staff Governor elections which we expect to hold in 2012. Also, in light of the NHS Staff Survey results we will be looking to all managers to help improve the morale of their staff and this will now form part of the new appraisal process

4. To embed the locality based service model

Our new Localities structure is now in place, but there will be ongoing work to ensure that our GPs and local Clinical Commissioning Groups (CCGs) benefit from localised and simplified services which can help us provide more tailored care to local communities. The GP practices and the CCGs must be at the heart of our services.

5. To achieve the Trust's financial targets

In order to meet our objectives and to remain an attractive provider to commissioners, we must continue to demonstrate that we can make best use of our resources and to operate as efficiently as possible. Within our organisation, there will be targeted reviews to ensure we are making best use of public money and sharing 'best practice' approaches with our colleagues. We will also continue to build upon our best services and look to make the most of new opportunities. Winning new contracts will secure further funding and security for our Trust and staff, but we must make sure we have raised our reputation for being efficient, effective and reliable to give ourselves the best chance of capitalising on upcoming opportunities.

6. To grow our services

Recently we were awarded an additional £1.5m investment into our CN&T services. The Trust also recently took over the provision of the local Night Nursing Service, which will help to make the night service more closely aligned with our Trust's 'in hours' nursing service. We have also made a clear decision to exit from the provision of prisons services. One of our tasks to be delivered early in the new financial year will be to embed our new services. However, we are always looking to develop and expand our business so we can reach even more local people.

7. Continue the process to achieve Foundation Trust status

If we deliver all of the above, then we will be well on the way to becoming an even stronger organisation. Work towards becoming a foundation trust continues at a pace and good progress has been made in preparing our application, for instance by developing our governance processes.

5.2 Quality goals for 2012/13

The Trust has prioritised the following quality goals for 2012/13:

Implement the 'safety thermometer' in four key areas:

- Achieve 95% Venous Thromboembolism (VTE) assessments for inpatients
- 50% reduction in catheter acquired urinary tract infections (CAUTI) by December 2012
- Reduction in the levels of injurious falls in our inpatient units
- Eradication of avoidable Pressure Ulcers

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 / clients 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 CQuIN (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.

- Deliver zero avoidable pressure ulcer target by December 2012
- Improve patient satisfaction to 70% 'very satisfied' and no area <50%
- Implement Patient experience 'net promoter' score system asking inpatients (on a score of 1-10) how likely they would be to recommend the service
- To achieve 'you're welcome' accreditation in school nursing service
- To achieve UNICEF 'baby friendly' accreditation at level 2

5.3 Patient experience in 2012/13

In 2012/13 the Trust aims to build on an excellent year of patient experience in 2011/12 by implementing the following projects:

- Demonstrate improvements in patient experience using the "Net Promoter Score" in all Community Hospitals
- Review results from the Community Services Survey and implement actions as required
- Continue 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
- Work in partnership with services to support locally managed surveys and other methodologies for capturing patient/carer experiences
- Work in partnership with Trust members and external voluntary organisations ensuring effective patient engagement/involvement
- Work in partnership with the Trust Learning Education and Development Team ensuring staff have the core skills, beliefs and values necessary for a good patient or carer experience

5.4 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 Norfolk and Suffolk NHS Foundation Trust (mental health). Additional competition comes from private providers such as Serco 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 (AQP), which also provides opportunities for the Trust.

6. Our staff

The Trust employs over 2,200 whole time equivalent substantive 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 operate 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 three Sure Start Children's Centres.

Reach for the Stars Awards

The Recognition of Excellence and Achievement in Community Health awards incorporates eight categories, clinical and non-clinical, and range from the Patient Centred Care Improvement Award to the Innovations Award. There are awards for individuals and for teams/departments and these are another way of our Trust saying a big thank-you to those people who go the extra mile. As well as recognising the long service of staff (30 and 40 years), the Trust sponsors a set of annual awards for excellence called Reach for the Stars and offers awards for teams and individuals across the Trust in a variety of categories:

- Innovations
- Team of the Year
- Inspirational Role Model
- Partnership/Collaborative Working
- New Business and Procurement
- Patient Centred Care Improvement
- Clinical Excellence
- Health and Safety

Finalist at national awards

A community nurse and care manager was named as a finalist in the national General Practice Awards, 'Nurse of the Year' category. Based at Sapphire House, Norwich, Tracey Blazey was one of over 200 nominations in this category put forward by colleagues. Tracey, who has 30 years' NHS experience, was nominated for the consistently high-quality of care she provides to adults who have learning disabilities.

Queen's Nurse Honour

A Specialist Neurological Nurse was awarded the title of 'Queens Nurse' in recognition of her commitment to delivering further improved community-based care. Katrine 'Trine' Kiertzner, who has 25 years' nursing experience, received the title from community nurses' charity the Queen's Nursing Institute. The title aims to unite nurses who have promoted high standards of care and encourages them to champion new ways of delivering innovative practices.

Improving teenagers' mental health

School Nurse, Bernadette Osterberg, is rolling out a trial project to provide innovative care for high school students who have a history of self-harm, substance abuse and risk-taking behaviours. Bernadette aims to improve their mental wellbeing by facilitating joined up care, working with partners such as Child and Adolescent Mental Health Services (CAMHS) and Mancroft Advice Project (MAP) to enable young people to get access to counsellors, youth workers and advisers.

Family praises 'absolutely fantastic' Community Matron

A Community Matron has been hailed as 'an amazing ambassador of the NHS and mankind' by the family of a former patient. Fiona Baldwin received the praise after caring for the patient at their home for over a year. In a letter, the family said; "Fiona showed such competence, care and support to the whole family … and despite mum's poor health, she would perk up at just the sound of Fiona's voice." "As a person I think she is a truly wonderful lady … and my family extend our warmest thanks to her."

Certificates of recognition

Each month we celebrate the commitment of our staff to the continued delivery of excellent care and support. Staff receive a Certificate of Recognition at the Management Forum and are named in the staff newsletter, The Exchange.

6.1 Staff engagement

Staff engagement is at the centre 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 of the Trust is predominantly clinical.

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, and 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 2011/12 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, and technical skills as well as leadership and management.

6.2 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

6.3 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 (NHS Act 2006 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

Norfolk Community Health and Care NHS Trust Board

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 of the Board. Non-executive directors have a particular duty to ensure appropriate challenges are made. 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.

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 CEO of acute hospital trusts, regional director within the Audit Commission and a director of the NHS Modernisation Agency. While CEO at a primary care trust, he also managed community services and their successful transition to a potential Foundation Trust.

Ken Applegate
Chair

In his role as Chairman, Ken is responsible for leading the Board and Non-Executives 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. 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.

Dr Ian Mack
Medical Director

Ian works with the Trust's teams and partners to develop services which continue to deliver high-quality, personalised care to patients. A GP himself, Dr Mack also ensures the Trust works closely with GP groups and provides advice to the Board. Ian has a particular interest in medicine for older people and champions further improvements to local services. He joined the Trust from local commissioning organisation NHS Norfolk, where he was a member of their Clinical Executive Committee for five years and its Chairman for 18 months. He has been a GP for 21 years, spending the last 18 of those years working as a GP in Norfolk. He is also a councillor for Watlington on King's Lynn and West Norfolk Borough Council.

Loyola Weeks
Director of Quality, Risk and Executive Nurse

Loyola has worked for the NHS for over 30 years, commencing with clinical posts as Midwife, District Nurse and Health Visitor. Undertaking various clinical and organisational leadership positions in Hertfordshire and London resulted in delivering projects at a regional and national level from Safeguarding to change management programmes. She has worked with a North London community healthcare provider as a Clinical Director and Head of Service Developments across Children, Young People/Adults, Older People and Learning Difficulties.

Anna Morgan
Director of 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.

Roy Clarke
Director of Finance

Roy is a Chartered Management Accountant with over 14 years of NHS provider experience including developing and implementing organisational strategies, financial recovery plans and estate development. He joined us from Mid Essex Hospital Services NHS Trust, where he held a number of roles including Acting Director of Finance and Deputy Director of Finance.

Non-Executive Directors

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 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 is a dissertation supervisor at the University of East Anglia, and has experience in marketing, counselling and has worked with Voluntary Norfolk. She has held political leadership roles in local government and stood for Parliament twice. Currently, Vivienne is a Vice-President of the Royal Norfolk Show and is a business consultant.

Patrick John Harris

Patrick qualified with KPMG in London and later moved to Norwich where he became a partner in 1983. In 2000 the Norwich office joined Grant Thornton. Patrick retired from Grant Thornton in July this year. As a partner, Patrick has acted for a wide range of clients in a number of sectors. A significant part of his portfolio has been in the public and not-for profit sectors. He led internal audit services for five district councils in Norfolk, a Government agency and external audits of charities, housing associations and other organisations receiving government support, for example a New Deal for Communities Trust. He is also responsible for external audits of two groups of local authority owned trading companies with turnovers in excess of £100 million.

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.

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.

7.1 Register of Directors

Voting Board members

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	
Vivienne Clifford-Jackson	Non Executive	Senior Independent Director
Michael Scott (From 9 January 2012)	Executive	Chief Executive
Roy Clarke (From 12 December 2011)	Executive	Director of Finance
Anna Morgan	Executive	Director of Operations
Ian Mack	Executive	Medical Director
Loyola Weeks	Executive	Executive Nurse and Director of Quality & Risk

Non-voting executive members

Name	Designation	Role
Matt Colmer (From 7 June 2011)	Executive	Director of Organisational Performance
Paul Cracknell (From 7 January 2012)	Executive	Interim Director of Business Development
Tracey Parkes (From 1 October 2011)	Executive	Interim Director of Human Resources

Register of Directors' Interests

Name	Title	Declared interest
Ken Applegate	Chair	Non-Executive Director, UNAT Direct Governor, Lowestoft College Director, Lowestoft and Waveney Education Services Ltd
Michael Scott	Chief Executive	Director, Barrowby Management Solutions Ltd (No current NHS contracts)
Roy Clarke	Director of Finance	None
Vivienne Clifford-Jackson	Non-Executive Director	Residential landlord – small monthly rental income Dissertation supervisor at the University of East Anglia Business consultant, Clifford Consulting – training and communications Vice-President of the Royal Norfolk Show
Matt Colmer	Director of Organisational Performance from 7 June 2011 Director of Finance from 4 January 2010 to 6 June 2011	Governor of City College, Norwich
Paul Cracknell	Interim Director of Human Resources 27 August 2011 to 31 August 2011 Interim Chief Executive from 1 September 2011 to 6 January 2012 Interim Director of Business Development from 7 January 2012 to 31 March 2012	Trustee/Director of charitable company, The Open Youth Trust Secondee, NHS Norfolk
Lisa Gamble	Non-Executive Director	Consultancy and coaching, from 1 March 2012 Company Director for Dream On – community interest company, working on funded client programmes and with personal and corporate clients such as FSA, Aviva, etc
Patrick Harris	Non-Executive Director	None
Dr Ian Mack	Medical Director	Elected Member, King's Lynn and West Norfolk Borough Council Partner, Watlington Medical Centre Director, Watlington Health Member, Transitional Executive West Norfolk Shadow GPC
Anna Morgan	Director of Operations	Peer Reviewer for RCN Publications – review all articles that have Safeguarding/LD/Older People context
Tracey Parkes	Interim Director of Human Resources From 1 October 2011 to 31 March 2012	None
Alex Robinson	Non-Executive Director	Governor, Millfield Primary School Director, Alex Robinson Ltd
James Ross	Non-Executive Director	None
Loyola Weeks	Director of Quality, Risk and Executive Nurse	None

Board attendance

The Board meets monthly and attendance at the meetings over the year was as follows:

	2011									2012		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Ken Applegate	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Alex Robinson	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Vivienne Clifford-Jackson	Y	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
James Ross	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Patrick Harris	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
Lisa Gamble	Y	Y	Y	Y	N	Y	Y	Y	N	Y	Y	Y
Chief Executive	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y
Director of Finance	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Medical Director	Y	Y	N	Y	Y	Y	N	Y	Y	Y	Y	Y
Executive Nurse	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Director of Operations	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

7.2 Committees

Audit Committee membership

Name	Designation
Patrick Harris	Non-Executive Director Committee Chair
Vivienne Clifford-Jackson	Non-Executive Director Deputy Committee Chair
Lisa Gamble	Non-Executive Director Committee member

Audit Committee attendance

The Committee met five times in 2011/12 and attendance was as follows:

Date	PH	VC-J	LG
16 May 2011	•	•	•
6 June 2011	•	•	•
16 September 2011	•	apologies	•
19 December 2011	•	•	apologies
23 March 2012	•	•	apologies

Quality and Risk Assurance Committee membership

Name	Designation
Alex Robinson	Non-Executive Director Committee Chair
Vivienne Clifford-Jackson	Non-Executive Director Deputy Committee Chair
Patrick Harris	Non-Executive Director

Finance Committee membership

Name	Designation
James Ross	Non-Executive Director Committee Chair
Alex Robinson	Non-Executive Director Deputy Committee Chair
Roy Clarke	Director of Finance
Paul Cracknell	Interim Director of Business Development
Tracey Parkes	Interim Director of Human Resources
Anna Morgan	Director of Operations

Charitable Funds Committee membership

Name	Designation
Patrick Harris	Non-Executive Director Committee Chair
Lisa Gamble	Non-Executive Director Deputy Committee Chair
Roy Clarke	Director of Finance
Anna Morgan	Director of Operations

Remuneration and Nominations Committee membership

All Non-Executive Directors and the Chair are members of the Remuneration and Nominations Committee which is chaired by Vivienne Clifford-Jackson.

Past Board members

Name	Role	Designation	From	To
Sheila Adams-O'Shea	Chief Executive	Voting executive member	1 September 2008	31 August 2011
Barbara Wilson	Director of Human Resources	Non voting executive member	4 January 2010	26 August 2011
Martin Pettifor	Director of Business Development	Non voting executive member	4 January 2010	31 January 2012
Dominic Tkaczyk	Interim Director of Finance	Voting executive member	7 June 2011	11 December 2011
Paul Cracknell	Interim Director of Human Resources	Non voting executive member	27 August 2011 On secondment from NHS Norfolk	31 August 2011
Paul Cracknell	Interim Chief Executive	Voting executive member	1 September 2011 On secondment from NHS Norfolk	6 January 2012

8. Remuneration report

8.1 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 2011/12 financial year, three of the Executive Directors were employed through a contract for services. Two were seconded from other NHS organisations.

Remuneration and Nomination Committee Membership:

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

The following tables and narrative in notes 8.2, 8.3 and 8.4 have been audited by the Audit Commission.

8.2 Salaries and allowances

The salaries and other allowances of the senior managers who have been in office during the 2011/12 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.

During the year the whole salary disclosed for two directors were paid to third parties as follows:

- Finegreen Associates (Dominic Tkacyzk)
- NHS Norfolk (Paul Cracknell, relating to the period 1 January 2012 to 31 March 2012 only)

During the year one director was on secondment from NHS Great Yarmouth & Waveney at no cost to the Trust (Tracey Parkes).

Salaries and allowances

		2011/12			2010/11		
Name	**Title**	**Salary (bands of £5,000) £000**	**Other remuneration (bands of £5,000) £000**	**Bonus payments (bands of £5,000) £000**	**Salary (bands of £5,000) £000**	**Other remuneration (bands of £5,000) £000**	**Bonus payments (bands of £5,000) £000**
Kenneth Applegate	Chair	20-25	0	0	5-10	0	0
Sheila Adams O'Shea	Chief Executive (from 01.04.11 to 31.08.11) On secondment to East of England Strategic Health Authority (01.09.11 to 31.03.12)	120-125	0	0	120-125	0	0
Michael Scott	Chief Executive (09.01.12 to 31.03.12)	25-30	0	0	0	0	0
Ian Mack	Medical Director	70-75	0	0	0	0	0
Loyola Weeks	Director of Quality & Risk (Executive Nurse)	95-100	0	0	100-105	0	0
Anna Morgan	Director of Operations	95-100	0	0	85-90	0	0
Matthew Colmer	Director of Finance (01.04.11 to 06.06.11) Director of Organisational Performance (07.06.11 to 31.03.12)	95-100	0	0	90-95	0	0
Dominic Tkacyzk	Interim Director of Finance (07.06.11 to 11.12.11)	160-165	0	0	0	0	0
Roy Clarke	Director of Finance (12.12.11 to 31.03.12)	30-35	0	0	0	0	0
Martin Pettifor	Director of Business Development (01.04.11 to 31.01.12)	80-85	0	0	95-100	0	0
Barbara Wilson	Director of Human Resources (01.04.11 to 26.08.11) Other senior duties (27.08.11 to 25.01.12)	75-80	0	0	95-100	0	0

Salaries and allowances continued

		2011/12			2010/11		
Name	**Title**	**Salary (bands of £5,000) £000**	**Other Remuneration (bands of £5,000) £000**	**Bonus Payments (bands of £5,000) £000**	**Salary (bands of £5,000) £000**	**Other Remuneration (bands of £5,000) £000**	**Bonus Payments (bands of £5,000) £000**
Paul Cracknell	Interim Director of HR (27.08.11 to 31.08.11) Interim Chief Executive (01.09.11 to 06.01.12) Interim Director of Business Development (07.01.12 to 31.03.12)	35-40	0	0	0	0	0
Tracey Parkes	Director of Human Resources (01.10.11 to 31.03.12)	0	0	0	0	0	0
Bob Mee	Interim Director of Learning Disability Service (01.04.11 to 14.09.11)	40-45	0	0	95-100	0	0
Alexander Robinson	Non-Executive Director	5-10	0	0	0-5	0	0
James Ross	Non-Executive Director	5-10	0	0	5-10	0	0
Lisa Gamble	Non-Executive Director	5-10	0	0	5-10	0	0
Patrick Harris	Non-Executive Director	5-10	0	0	5-10	0	0
Vivienne Clifford-Jackson	Non-Executive Director	5-10	0	0	5-10	0	0

8.3 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 2011/12 was £120-£125k (no change from 2010/11). This was 4.9 times (no change from 2010/11) the median remuneration of the workforce, which was £25,528 (£25,472 in 2010/11).

In 2011/12, 3 part-time (2 part-time in 2010/11) 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.

8.4 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 on page 46. These benefits relate to membership of the NHS Pension Scheme which is open to all employees.

Pension benefits

Name	Title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2012 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Sheila Adams O'Shea	Chief Executive (01.04.11 to 31.08.11) On secondment to East of England Strategic Health Authority (01.09.11 to 31.03.12)	5.0-7.5	12.5-15.0	50-55	155-160	869	1055	160	0
Michael Scott	Chief Executive (from 09.01.12 to 31.03.12)	n/a	n/a	50-55	150-155	n/a	1036	n/a	0
Loyola Weeks	Director of Quality & Risk/Executive Nurse	0-2.5	2.5-5.0	25-30	75-80	479	552	58	0
Anna Morgan	Director of Operations	0-2.5	2.5-5.0	15-20	45-50	208	271	57	0
Matthew Colmer	Director of Finance (01.04.11 to 06.06.11) Director of Organisational Performance (07.06.11 to 31.03.12)	0-2.5	2.5-5.0	20-25	70-75	266	359	84	0
Roy Clarke	Director of Finance (12.12.11 to 31.03.12)	n/a	n/a	15-20	45-50	n/a	179	n/a	0
Martin Pettifor	Director of Business Development (01.04.11 to 31.01.12)	0	0	0-5	0	21	45	23	0
Barbara Wilson	Director of Human Resources (01.04.11 to 26.08.11) Other senior duties (27.08.11 to 25.01.12)	0-2.5	0	0-5	0	17	39	21	0

8.5 Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. 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.

In the budget on 23 March 2011, HM Treasury confirmed its intention to review the basis for the calculation of CETVs payable from public service schemes, including the NHS Pension Scheme. The review was undertaken and revised guidance was issued on 26 October 2011.

For the calculation of CETVs as at 31 March 2012, NHS Pensions have followed the revised guidance and have used the updated Government Actuary Department (GAD) factors in their calculations. The revised GAD factors are different to those used as at 31 March 2011 so direct comparison between financial periods is not possible.

The new factors will have differing impacts of the CETVs of the individuals concerned depending on their age and normal retirement age.

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 and contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

9. Emergency preparedness

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.

10. 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

11. 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 aims to become a leading public sector exemplar."

11.1 Carbon Footprint

Norfolk Community Health and Care 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 successfully managed a sustainable development process for the last four 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 Non-Executive Director and Executive Director lead for sustainable development.

The Trust has completed carbon footprint assessments for 2007 and 2010. The Trust has in the past, been assessing on the basis of calendar year and 100% occupancy at each location. Performance against the Climate Change Act Targets is measured against this 2007 assessment – see figure 1.

Figure 1. 2007 Carbon Footprint Performance

Scope	Source	tCO2e	%
1	Gas	3012	25%
	Gas Oil	106	1%
	Heating Oil	512	4%
	Travel	2569	21%
2	Electricity	2505	21%
3	Freight	290	2%
	Procurement	2176	18%
	Pharmaceuticals	858	7%
Total		**12028**	**100%**

Figure 1 illustrates high impact areas include gas, travel and electricity.

Each year, the Trust conducts a carbon footprint assessment and compares against the baseline. The results of the assessment for 2010 are outlined below.

Figure 2. 2010 Footprint Performance

Scope	Source	tCO2e	%
1	Gas	2680	24%
	Gas Oil	33	0%
	Heating Oil	162	1%
	Travel	1679	15%
2	Electricity	2935	27%
3	Freight	104	1%
	Procurement	2046	19%
	Pharmaceuticals	1096	10%
	Waste	229	2%
Total		**10964**	**100%**

Figure 2 illustrates high impact areas still include gas and electricity.

The 2010 footprint now includes emissions arising from waste. The Trust will improve the carbon footprint for 2011 and 2012 to include all areas required.

Outstanding areas include air and rail travel under the scope of passenger transport and refrigeration and air conditioning under the scope of energy. This will lead to a fully comprehensive carbon footprint measuring all areas required. The 2010 footprint has been assessed on the basis of 100% occupancy. To improve the scope and methodology of these assessments, the Trust will complete the carbon footprint for 2011 by financial year and actual percentage occupied at each location. This will ensure the Trust measures and manages its own carbon footprint in both fully and partially occupied buildings

11.2 Sustainable Development Management Plan

Following an early success in winning the Sustainability in Care: Health and Social Care Awards 2009 for the Eastern region with NHS Norfolk, the Trust has gone on to develop strong policy and practice within the sustainable development management plan (SDMP). The management plan outlines actions to be completed by members of the Trust in each of the following areas: Carbon, Energy, Procurement, Food, Travel, Water, Waste, Workforce, Governance, Buildings, Finance.

Actions are tracked by the Trust's sustainable development committee on a bi monthly basis. Recent actions have led to an increase in recycling facilities and rates. Prior to April 2011, the Trust's recycling rate was approximately 17%. All Trust sites now have access to dry-mixed recycling facilities. Since April 2011, the average Trust recycling rate has increased to 31%. Some sites have achieved significantly higher levels of recycling, for example Elliot House is currently recycling 68% of its waste. The Trust will focus in 2012/13 on increasing rates at low-performing sites.

The SDMP is reviewed on an annual basis by the Estates and Facilities Department. The review for 2012 will include the addition of new areas such as adaptation. Within this area of work, the Trust will further develop site and departmental continuity plans throughout 2012. The key focus for development in 2012/13 will include climate change adaptation. The Trust will utilise its integrated working with local public sector estates services to incorporate available data in estate planning such as consideration of development around flood plains and adaptation of estates projects to mitigate weather effects on care.

11.3 Good Corporate Citizenship Assessment (GCCA)

The Trust recognises the significant role it can play as a community leader and demonstrating good corporate citizenship. The Trust's SDM is built on the Good Corporate Citizenship model and a robust carbon measurement system to manage progress.

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. The test includes questions under the following areas: Travel, Procurement, Facilities Management, Workforce, Community engagement and, Buildings.

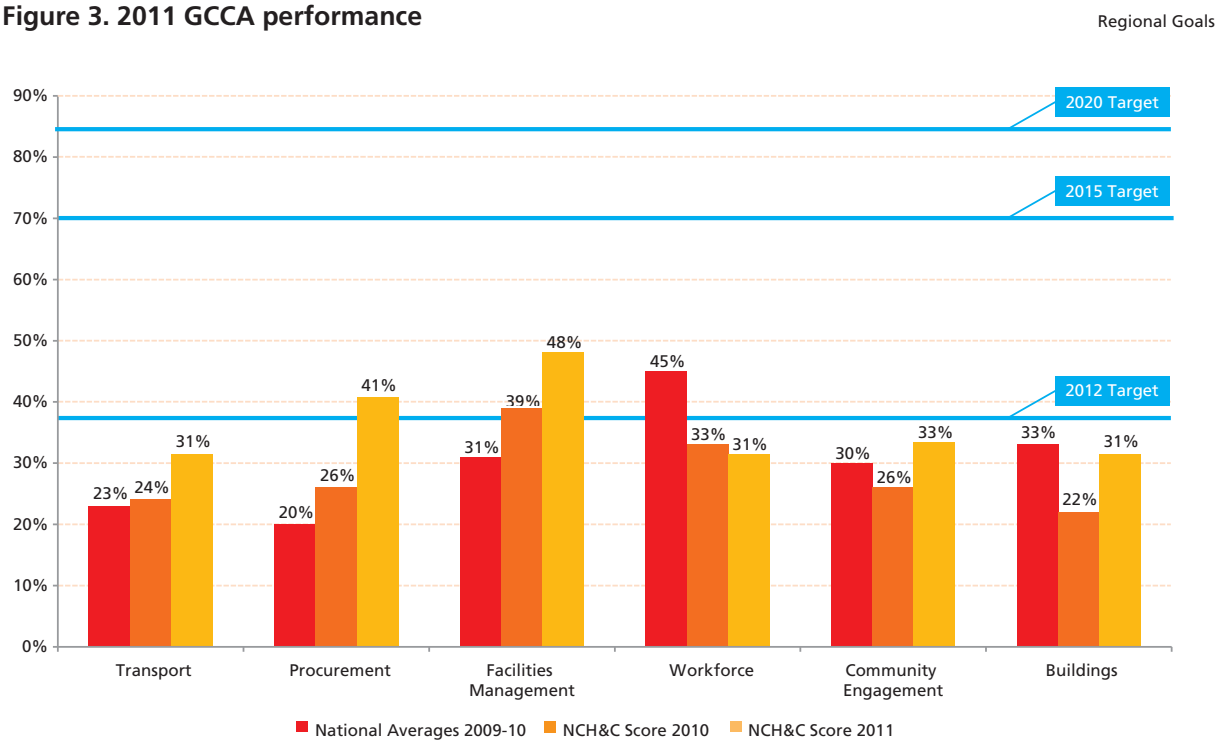
The Trust has conducted workshop assessments with representatives drawn from across the Trust, from key service / function areas. The output of each assessment is incorporated into the Sustainable Development Strategy and Management Plan.

Figure 3 below shows how the Trust performs against national average, target levels and its own previous performance.

Figure 3 demonstrates areas for improvement in workforce and buildings. Good Corporate Citizenship actions are tracked by the Trust's sustainable development committee on a bi monthly basis. Recent proposals include the development of an energy champion network to promote and manage the sustainability agenda at site level.

In 2010 the Trust was assessed as part of NHS Norfolk. In 2011 the Trust used a more robust self assessment methodology which coupled with assessment as a separate trust gave more valid results. It is recognised that as a result of these changes the Trust's workforce results have decreased but this is not of significant concern. Good Corporate Citizenship Assessments will be updated for 2012 and reported to the Board.

Figure 3. 2011 GCCA performance



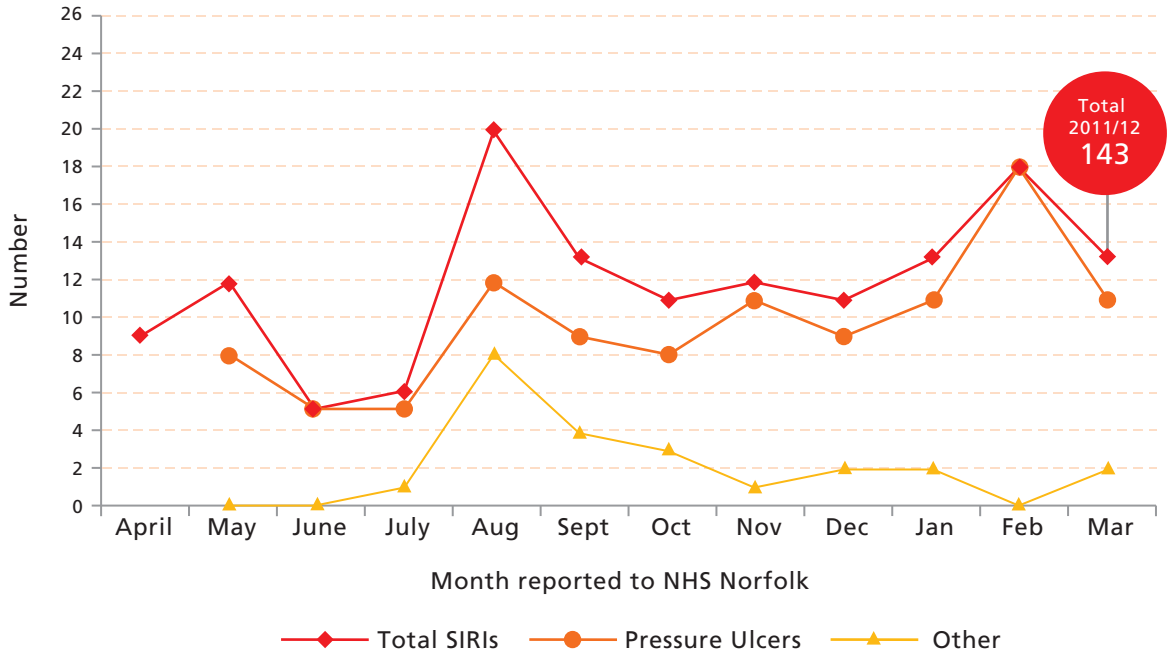
11.4 Annual sustainability planning and reporting

The Trust has included an overview of performance and its future plans in sustainability within its annual report. The Trust has been given access to the NHS Sustainability Reporting Framework being developed by the Sustainable Development Unit to compare financial and non financial indicators.

The Trust aims to use the framework to improve its annual reporting processes and will work towards providing our first sustainable development report during 2012/13.

12. 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.



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 Managing Public Money.

14. 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 two serious incidents requiring investigation involving data loss or confidentiality breaches and a further incident reported to the Information Commissioner's Office. These are described in the Annual Governance Statement below.

Norfolk Community Health and Care NHS Trust

Accounts 2011/2012

Looking after you locally

Getting better together

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
- 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

08 June 2012

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

Roy Clarke
Director of Finance

08 June 2012

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 three non voting Executive Directors who lead the clinical and corporate services that deliver quality care to patients and service users.

The Board applies the principles of integrated governance to ensure that clinical services are consistently safe, effective and patient experience is good, and that resources are used and managed effectively.

The Board operates to a forward agenda plan that covers quality, strategy, performance and planning and corporate governance matters.

The Board monitors monthly integrated performance reports, quality and risk 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 and Quality and Risk Assurance 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, and the Finance Committee reviews the financial strategy, financial 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, including its committees, 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 2012/13 continues to embed the lessons learned from the activities undertaken during 2011/12, 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.

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 and 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 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.

3 Risk assessment

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

The Trust achieved level 1 against the NHSLA (NHS Litigation Authority) risk management standards in its own right as an NHS Trust. Previously level 1 had been achieved as an arms length body of NHS Norfolk. 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 website at www.nhsla.com/riskmanagement. All the standards are divided into three levels: one, two and three. 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 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 risk management 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 focussed 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 monthly 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 and Risk 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 2011/12

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 at the year end:

- Delivery of the cost improvement plans
- The impact of pressure ulcers on patient care
- Future unfunded demographic pressures and the impact on finance and quality due to the nature of the block contract arrangements

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 2011, the Board Assurance Framework comprised twelve risks to the achievement of its strategic objectives rated as: four with a risk rating of 20, five with a risk rating of 16, and three with a risk rating of 12. At the year end in March 2012, there were three risks on the BAF, with the following rating: two rated as 20, and one rated as 16. 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 two areas of high risk and one of medium risk in the Trust's assurance framework. These are covered in more detail under section 15.5 below. The recommendations made by Internal Audit are being fully implemented. Looking forward, the Trust's risk profile is being categorised into: organisational, clinical quality, workforce, estates, IM&T, and finance.

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 2012 and up to the date of approval of the Annual Report and accounts.

The Trust received its first independent quality and risk profile as an independent NHS Trust in August 2011. This profile summarises how the Care Quality Commission currently views 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 team. Any new areas of concern are reported to the monthly 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 two serious incidents requiring investigation involving data loss or confidentiality breaches. These are summarised below:

The first incident was the potential loss of a nurse's ward handover sheet. The investigation showed that it had been found by another member of staff within the ward area and disposed of correctly. The second incident involved inappropriate access to information by staff. The Trust takes such incidents very seriously as patients trust us with personal and often sensitive information in order to provide care. As professionals, our staff are aware of keeping this information safe and secure and receive appropriate training to support them to do so. As a result of the investigation, the staff members involved were dismissed and the Information Commissioner's Office was kept fully informed.

A further incident occurred in March 2012. The Trust was informed by a healthcare contractor that they had inadvertently collected items of personal patient information along with items of product performance data they routinely downloaded from diagnostic equipment that they had provided to the Trust. The Trust was one of a number of NHS organisations where this process had inadvertently taken place and therefore the incident investigation and management was undertaken by the Department of Health. The incident was notified to the Information Commissioner's Office and the joint view of the Department of Health and Information Commissioner's Office was that the risk of harm to patients was negligible. The data is held in a complex format and is not readily accessible and the contractor gave assurance, independently verified, that the data remained secure, had not been subject to loss, hacking, misuse or theft and was destroyed on the completion of the investigation.

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 effected in 2011/12. These structures were strengthened and supported through the appointment of a Chief Executive in January 2012, a Director of Finance in December 2011, and a Trust Secretary in January 2012. The Director of Quality and Risk and Executive Nurse provides the leadership and management for the risk management function within the Trust, and 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 exception reports from a number of sub committees that closely monitor areas of risk including: the Quality and Clinical Effectiveness, Infection Prevention and Control Committee, multi-agency safeguarding committees, the Health and Safety and Information Governance Committees. All these groups 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 Units, Trust Management Team, and the Operational Management Group 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
- National Patient Safety Agency data
- Assurance from Internal and External Audit reports
- Clinical Audit

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, 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 centrally maintained drives. This system is supported through monthly risk review processes led by the quality and risk team; risk register reports are then scrutinised at service level and corporate meetings. Risks that are not being successfully mitigated and controlled are escalated and discussed at 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 Committee 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 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.

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 on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Finance 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
- 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 and risk 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

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
- Results of national patient and staff surveys
- Investigation reports and action plans following serious incidents requiring investigation
- Clinical audit reports

The Trust has proactively recognised the need for ongoing 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
- Key finance controls
- Mandatory training
- Data quality - alerts system
- Performance data for Datix and Meridian systems
- Clinical audit

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.

The design and operation of the Assurance Framework and associated processes

Internal Audit reviewed the central methodology through which the Trust conducts its review of the system of internal control through our review of the Board Assurance Framework (BAF) and Risk Management. This review considered the policies and procedures for the identification, reporting and management of risks as well as whether the form and content of the BAF complies with best practice guidelines, is kept up to date and actively used by the Board as a tool for managing significant business risks. An overall classification of Medium Risk was assigned to this review. Two high risk findings and one medium risk finding were identified:

The completeness and quality of information in local and business unit risk registers is insufficient. The quality of information recorded for business objectives, risks, controls and control assurances in the local and delivery unit risk registers is insufficient (High Risk), the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF) do not include all appropriate risks (High Risk), and not all extreme (red) risks are escalated from the corporate risk register to the BAF (Medium Risk).

The Trust fully accepts the recommendations identified in this report. Implementation of the recommendations will improve the control effectiveness of risk registers and the escalation and de-escalation of risks from service level up to CRR and BAF. This will further strengthen the processes in place across the operational teams to ensure appropriate levels of risk are assessed, recorded and escalated. All extreme risks (red) are now escalated to the BAF for consideration by the Board.

Other high risk issues noted from Internal Audit work during 2011/12:

In addition to the comments above on Internal Audit's review of the Assurance Framework, listed below are other high risk issues identified from the work of Internal Audit, together with a summary of the actions / plans the Trust has to implement to mitigate the control failings identified:

Key Finance Controls

Contract reconciliations for significant suppliers are not performed (High Risk); no supporting documentation was in place for the Prison Pharmacy contract variation (High Risk); and the write-off for £234k of bad debts undertaken in September 2011 was not authorised in line with the Scheme of Delegation (High Risk).

Management accepts the recommendations and actions include: formal contract variation document will be agreed between the Trust and provider. The Trust ensures that there are supporting documents for all contracts and contract variations. The scheme of delegation will be followed with respect to authorisation of bad debt write-offs. Contract reconciliations for significant suppliers will be performed at year end and on a quarterly basis from April 2012 onwards. The Trust has reviewed the key policy documents and amended them as appropriate to ensure ongoing compliance. A full review and revision of the documentation of those procedures is planned during the first half of 2012/13.

HR - Mandatory Training

Trust employees are not in every case undertaking training in accordance with the Mandatory Training Policy Summary (High Risk); new joiners do not in every case complete the mandatory training within the required period of three months (High Risk); and there are as yet no formal systems in place to ensure that agency staff have the appropriate training (High Risk).

The Trust fully accepts the recommendations and has initiated the following actions: bank staff receive all mandatory training prior to commencement of shift work; permanent staff are reminded of their duties to complete all mandatory training in accordance with the Trust's Mandatory Training Policy. Performance on mandatory training is monitored by the Board to ensure appropriate action plans are in place to address areas of non-compliance and target areas for intervention. Departments are supported to access different and various forms of mandatory training. The Trust has agreed that the filing of paperwork could be improved and is working with line managers to agree a more efficient process. The combination of the NHS LA Training Needs Analysis and Local Induction gives the managers the knowledge to ensure staff access the appropriate training.

Data Quality - Alerts System

Clinical data on SystmOne is incomplete. In addition, a duplicate patient record system ('Alpha system') is in existence, with limited controls to ensure the security of this data or consistency of patient data between SystmOne and Alpha system (High Risk).

The Trust has agreed to close down the Alpha system and re-iterate to all staff that they are required to record all patient information on SystmOne.

Performance Data for Datix (incident reporting system) and Meridian (patient experience software system).

Datix - Confidential patient data is not isolated from general data, and the approvers list is not being reviewed regularly (High Risk).

The Trust fully accepts the recommendations and has reviewed the following: access to all sensitive patient information to ensure it is appropriately secured within the correct databases; security measures on sensitive and non sensitive data to achieve the appropriate balance between adequate security measures and resources responsible for the management of that data; the approver list embedded in the system at least quarterly, and; the incident contacts list for duplication monthly and rectify.

Clinical Audit

There is limited evidence to show that clinical audit is an integral part of the Board's quality assurance process and there is scope to clarify the roles of the Quality and Risk Assurance Committee and the Audit Committee in the monitoring of clinical audit as a source of assurance (High Risk); There is scope to improve the level of clinical engagement in the clinical audit function (High Risk); The development of the annual clinical audit programme does not fully comply with HQIP guidance (High Risk); The central clinical audit resource has limited capacity (High Risk); There is no mechanism for reporting the progress of the annual clinical audit programme (High Risk); There is a lack of performance management and quality checking throughout the clinical audit cycle, and also inadequate processes to follow up on recommendations made to ensure improvements in quality are achieved (High Risk); and the format of the clinical audit report template could be improved (High Risk).

The Trust takes these issues extremely seriously, and has put in place a robust action plan which is being monitored by the Quality and Risk Assurance Committee on a monthly basis and updated to reflect completed actions with the following key documents having been approved:

- Terms of Reference for the Clinical Audit and Effectiveness Committee have been updated and approved by the parent committee, the Quality and Risk Assurance Committee, and an executive lead has been nominated
- The final Clinical Audit Strategy has been approved and published
- The Clinical Audit Policy has been revised to reflect HQIP principles and has been published
- The Clinical Audit Annual Plan for 2012/13 has been produced with clinicians
- An Annual Report has been compiled and presented to the Quality and Risk Assurance Committee
- Quarterly update reports, including use of the HQIP template, will be in place for quarter one 2012/13

6 Other significant issues to report

Downham Market Health Centre

Within a 12 month period (March 2010 – Feb 2011) there were four serious incidents requiring investigation (SIRI), resulting in the suspension of two GPs at Downham Market Health Centre, a nurse led Personal Medical Service practice. The service was managed by Norfolk Community Health and Care (an arms length organisation to NHS Norfolk) until formal separation on 1 November 2010 when Norfolk Community Health and Care became an independent NHS Trust. As from 1 April 2011 the Trust ceased to manage the service and it was transferred to another provider. The most recent of the SIRIs resulted in high profile national and local media interest. The Board firmly believes that the Trust has taken seriously the learning outcomes from the incidents at Downham Market Health Centre and has put in place new systems where appropriate and strengthened existing processes to ensure that we have robust quality governance systems in place. All recommendations from both external and internal reviews into the incidents have been acted upon and implemented.

Looked After Children – OFSTED & Care Quality Commission (CQC) report

The Office for Standards in Education (OFSTED) and the Care Quality Commission published a report entitled "Inspection of safeguarding and looked after children services - Norfolk County Council" (July 2011).
This identified six key areas for improvement of the Looked After Children service, and two of these areas were the direct responsibility of the Trust as follows:

- Within three months: ensure that looked after children placed out of area receive health assessments and that all looked after children initial assessments are undertaken by a medical practitioner in accordance with guidance
- Within six months: provide an effective health 'leaving care' service

The Board implemented an action plan that has satisfactorily addressed these issues and has ensured full compliance within the required timescales.

HM Prison Norwich

From April 2011 to October 2011 the Trust had the following conditions on its registration with the Care Quality Commission:

The registered provider must not carry on the regulated activity "Treatment of Disease Disorder or Injury" in the Local Discharge Unit at HMP Norwich, Knox Road, Norwich, Norfolk, NR1 4LU.

This condition was is in place following a visit the Care Quality Commission undertook at HMP Norwich when authorising another provider's registration. They found that the discharge unit did not comply with the regulations because it did not protect people's right to privacy, dignity, choice and confidentiality.

The Trust took the following actions to ensure compliance:

To ensure privacy and dignity is maintained at all times, the Trust has ensured that the room is only utilised by one clinician at any time. Two benches have been installed in the recess outside the adjudication room providing a waiting area a few metres away from the consultation room. It will not be possible for any waiting prisoners to overhear any consultations. Privacy screens have also been allocated to the room to protect people's privacy and dignity. By making the above changes the Trust now protect people's rights to privacy, dignity, choice and confidentiality.

The Care Quality Commission has confirmed to the Trust through the issue of a Notice of Decision that the condition applied to its registration, restricting it from providing "Treatment of Disease Disorder or Injury" from the treatment room in the Local Discharge Unit at HMP Norwich, has now been lifted.

Severance agreement

During the year the Trust's external auditors reviewed a Trust severance agreement and made several recommendations on where the Trust can secure best practice in its governance and decision-making process for terminations of employment. These recommendations have been fully accepted by the Trust with a full implementation action plan in place. The implementation of the action plan is subject to scrutiny by the Chief Executive and the Remuneration Committee.

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.

Accountable Officer:

Michael Scott
Organisation: **Norfolk Community Health and Care NHS Trust**

Date: **08 June 2012**

Independent auditors' report to the directors of Norfolk Community Health and Care NHS Trust

I have audited the financial statements of Norfolk Community Health and Care NHS Trust for the year ended 31 March 2012 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. 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. I have also audited the information in the Remuneration Report that is described as having been audited.

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.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me 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, I read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my 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 2012 and of its expenditure and income for the year then ended
- 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 my opinion:

- the part of the Remuneration Report to be audited 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
- 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 I report by exception

I report to you if:

- in my opinion the governance statement does not reflect compliance with the Department of Health's Guidance
- I refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because I have a 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
- I issue a report in the public interest under section 8 of the Audit Commission Act 1998

I 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 auditor

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.

I am required under Section 5 of the Audit Commission Act 1998 to satisfy myself 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 me to report to you my conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

I report if significant matters have come to my attention which prevent me from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I am not required to consider, nor have I 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

I have undertaken my audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2011, as to whether the Trust has proper arrangements for:

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

The Audit Commission has determined these two criteria as those necessary for me to consider under the Code of Audit Practice in satisfying myself 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 2012.

I planned my work in accordance with the Code of Audit Practice. Based on my risk assessment, I undertook such work as I 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 my work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2011, I am 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 2012.

Certificate

I certify that I 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

District Auditor and Engagement Lead Officer of the Audit Commission

The Audit Commission,
3rd Floor, Eastbrook,
Shaftesbury Road,
Cambridge,
CB2 8BF

08 June 2012

Accounts

Statement of Comprehensive Income for year ended 31 March 2012

Notes 1-29 on pages 19 to 57 form part of these accounts.

	NOTE	2011/12 £000	2010/11 £000
Employee benefits	9	**(88,321)**	(90,109)
Other costs	7	**(38,664)**	(39,918)
Revenue from patient care activities	4	**120,861**	127,945
Other operating revenue	5	**6,864**	2,764
Operating surplus		**740**	682
Finance costs	11	**0**	(4)
Surplus for the financial year		**740**	678
Public Dividend Capital dividends payable		**(195)**	(150)
Retained surplus for the year		**545**	528
Other comprehensive income		**0**	0
Total comprehensive income for the year		**545**	528

Financial performance for the year	
Retained surplus for the year	**545**
Impairments	**92**
Adjusted retained surplus*	**637**

***** A Trust's adjusted retained surplus is derived from its retained surplus, but adjusted for impairments to non-current assets. An impairment charge is not considered part of the organisation's operating position.

PDC dividend: balance receivable at 31 March 2012	**161**

Statement of Financial Position as at 31 March 2012

Non-current assets	NOTE	31 Mar 2012 £000	31 Mar 2011 £000
Property, plant and equipment	12	**8,981**	4,910
Intangible assets	13	**87**	70
Total non-current assets		**9,068**	4,980
Current assets			
Inventories	17	**404**	510
Trade and other receivables	18.1	**8,418**	10,015
Cash and cash equivalents	19	**14,484**	2,013
Total current assets		**23,306**	12,538
Total assets		**32,374**	17,518
Current liabilities			
Trade and other payables	20	**(15,696)**	(5,191)
Provisions	22	**(517)**	(611)
Total current liabilities		**(16,213)**	(5,802)
Non-current assets plus net current assets		**16,161**	11,716
Non-current liabilities			
Provisions	22	**(145)**	(120)
Total non-current liabilities		**(145)**	(120)
Total assets employed		**16,016**	11,596
Financed by taxpayers' equity			
Public Dividend Capital		**14,943**	11,068
Retained earnings		**1,073**	528
Total taxpayers' equity		**16,016**	11,596

These accounts were approved by the Trust's Audit Committee under delegated authority from the Trust Board and signed on its behalf by:

Michael Scott
Chief Executive
08 June 2012

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2012

Changes in taxpayers' equity for 2011/12	Public Dividend Capital £000	Retained earnings £000	Total reserves £000
Balance at 1 April 2011	11,068	528	**11,596**
Retained surplus for the year	0	545	**545**
New Public Dividend Capital received	3,875	0	**3,875**
Net recognised revenue for the year	3,875	545	**4,420**
Balance at 31 March 2012	14,943	1,073	**16,016**

Changes in taxpayers' equity for 2010/11			
Balance at 1 April 2010	0	0	**0**
Retained surplus for the year	0	528	**528**
New Public Dividend Capital received	11,068	0	**11,068**
Net recognised revenue for the year	11,068	528	**11,596**
Balance at 31 March 2011	11,068	528	**11,596**

Statement of cash flows for the year ended 31 March 2012

Cash flows from operating activities	2011/12 £000	2010/11 £000
Operating surplus	740	682
Depreciation and amortisation	1,674	1,428
Impairments and reversals	92	24
Interest paid	0	0
Dividend paid	(356)	(156)
(Increase)/decrease in inventories	106	35
(Increase)/decrease in trade and other receivables	1,597	(4,654)
Increase/(decrease) in trade and other payables	9,124	(1,292)
(Increase)/decrease in other current liabilities	0	(813)
Provisions utilised	(480)	(3,586)
Increase/(decrease) in provisions	411	1,558
Net cash inflow/(outflow) from operating activities	12,908	(6,774)
Cash flows from investing activities		
(Payments) for property, plant and equipment	(4,259)	(2,317)
(Payments) for intangible assets	(53)	(59)
Proceeds of disposal of assets held for sale (PPE)	0	95
Net cash inflow/(outflow) from investing activities	(4,312)	(2,281)
Net cash inflow/(outflow) before financing	8,596	(9,055)
Cash flows from financing activities		
Public Dividend Capital received	3,875	11,068
Net cash inflow/(outflow) from financing activities	3,875	11,068
Net increase/(decrease) in cash and cash equivalents	12,471	2,013
Cash and cash equivalents (and bank overdraft) at beginning of the period	2,013	0
Cash and cash equivalents (and bank overdraft) at year end	14,484	2,013

Notes to the accounts

1 Accounting policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011/12 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Transforming Community Services (TCS) transactions

Under the TCS initiative, services historically provided by PCTs have transferred to other providers - notably NHS Trusts and NHS Foundation Trusts.

Such transfers fall to be accounted for by use of merger accounting. The Treasury Financial Reporting Manual (FReM) provides that where a transfer takes place in 2011/12, the recipient of the transfer will account for transferred activity in full for the period (and the original provider for none) to reflect the position had the transfer always applied.

For TCS transactions specifically, it is impracticable to adjust the prior period's revenue account in each body and so restatement is effected by an adjustment to opening balances rather than by full restatement of comparators.

As part of the TCS initiative, Norfolk Community Health and Care NHS Trust was formally established as an NHS Trust on 1 November 2010, having previously operated as the provider arm of NHS Norfolk. The figures stated in these accounts for the previous financial year ended 31 March 2011, against which the current year results are compared, were prepared on a merger accounting basis in line with the Treasury FReM. There have been no TCS transfers during the 2011/12 financial year.

1.4 Critical accounting judgements and key sources of estimation uncertainty

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

1.4.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Critical judgements have been made in assessing the lease classification of estates rental charges from NHS Norfolk. Department of Health guidance has been followed in applying IAS 17 Leases, with the resulting classification of the leases as operating leases (note 8 to the accounts).

1.4.2 Key sources of estimation uncertainty

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

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

1.5 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services.

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

1.6 Employee Benefits

1.6.1 Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

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

1.6.2 Retirement benefit costs

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

Further details of the scheme are provided in note 9.5 to the accounts.

a) Full actuarial (funding) valuation

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

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

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

c) Scheme provisions

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

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

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

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

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

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

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

1.7 Other expenses

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

1.8 Property, plant and equipment

1.8.1 Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably, and
- the item has a cost of at least £5,000, or

- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control, or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost

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

1.8.2 Valuation

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

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

1.8.3 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Intangible assets

1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights.

They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

1.9.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.10 Depreciation, amortisation and impairments

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

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011/12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.11 Leases

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

1.11.1 The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

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

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

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

1.11.2 The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

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

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value using replacement cost. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.13 Cash and cash equivalents

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

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

1.14 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (2.8% for employee early departure obligations).

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

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

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.15 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 22.

1.16 Non-clinical risk pooling

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

1.17 EU Emissions Trading Scheme

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

1.18 Contingencies

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

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.19 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

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

The Trust has not held any financial assets at fair value through profit and loss, held to maturity investments or available for sale financial assets to date.

Loans and receivables

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

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

1.20 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

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

1.21 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in note 29 to the accounts.

1.24 Public Dividend Capital (PDC) and PDC dividend

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

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as Public Dividend Capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.25 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments.

They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.26 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. The Trust does not have any subsidiaries.

For 2010/11 and 2011/12 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the corporate trustee.

1.27 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2011/12. The application of the Standards as revised would not have a material impact on the accounts for 2011/12, were they applied in that year:

- IAS 1 Presentation of Financial Statements (Other Comprehensive Income) - subject to consultation
- IAS 12 - Income Taxes (amendment) - subject to consultation
- IAS 19 Post-employment benefits (pensions) - subject to consultation
- IAS 27 Separate Financial Statements - subject to consultation
- IAS 28 Investments in Associates and Joint Ventures - subject to consultation
- IFRS 7 - Financial Instruments: Disclosures (annual improvements) - effective 2012/13
- IFRS 9 Financial Instruments - subject to consultation
- IFRS 10 Consolidated Financial Statements - subject to consultation
- IFRS 11 Joint Arrangements - subject to consultation
- IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
- IFRS 13 Fair Value Measurement - subject to consultation
- IPSAS 32 - Service Concession Arrangement - subject to consultation

2 Operating segments

The Trust does not have separately identifiable operating segments. Almost all of the Trust's income generating activity is from community healthcare services. Income from PCTs accounts for over 80% of total income.

3 Income generation activities

Income generation activities are defined as activities undertaken with the aim of achieving profit, which is then used in patient care. The Trust does not undertake income generation activities that could be considered material.

4 Revenue from patient care activities

	2011/12 £000	2010/11 £000
Strategic Health Authorities	155	221
NHS Trusts	1	16
Primary Care Trusts - non-tariff	102,397	106,926
Foundation Trusts	4,275	5,380
Local Authorities	9,422	12,595
Department of Health	2	7
NHS other	0	77
Non-NHS: Other	4,609	2,723
	120,861	127,945

5 Other operating revenue

	2011/12 £000	2010/11 £000
Recoveries in respect of employee benefits	0	95
Education, training and research	991	586
Charitable and other contributions to expenditure	0	107
Non-patient care services to other bodies	2,067	12
Rental revenue from operating leases	2,320	1,643
Other revenue	1,486	321
	6,864	2,764
Total operating revenue	127,725	130,709

6 Revenue

	2011/12 £000	2010/11 £000
From rendering of services	127,725	130,709

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

7 Operating expenses (excluding employee benefits)

	2011/12 £000	2010/11 £000
Services from other NHS Trusts	**858**	1,784
Services from Primary Care Trusts	**24**	1,003
Services from other NHS bodies	**55**	67
Services from Foundation Trusts	**5,249**	4,017
Purchase of healthcare from non-NHS bodies	**447**	636
Trust Chair and Non-Executive Directors	**55**	21
Supplies and services - clinical	**6,268**	6,897
Supplies and services - general	**5,140**	4,952
Consultancy services	**322**	362
Establishment	**1,728**	1,541
Transport	**3,040**	3,074
Premises	**11,664**	12,434
Impairments and reversals of receivables	**813**	160
Inventories write down	**0**	0
Depreciation	**1,638**	1,420
Amortisation	**36**	8
Impairments and reversals of property, plant and equipment	**92**	24
Audit fees	**106**	129
Internal audit	**72**	52
Clinical negligence	**227**	189
Education and training	**415**	589
Other	**415**	559
	38,664	39,918

Employee benefits		
Employee benefits excluding Board members	**87,132**	89,115
Board members	**1,189**	994
Total employee benefits	**88,321**	90,109
Total operating expenses	**126,985**	130,027

8 Operating leases

The majority of lease arrangements are with NHS Norfolk. The lease terms on these arrangements are under one year in duration as all community estate is expected to transfer either to the Trust or to an alternative organisation before 31 March 2013. All other lease agreements are shown on the basis of the individual agreements.

8.1 Trust as lessee

Payments recognised as an expense	2011/12 £000	2010/11 £000
Minimum lease payments	**7,847**	7,853
Contingent rents	**0**	0
Sub-lease payments	**0**	0
Total	**7,847**	7,853

Total future minimum lease payments payable	Land £000	Buildings £000	Other £000	2011/12 Total £000	2010/11 Total £000
No later than one year	625	5,781	835	**7,241**	2,231
Between one and five years	24	1,469	793	**2,286**	3,965
After five years	0	248	0	**248**	243
Total	649	7,498	1,628	**9,775**	6,439
Total future sublease payments expected to be received				**1,894**	2,934

8.2 Trust as lessor

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

Recognised as income	2011/12 £000	2010/11 £000
Rents	**2,320**	1,643
Contingent rents	**0**	0
Total	**2,320**	1,643

Total future minimum lease payments receivable		
No later than one year	**1,894**	1,638
Between one and five years	**0**	1,140
After five years	**0**	156
Total	**1,894**	2,934

9 Employee benefits and staff numbers

9.1 Employee benefits

Employee Benefits 2011/12 - gross expenditure	Total £000	Permanently employed £000	Other £000
Salaries and wages	73,876	68,725	5,151
Social security costs	5,257	4,892	365
Employer contributions to NHS Pensions scheme	8,807	8,201	606
Termination benefits	381	381	0
Total employee benefits	88,321	82,199	6,122
Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	88,321	82,199	6,122

Employee Benefits 2010/11 - gross expenditure	Total £000	Permanently employed £000	Other £000
Salaries and wages	74,744	68,799	5,945
Social security costs	5,240	4,823	417
Employer contributions to NHS Pensions scheme	8,884	8,178	706
Other pension costs	84	84	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	1,157	1,157	0
Total employee benefits	90,109	83,041	7,068
Employee costs capitalised	0		
Net employee benefits excluding capitalised costs	90,109		

9.2 Staff numbers

Average staff numbers	Total number	Permanently employed number	2011/12 Other number	2010/11 (restated)* Total number
Medical and dental	34	31	3	40
Administration and estates	530	462	68	487
Healthcare assistants and other support staff	626	576	50	627
Nursing, midwifery and health visiting staff	866	815	51	895
Nursing, midwifery and health visiting learners	0	0	0	14
Scientific, therapeutic and technical staff	421	415	6	487
Other	40	37	3	5
Total	2,518	2,336	182	2,555
Of the above - staff engaged on capital projects	0	0	0	0

* 2010/11 figures have been revised to ensure consistency of information with 2011/12 figures.
The figures included within the 2010/11 accounts incorrectly deducted temporary staff from the total.
This has been corrected in the table above.

9.3 Staff sickness absence and ill health retirements

	2011/12 number	2010/11 number
Total days lost	**41,943**	38,965
Total staff years	**2,280**	2,391
Average working days lost	**18.4**	16.3

There were no early retirements on the grounds of ill health during 2011/12 or 2010/11 as defined by the NHS Pensions Agency, and for which the cost of any additional pension liability would be met by the scheme (see note 9.5).

During 2010/11 there was one early retirement from the Trust agreed on the grounds of permanent injury. The cost of this is met in full by the Trust (see note 9.5). The additional pension liability of this permanent injury retirement is estimated at £154,638 as at 31 March 2012. This an updated estimate from that at 31 March 2011, where the estimate was £126,767, based on a revised annuity factor in line with the latest life tables provided by the Office for National Statistics.

9.4 Exit packages agreed in 2011/12

	2011/12			2010/11		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
Less than £10,000	5	0	**5**	0	0	**0**
£10,001-£25,000	2	0	**2**	2	0	**2**
£25,001-£50,000	1	0	**1**	2	0	**2**
£50,001-£100,000	2	1	**3**	1	0	**1**
£100,001 - £150,000	3	0	**3**	1	0	**1**
£150,001 - £200,000	0	0	**0**	0	0	**0**
>£200,000	0	0	**0**	1	1	**2**
Total number of exit packages by type	13	1	**14**	7	1	**8**
Total resource cost (£000s)	660	79	**739**	501	327	**828**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Agenda for Change national framework. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pension Scheme. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the table.

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

9.5 Pension costs

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

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

a) Full actuarial (funding) valuation

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

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

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

c) Scheme provisions

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

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

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

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

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

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

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

10 Better Payment Practice Code

10.1 Measure of compliance

Non-NHS payables	2011/12 Number	2011/12 £000	2010/11 Number	2010/11 £000
Total non-NHS trade invoices paid in the year	**19,105**	**29,329**	26,072	25,015
Total non-NHS trade invoices paid within target	**16,938**	**25,528**	21,906	20,588
Percentage of NHS trade invoices paid within target	**88.7%**	**87.0%**	84.0%	82.3%

NHS payables				
Total NHS trade invoices paid in the year	**1,018**	**13,089**	1,378	16,112
Total NHS trade invoices paid within target	**757**	**11,219**	967	13,708
Percentage of NHS trade invoices paid within target	**74.4%**	**85.7%**	70.2%	85.1%

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

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

There have been no costs incurred during 2011/12 (also nil in 2010/11) in relation to the late payment of commercial debts.

11 Finance costs

Interest	2011/12 £000	2010/11 £000
Provisions - unwinding of discount	**0**	4
Total interest expense	**0**	4
Other finance costs	**0**	0
Total	**0**	4

12 Property, plant and equipment

12.1 Property, plant and equipment

2011/12	Land £000	Buildings excluding dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation								
At 31 March 2011	155	460	0	3,183	76	2,984	3,052	**9,910**
Additions purchased	0	0	4,839	701	0	261	0	**5,801**
Impairments/negative indexation	0	0	0	0	0	0	0	**0**
At 31 March 2012	155	460	4,839	3,884	76	3,245	3,052	**15,711**
Depreciation								
At 31 March 2011	0	9	0	1,689	76	969	2,257	**5,000**
Impairments	0	0	0	63	0	12	17	**92**
Charged during the year	0	19	0	529	0	753	337	**1,638**
At 31 March 2012	0	28	0	2,281	76	1,734	2,611	**6,730**
Net book value at 31 March 2012	155	432	4,839	1,603	0	1,511	441	**8,981**
Purchased	155	432	4,839	1,603	0	1,511	441	**8,981**
Total at 31 March 2012	155	432	4,839	1,603	0	1,511	441	**8,981**
Asset financing								
Owned	155	432	4,839	1,603	0	1,511	441	**8,981**
Total	155	432	4,839	1,603	0	1,511	441	**8,981**

12.2 Property, plant and equipment

2010/11	Land £000	Buildings excluding dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation								
At 1 April 2010	0	0	0	3,151	76	1,554	2,936	**7,717**
Additions - purchased	155	460	0	156	0	1,430	116	**2,317**
Disposals other than by sale	0	0	0	(124)	0	0	0	**(124)**
At 31 March 2011	155	460	0	3,183	76	2,984	3,052	**9,910**
Depreciation								
At 1 April 2010	0	0	0	1,156	52	530	1,847	**3,585**
Disposals other than for sale	0	0	0	(29)	0	0	0	**(29)**
Impairments	0	0	0	9	15	0	0	**24**
Charged during the year	0	9	0	553	9	439	410	**1,420**
At 31 March 2011	0	9	0	1,689	76	969	2,257	**5,000**
Net book value at 31 March 2011	155	451	0	1,494	0	2,015	795	**4,910**
Purchased	155	451	0	1,494	0	2,015	795	**4,910**
Total at 31 March 2011	155	451	0	1,494	0	2,015	795	**4,910**
Asset financing								
Owned	155	451	0	1,494	0	2,015	795	**4,910**
Total	155	451	0	1,494	0	2,015	795	**4,910**

12.3 Property, plant and equipment

The Trust owns one building which was last independently revalued at 31 March 2010. The current market value is not considered to be materially different to the carrying amount.

Economic lives of non-current assets	Min life years	Max life years
Intangible assets		
Software licences	2	5
Licences and trademarks	1	5
Property, plant and equipment		
Buildings excluding dwellings	15	40
Plant and machinery	3	15
Transport equipment	5	7
Information technology	3	5
Furniture and fittings	5	10

One revision to useful economic life has been made during the year. This related to some dental equipment which was identified as nearing the end of its useful life.

13 Intangible non-current assets

13.1 Intangible non-current assets

2011/2012	Software purchased £000	Licences and trademarks £000	Total £000
Cost or valuation			
At 31 March 2011	54	28	**82**
Additions - purchased	0	53	**53**
At 31 March 2012	54	81	**135**
Amortisation			
At 31 March 2011	12	0	**12**
Charged during the year	14	22	**36**
At 31 March 2012	26	22	**48**
Net book value at 31 March 2012	28	59	**87**
Net book value at 31 March 2012 comprises			
Purchased	28	59	**87**
Total at 31 March 2012	28	59	**87**

13.2 Intangible non-current assets

2010/11	Software purchased £000	Licences and trademarks £000	Total £000
Cost or valuation			
At 1 April 2010	23	0	**23**
Additions - purchased	31	28	**59**
At 31 March 2011	54	28	**82**
Amortisation			
At 1 April 2010	4	0	**4**
Charged during the year	8	0	**8**
At 31 March 2011	12	0	**12**
Net book value at 31 March 2011	42	28	**70**
Net book value at 31 March 2011 comprises			
Purchased	42	28	**70**
Total at 31 March 2011	42	28	**70**

13.3 Intangible non-current assets

Intangible assets are valued at depreciated historical cost due to their short finite life and relatively low value. Intangibles are amortised over the shorter of the term of the license and their useful economic lives which is assessed as being between 3 and 5 years.

14 Analysis of impairments and reversals recognised in 2011/12

Property, plant and equipment impairments and reversals taken to SoCI	2011/12 Total £000
Loss or damage resulting from normal operations	92
Total charged to Departmental Expenditure Limit	**92**
Total impairments of property, plant and equipment	**92**

Total impairments charged to revaluation reserve	0
Total impairments charged to SoCI - DEL	92
Total impairments charged to SoCI - AME	0
Overall total impairments	**92**

There were £24,152 of impairments recognised during 2010/11.

15 Commitments

15.1 Capital commitments

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

	31 March 2012 £000	31 March 2011 £000
Property, plant and equipment	122	0
Intangible assets	**0**	0
Total	122	0

16 Intra-Government and other balances

2011/12	Current receivables £000s	Current payables £000s
Balances with other central government bodies	1,807	9,703
Balances with local authorities	2,586	463
Balances with NHS Trusts and Foundation Trusts	975	479
Balances with public corporations and Trading Funds	0	0
Balances with bodies external to government	3,050	5,051
At 31 March 2012	**8,418**	**15,696**

2010/11		
Balances with other central government bodies	910	178
Balances with local authorities	1,945	264
Balances with NHS Trusts and Foundation Trusts	3,090	682
Balances with public corporations and Trading Funds	0	0
Balances with bodies external to government	4,070	4,067
At 31 March 2011	**10,015**	**5,191**

17 Inventories

2011/12	Consumables £000	Energy £000	Other £000	Total £000
Balance at 1 April 2011	118	16	376	**510**
Prior period adjustment	0	0	0	**0**
Merger adjustment	0	0	0	**0**
Restated at 1 April 2011	118	16	376	**510**
Additions	2,864	44	1,167	**4,075**
Inventories recognised as an expense in the period	(2,905)	(40)	(1,236)	**(4,181)**
Write-down of inventories (including losses)	0	0	0	**0**
Reversal of write-down previously taken to SoCI	0	0	0	**0**
Transfers (to)/from other bodies	0	0	0	**0**
Transfers (to) Foundation Trusts	0	0	0	**0**
Balance at 31 March 2012	**77**	**20**	**307**	**404**

18 Receivables

18.1 Trade and other receivables

	Current	
	31 March 2012 £000	**31 March 2011 £000**
NHS receivables - revenue	**2,720**	4,000
NHS prepayments and accrued income	**0**	0
Non-NHS receivables - revenue	**5,606**	4,836
Non-NHS prepayments and accrued income	**601**	883
Provision for the impairment of receivables	**(975)**	(436)
VAT	**62**	373
Operating lease receivables	**404**	359
Total	**8,418**	10,015
Total current and non-current	**8,418**	10,015

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

18.2 Receivables past their due date but not impaired

	31 March 2012 £000	**31 March 2011 £000**
By up to three months	**900**	2,570
By three to six months	**21**	477
By more than six months	**33**	140
Total	**954**	3,187

18.3 Provision for impairment of receivables

	2011/12 £000	2010/11 £000
Balance at 1 April	**(436)**	(276)
Amount written off during the year	**274**	0
(Increase)/decrease in receivables impaired	**(813)**	(160)
Balance at 31 March	**(975)**	(436)

The Trust has reviewed its outstanding receivables and determined that a number of items are unlikely to be collected. In conducting this review the Trust has considered the age of the debt, and any disputes that have been or are expected to be lodged by customers, and any other relevant credit control information.

19 Cash and cash equivalents

	31 March 2012 £000	31 March 2011 £000
Opening balance	**2,013**	0
Net change in year	**12,471**	2,013
Closing balance	**14,484**	2,013
Comprising		
Cash with Government Banking Service	**14,459**	1,993
Commercial banks	**11**	20
Cash in hand	**14**	0
Cash and cash equivalents as in statement of financial position	**14,484**	2,013
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**14,484**	2,013
Patients' money held by the Trust, not included above	**2**	2

20 Trade and other payables

	Current	
	31 March 2012 £000	31 March 2011 £000
Interest payable	0	0
NHS payables - revenue	6,054	860
NHS payables - capital	254	0
NHS accruals and deferred income	1,123	470
Non-NHS payables - revenue	559	917
Non-NHS payables - capital	1,288	0
Non-NHS accruals and deferred income	3,667	2,881
Social security costs	2,751	63
Total	15,696	5,191
Total payables (current and non-current)	15,696	5,191
Included above		
Outstanding pension contributions at the year end	1065	2

There were no non-current payables as at 31 March 2012.

21 Deferred income

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Opening balance at	273	0	0	0
Deferred income addition	950	273	0	0
Transfer of deferred income	(260)	0	0	0
Closing balance	963	273	0	0
Total other liabilities (current and non-current)	963	273	0	0

22 Provisions

	Total £000s	Comprising Pensions relating to other staff £000s	Legal claims £000s	Redundancy £000s
Balance at 1 April 2011	**731**	128	67	536
Prior period adjustment	**0**	0	0	0
Merger adjustments	**0**	0	0	0
Restated balance 1 April 2011	**731**	128	67	536
Arising during the year	**486**	0	46	440
Utilised during the year	**(480)**	(6)	(14)	(460)
Reversed unused	**(108)**	0	(28)	(80)
Unwinding of discount	**0**	0	0	0
Change in discount rate	**33**	33	0	0
Balance as at 31 March 2012	**662**	155	71	436
Expected timing of cash flows				
No later than one year	**517**	10	71	436
Later than one year and not later than five years	**31**	31	0	0
Later than five years	**114**	114	0	0

Amount included in the provisions of the NHS litigation authority in respect of clinical negligence liabilities	
As at 31 March 2012	1,051
As at 31 March 2011	621

The provision for pensions relating to other staff relates to an injury benefit claim for a former employee. Its carrying amount is the present value of the expected future cash flows discounted using HM Treasury's rate of 2.8% for pension liablities.

There is no uncertainty in respect of timings of future payments.

The legal claims provision relate to employer and public liability cases which are managed on the Trust's behalf through the NHS Litigation Authority. The timings of payments are uncertain but expected to fall within the next 12 months. A further £35,000 is disclosed as a contingent liability in relation to employer and public liability cases.

The redundancy provision relates to a number of staff whose roles have been disestablished following service reconfiguration. These payments are all expected to be made within the next 12 months.

The Trust is a member of the NHS Litigation Authority's Clinical Negligence Scheme for Trusts. Any provisions relating to clinical negligence cases against the Trust are held in the accounts of the NHS Litigation Authority.

As at 31 March 2012, the NHS Litigation Authority has provisions totalling £1,050,972 (£621,077 in 2010/11) in respect of clinical negligence liabilities of the Trust.

23 Contingencies

Contingent liabilities	31 March 2012 £000	31 March 2011 £000
Third party liability (NHSLA)	35	50
Other - restructuring	0	743
Commercial	275	0
Amounts recoverable against contingent liabilities	0	0
Net value of contingent liabilities	**310**	793
Contingent assets	**0**	0
Net value of contingent liabilities	**310**	793

The Trust has a contingent liability of £35,000 (£50,000 in 2010/11) in respect of employers and public liabliity claims under the NHS Litigation Authority Liabilities to Third Parties Scheme. A further amount of £71,000 is included within provisions (£67,000 in 2010/11).

The other constructive liability relates to a commercial agreement whereby the Trust has agreed during the year to make a payment to a customer as consideration for the jointly agreed termination of a contract for services, subject to certain conditions being met.

24 Financial Instruments

24.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department in conjunction with the Trust's shared financial services provider, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Strategic Health Authority. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2012 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

24.2 Financial Assets

	Loans and receivables £000	Total £000
Receivables - NHS	2,011	**2,011**
Receivables - non-NHS	5,583	**5,583**
Cash at bank and in hand	14,482	**14,482**
Total at 31 March 2012	22,076	**22,076**
Receivables - NHS	4,000	**4,000**
Receivables - non-NHS	5,132	**5,132**
Cash at bank and in hand	2,013	**2,013**
Total at 31 March 2011	11,145	**11,145**

24.3 Financial Liabilities

	Other £000	Total £000
NHS payables	6,308	**6,308**
Non-NHS payables	1,847	**1,847**
Total at 31 March 2012	8,155	**8,155**
NHS payables	860	**860**
Non-NHS payables	980	**980**
Total at 31 March 2011	1,840	**1,840**

25 Events after the end of the reporting period

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

26 Related party transactions

Details of related party transactions are as follows:

	Payments to related party £	Receipts from related party £	Amounts owed to related party £	Amounts due from related party £
Norfolk Community Health and Care Charitable Fund	26,468	224,107	0	245,995
Bob Mee (Interim Director of Learning Disabilities Service) trading as Bob Mee Associates	49,771	0	0	0

Payments to Bob Mee Associates were made for the services of Bob Mee as Interim Director of Learning Disabilities during the year.

Norfolk Community Health and Care Charitable Fund (registered charity number 1051173) is a related party due to it being under common control to the Trust (the Trust is the Corporate Trustee of the Charitable Fund). The Trust has received revenue payments during the 2011/12 financial year relating to recharges of staffing at the Trust's specialist palliative care service, and equipment and other consumables which the Trust has procured on the Charitable Fund's behalf.

The Department of Health is regarded as a related party. During the year Norfolk Community Health and Care NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

- NHS Norfolk (Primary Care Trust)
- NHS Great Yarmouth & Waveney (Primary Care Trust)
- NHS Suffolk (Primary Care Trust)
- NHS Cambridgeshire (Primary Care Trust)
- NHS Lincolnshire (Primary Care Trust)
- NHS East of England (Strategic Health Authority)
- Norfolk & Norwich University Hospitals NHS Foundation Trust
- Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- Cambridge & Peterborough Mental Health NHS Foundation Trust (trading as Anglia Support Partnership)
- Hertfordshire Partnership NHS Foundation Trust
- Norfolk & Suffolk NHS Foundation Trust
- East Anglian Ambulance NHS Trust
- NHS Litigation Authority
- NHS Pensions Agency
- NHS Supply Chain

The Trust also had a number of immaterial transactions with other NHS Primary Care Trusts.

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with:

- Norfolk County Council
- Audit Commission
- HM Revenue & Customs

27 Losses and special payments

The total number of losses cases and their total value was as follows:

	2011/12		2010/11	
	Total value of cases £s	Total number of cases	Total value of cases £s	Total number of cases
Losses	1,725	17	12,618	3
Special payments	1,279	7	409,777	9
Total losses and special payments	3,004	24	422,395	12

The £422,395 total of losses and special payments for 2010/11 includes a compensation payment of £327,000 made to a member of staff, resulting from several claims made against the Trust with resolution provided by judicial mediation following discussion with the East of England Strategic Health Authority and HM Treasury.

28 Financial performance targets

28.1 Breakeven performance

	2011/12 £000	2010/11 £000
Turnover	127,725	130,709
Retained surplus for the year	545	528
Adjustments for impairments	92	24
Break-even in-year position	637	552
Break-even cumulative position	1,189	552

28.2 Capital cost absorption rate

From 2009/10 the dividend payable on Public Dividend Capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

28.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	£000	2011/12 £000	2010/11 £000
External financing limit		6,264	11,068
Cash flow financing	(8,596)		9,056
External financing requirement		(8,596)	9,056
Undershoot		14,860	2,012

28.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2011/12 £000	2010/11 £000
Gross capital expenditure	5,854	5,657
Charge against the capital resource limit	5,854	5,657
Capital resource limit	7,825	5,724
Underspend against the capital resource limit	1,971	67

29 Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2012 £000s	31 March 2011 £000s
Third party assets held by the Trust	2	2

The Trust does not hold any other third party assets.

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