NHS
Norfolk and Suffolk
NHS Foundation Trust

Annual report and accounts

April 2017 to March 2018

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

Contents

Chair's report

The last 12 months have seen mental health becoming increasingly prominent in the news, reflecting the growing demand for equal funding with physical health and the welcome efforts to reduce the stigma associated with mental illness. The Trust has continued to campaign on both of these issues. We have seen some extra investment in Norfolk and Suffolk with new services opening in Perinatal Mental Health in both counties, a new Mother and Baby Unit due to open on the Hellesdon Hospital site in January 2019 and five extra beds commissioned in our Dragonfly Unit for young people with mental health conditions at Carlton Court. There was also an ambitious £4m project to further improve healthcare in King's Lynn by bringing the town's specialist mental health services onto one site, including a 16-bed inpatient unit at Chatterton House, replacing the existing suite at the Fermoy Unit.

The Emotional Wellbeing Hub in Suffolk, which officially launched in May 2018, aims to improve access to services, support and advice for people aged up to 25 years old, from a central point of contact. We have worked together with young people and their families, Suffolk Parent Carer Network, CCGs and Suffolk County Council on this onestop point of information and support.

However, the demand for our services is higher than ever putting enormous pressure on our teams and, despite recent investment some of our estate still requires significant investment to meet the standards required by our regulators.

We also recognise that there is still work to do to ensure the services we provide are safely staffed and service users receive care in an environment that is safe and provides for dignity. We also recognise that we must improve engagement with our staff, service users and carers. This means that we have to ensure the clinical voice is given greater prominence in the running of our Trust and that we listen and respond to what our service users and carers are telling us. This will require a change in the culture of our organisation. Work is well underway to address the recommendations made in the CQC report and as we rebuild the Executive Team under the leadership of our experienced new Chief Executive, Antek Lejk, we will start to work on the cultural change that is required to deliver sustainable improvements in the Trust.

The Trust will continue to participate fully in the two Sustainability and Transformation Partnerships which cover Norfolk and Suffolk to ensure that mental health is given the priority it deserves and works in a more integrated way with other parts of the health and social care system.

In spite of what has been a very difficult year, our caring dedicated staff continued to deliver services to over 48,000 service users. I am enormously proud of what they do day-in day-out with some of the most vulnerable people across our two counties. I would also like to put on record the Board's enormous appreciation for the work of Julie Cave who stepped up as our Interim Chief Executive for seven months at an especially difficult time for the Trust.

I would like to thank our staff, service users and carers and all of our stakeholders for the significant support which they have shown to the Trust over the last year.

Gary Page
Chair

Performance report

Overview

This has been a very challenging year for our Trust as, following an inspection of our services by the Care Quality Commission (CQC) in autumn 2017 our Trust was placed back into 'special measures' by our regulators.

Having made steady progress in 2016 this was a real setback for the morale of our staff who had been working so hard to continue to improve our services. But our Trust fully recognises that while we had made improvements in some areas, we had not kept up the pace and made consistent enough improvements across the board.

Over recent months we have been doing all that we can to get back on track and we will continue to focus on making improvements which are sustainable and which address the issues in the medium and longer-term, as well as the short-term.

Many improvements are already underway at NSFT due to the extreme commitment and hard work of our staff, with an increased pace and focus in recent months.

An extensive ligature reduction programme has been underway to keep our service users safe; we have won funding to open additional beds within our young people's inpatient unit; transformative improvements in our adult acute and secure services are being delivered; and we have appointed a Quality Improvement Lead, among many other things.

The full benefits of these positive steps are yet to be completely felt and there is still much work to do to ensure our services are recognised as being consistently safe, effective and responsive across our Trust, while demand upon our services increases.

Some of this work, looking into 2018/19, is to review how service users travel through our services and our beds, to identify where we can improve our practices to ensure the right people are receiving the right care, consistently.

Safe staffing levels and filling vacancies will remain our top priority for NSFT and is one of the most significant challenges facing our organisation, and indeed the wider NHS.

As well as focusing on our Quality Priorities and overarching Quality Improvement Plan, in order to eventually make NSFT an "Outstanding" organisation, we must also focus on improving four overarching areas in the coming year:

Staff Engagement

The positive engagement of our staff is critical to our improvement. Evidence shows that engaged staff are more likely to show empathy and compassion and to feel enthusiastic about their work. In turn, this leads to higher patient satisfaction levels and more service users and carers reporting that they are treated with dignity and respect.

We want to create an environment of continuous learning in NSFT which supports our approach to quality improvement, where our staff can participate at all levels and feel able to deliver and lead the improvements we need to make.

Our aim is to be inclusive, to promote collaboration, to involve our staff in decisions, as well as to encourage, coach and support them to collectively address organisational challenges.

Just as importantly, our staff must feel able to raise concerns and to identify opportunities for improvement.

Medical Engagement

We aim to develop a culture where our managers and our clinicians work in partnership to deliver high quality care. To do this, we have to be clear on our vision and values, working together to achieve a common objective with an absolute commitment to quality, safety, improvement and engagement.

Culture

It is vital that we ensure that our organisational culture supports a high level of staff, partner, service user and carer involvement - all of which underpins safe, high quality patient care.

To achieve this, we will continue to work on embedding and living our Trust values to ensure that we adopt professional behaviours associated with high-performing organisations, and by taking responsibility for our actions, being accountable and holding people to account for delivery.

We will help our service users and carers to have a say in how we run our Trust and work together with us so that we can offer better services for all.

Leadership

Achieving our aim of sustained quality improvement begins with it strong leadership, which helps to shape our culture, promotes engagement and creates an environment open to learning and quality improvement.

We need to ensure that our managers are equipped with the right skills to lead their teams in delivering excellent care to our service users, and support to our carers.

To this point, we are now in the process of revitalising our Board by the restructuring of our Executive Team. I was delighted to join the Trust in May as its new Chief Executive, supported by existing Executive Directors.

Our Executive team will be further strengthened within 2018/19 by new or refocused Director posts including a Chief Operating Officer, Director of Human Resources and Organisational Development, Chief Nurse and Managing Director.

All of us will be very proud to lead NSFT to make this an even better place to work and to receive services.

We have a positive foundation to build upon. In the CQC 2017 report on our services, inspectors rated as 'Outstanding' for the first time some of our services, and we saw significantly more 'Good' ratings across our service lines, and far fewer 'Inadequate' ratings than we saw in 2014.

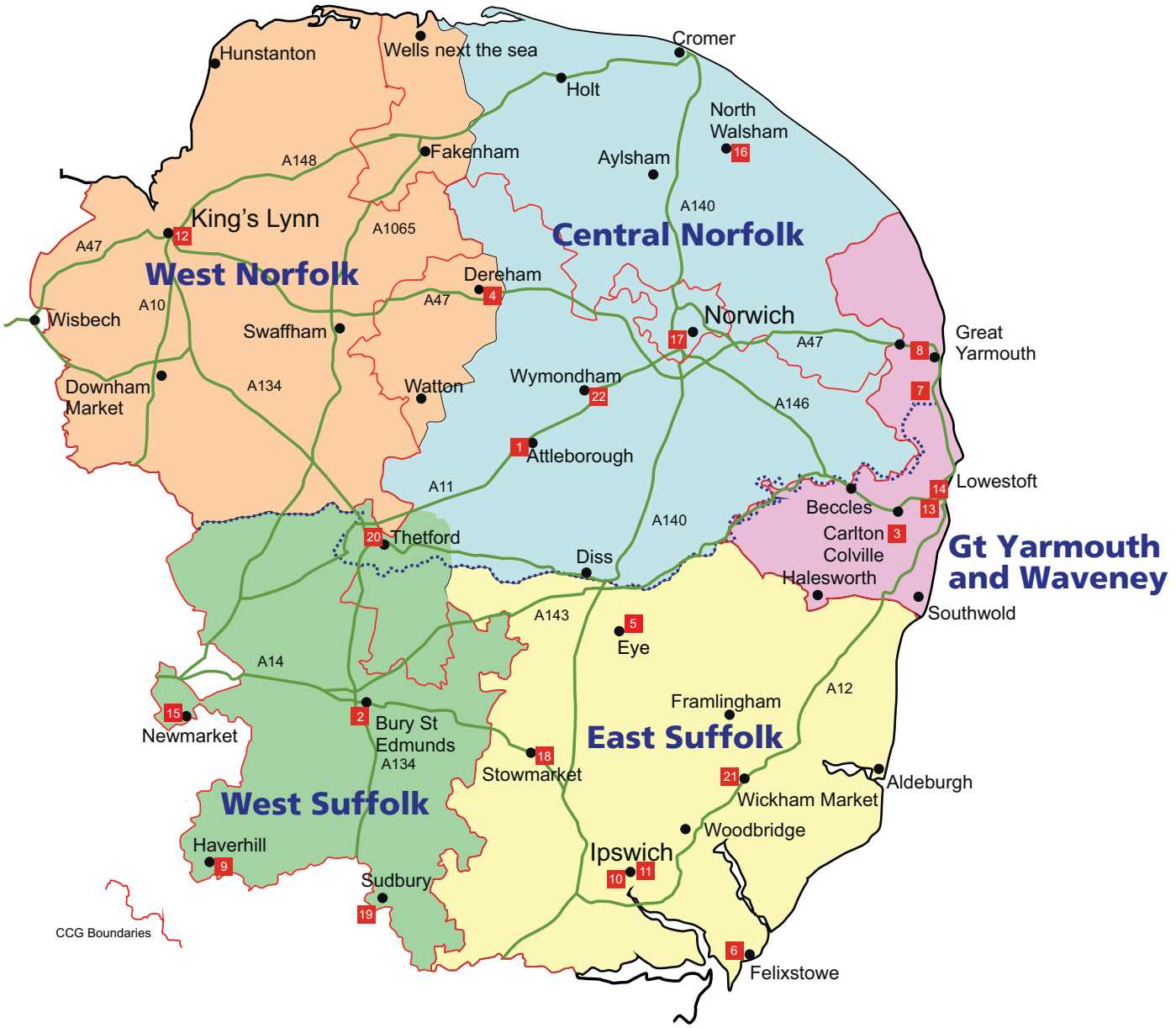
The CQC also concluded that in all parts of our Trust the caring nature of our staff was either 'Good' or 'Outstanding'. Having dedicated, caring and compassionate staff is fundamental to our providing a high quality service and will be our key to continuing to improve as an organisation.

We would like to offer the appreciation of our Board to our staff for everything that they do every day to deliver caring services, often in the most challenging of circumstances.

We recognise that the next year will continue to be challenging for everyone, but by fully involving our staff, our service users and carers in devising, agreeing and implementing the improvements we believe we can achieve our aims.

Antek Lejk
Chief Executive

Date: 22 May 2018



1 Attleborough
Bickley Day Hospital NR17 2QE

2 Bury St Edmunds
Child Development Centre IP33 3ND
Child Health Centre IP3 3ND
Wedgwood Unit IP33 2QZ
50 Barons Road IP33 2JW
Hospital Road Site IP33 3NR (Bury South IDT)

3 Carlton Colville
Carlton Court NR33 8AG

4 Dereham
Springwell NR19 1DL
Signpost House NR20 3TL

5 Eye
Hartismere Hospital IP23 7BH

6 Felixstowe
Grove Medical Centre IP11 9JL

7 Gorleston
Stepping Out, 1b St Catherine's Way NR31 7QB

8 Great Yarmouth
Northgate Hospital NR30 1BU
Compass Centre, Belton Bungalow NR31 9LD

9 Haverhill
Haverhill Health Centre CB9 8HF

10 Ipswich
The Hollies IP3 8LS
Mariner House IP1 2GA (Ipswich IDT)
Woodlands IP4 5PD
Walker Close IP3 8LY (Coastal IDT)
Eccles Road IP2 2RF
Chilton Houses IP3 8LY
Foxhall House IP3 8LY
Endeavour House IP1 2BX

11 Kesgrave
Grange Lodge IP5 1JF

12 King's Lynn
Chatterton House PE30 5PD
Chapel Street PE30 1EG
Fermoy Unit PE30 4ET
Providence Street Community Centre PE30 5ET

13 Lothingland
Airey Close NR32 3JQ
Allington Smith Close NR32 3JW

14 Lowestoft
Victoria House NR32 1PL
Meridian House NR32 1PL
Barley Way NR33 7NH
Kirkley Cliff NR33 0DF
Riverside Business Centre NR33 0TQ

15 Newmarket
Newmarket Hospital, Sage Centre CB8 7JG (Bury North IDT)
Newmarket Hospital, Gibson Centre CB8 7JG

16 North Walsham
St Nicholas Court NR28 9BY
The Atrium NR28 9HZ

17 Norwich
Hellesdon Hospital NR6 5BE
The Julian Hospital NR2 3TD
Mary Chapman House NR2 4HN
Norvic Clinic NR7 0HT
80 St Stephens Road NR1 3RE
The Bure Centre NR2 2PA
296 Drayton High Road NR6 5BJ
Holland Court NR1 4DY
The Open NR2 4SF

18 Stowmarket
Old Fox Yard IP14 1AB
Haymills IP14 1RF

19 Sudbury
Sudbury Community Health Centre,
Churchfield Road CO10 2DZ

20 Thetford
Thetford Healthy Living Centre IP24 1JD

21 Wickham Market
Riverview IP13 0TA

22 Wymondham
Gateway House NR18 0WF

Purpose and activities

The Trust's principal activities are to support and enable people with mental health problems to live fulfilling lives. We believe in recovery and understand the importance of good physical health, maintaining relationships and incorporating treatment into an active life.

Service users and carers are at the centre of all our work. We listen to their opinions and use their views and experiences to shape our services and enhance all aspects of our care. We want to be recognised in the local community for providing excellent advice and treatment, and for our friendly, flexible approach.

We are committed to research and innovation and our ambition is to become a national leader in the provision of high quality and cost-effective mental health services.

We provide a range of health and social care services specialising in mental health across Norfolk and Suffolk including:

- Adult services
- Services for children, families and young people
- Dementia and complexity in later life
- Neurodevelopmental
- Wellbeing
- Low and medium secure services
- Alcohol and substance misuse services (up to 31 March 2018)

We have inpatient facilities across Norfolk and Suffolk, with smaller bases in rural locations. Many of our services are offered in the community, enabling service users to receive the support they need in a familiar environment.

Brief history of the Trust and its statutory background

Norfolk and Suffolk NHS Foundation Trust was formed on 1 January 2012 by the merger of Norfolk and Waveney Mental Health NHS Foundation Trust and Suffolk Mental Health Partnership NHS Trust. We have been a foundation trust since 2008 and have almost 13,000 public, service user and carer members.

The Trust now employs around 4,000 staff who work from sites across the two counties. We continue to develop strong working partnerships with social care, primary care, the police, the voluntary sector and, of course, all parts of the NHS.

We have a long history of working closely with health, social care and voluntary sector partner organisations in both counties and have a S.75 (NHS Act 2006) agreement with Suffolk County Council. Over the course of 2017/18, Sustainability and Transformation Partnerships have become increasingly important in planning the future shape of services. We play a full part in both STP footprints (Suffolk and North East Essex and Norfolk and Waveney) and provide mental health system leadership.

Key issues and risks that could affect the Trust in delivering its objectives

During 2017/18 the top risks facing the Trust included a range of business, quality and financial risks, all of which were considered by the Board and its committees throughout the year. The key risks are identified as follows:

1. The Care Quality Commission (CQC) inspected the Trust in July 2017. The outcome of the review was an overall rating of Inadequate. As a result, NHS Improvement placed the Trust in Special Measures in October 2017. In response, the Trust implemented an improvement plan to address the concerns raised. This plan places quality and safety as our number one priority and as a result has had a considerable impact on both financial and workforce resources.

2. Recruitment and retention of our staff continues to be a challenge. While our agency spend has reduced to within the agency cap set by NHS Improvement, the dependence on agency clinical and medical staff remains a major concern in terms of spend and continuity of service. A task and finish group has been created to look at appropriate incentives that the Trust could implement to attract new staff into the Trust, and equally to retain existing loyal staff. The national shortage of registered clinical staff and psychiatric medical staff makes this challenge more difficult.

3. The Trust continued to deliver the financial plan to address its long-term financial sustainability. This improved the Trust's financial position to a £1.1m surplus (underlying deficit £2.1m) in 2017/18, an improvement of £1.2m on the position in 2016/17. The Board is aware of the need to continue to operate financial control while addressing the service improvements identified by the CQC. The financial plan is monitored at the Performance and Finance Committee and the Board on a monthly basis.

Performance analysis

Performance measures and accountability

The Performance and Finance Committee is the main meeting for review of the Trust's operational performance. Other Committees exist to review the workforce indicators and the quality indicators, which also contribute to the final Board papers to monitor the Trust's overall performance. The Performance and Finance Committee is a subcommittee of the Board of Directors. This meeting has a role in holding to account as well as guiding the Trust to manage external pressures.

During 2017/18 the Committee has assisted in driving the development of key mental health operational performance indicators. The Digital Information Improvement Group (DIIG) has been established to develop new dashboards for performance monitoring across the Trust, with the focus being on ensuring all performance is consistently managed and measured despite differences in the ways services are commissioned.

Through the development of this dashboard there has been an increased awareness of performance and the use of data to evidence and monitor activity. The DIIG is also working on training programmes, raising awareness of the importance of data, and related developments such as a new data warehouse and Business Intelligence tools. A new tool has been developed in-house to support the analysis and evaluation of activity to support patient flow and understanding of bottlenecks. The intelligence gained is fed in to service-level action plans and developments.

During 2017/18 the performance reporting structures and reporting requirements have continued to be monitored for effectiveness. Organisational accountability continues to be assessed for services and localities within the Performance Accountability Review Meetings (PARM), corporate teams are always in attendance. The Director of Finance chairs these monthly performance reviews. The PARM agenda covers the following key items:

- Performance against quality and operational standards
- Finance including Cost Improvement Plans
- Workforce performance including sickness, recruitment and training
- Patient experience
- Mental Health Act compliance
- Equality and diversity plans
- Risks

It is at these meeting that issues and concerns, risks to patients and staff, over or under performance against targets are discussed and actions and timeframes for resolution agreed and shared.

The Trust comprises of five localities, three in Norfolk, two in Suffolk, and two Trust-wide services. Services provided by the Trust include:

- Child and adolescent mental health
- Community mental health
- Crisis resolution
- Inpatient care
- Older people and dementia
- Learning disability
- Community eating disorder
- Wellbeing and improving access to psychological therapies

The Trust reports on the metrics shown in table PA1 each month. Some metrics report for the month, others give a year-to-date or quarterly figure for analysis. PA1 lists the Trust performance as reported for March 2018 and also the corresponding target. At each monthly Performance and Finance Committee, the Operations Directors, with the support of corporate teams, present an analysis of the month's achievement and outline any action taken to resolve any failure to meet the target with a trajectory for resolution. Areas of specific interest in 2017/18 were Out of Area Placements and Improving Access to Psychological Therapies (IAPT). Within the IAPT service, when targets have consistently not been achieved, the Trust has worked with NHSI and local Commissioners to develop an action plan. This has included a review of the service delivery model and analysis of demand and capacity. The action plan is now delivering improvements against target.

Single Oversight Framework

The Single Oversight Framework (SOF) has developed further with national direction in 2017/18 and has been adopted by the Trust to monitor performance as prescribed by NHS Improvement. Table PA1 shows the SOF metrics and additional national measures.

(PA1)

Target description	Actual	Target
Referrals with suspected first episode psychosis start NICE-recommended care within two weeks	62.82%	50%
Data Quality Majority Index (DQMI) – Mental Health Services Data Set dataset score	97.88%	95%
People referred to the IAPT programme will be treated within 6 weeks or referral	89.62%	75%
People referred to the IAPT programme will be treated within 18 weeks or referral	99.98%	95%
IAPT patients who complete treatment and 'move to recovery'	44.64%	50%
Total number of bed days patients have spent in inappropriate out of area placements	1018	No target in place for 2017/18
IAPT patients who have depression and/or anxiety disorders who receive psychological therapy	17.36%	15.4%
Meeting commitment to serve new psychosis cases by early intervention teams	120.4%	95%
Care Programme Approach (CPA) patients receiving follow up within 7 days of discharge	96.27%	95%
CPA patients having formal review within 12 months	96.06%	95%
Admissions to inpatient services had access to Crisis Resolution and Home Treatment (CRHT) teams	97.86%	95%

The main block contracts are commissioned to deliver differing services, and metrics are developed accordingly. This means for example that waiting time standards are different for different localities and service lines across the Trust.

Primary and secondary care services

In 2017/18 the Trust operated within 'block' contract arrangements with Norwich Clinical Commissioning Group (CCG), North Norfolk CCG, South Norfolk CCG, West Norfolk CCG, Great Yarmouth and Waveney CCG, Ipswich and East Suffolk CCG and West Suffolk CCG. The Trust also provides Primary Care Mental Health services to the CCGs listed. The contracts include a range of agreed performance indicators.

Medium and low secure, and CAMHS Tier 4

The Trust's contract with the NHS England – Midlands and East (East of England), Regional Specialised Commissioning is for the provision of medium and low secure mental health services and a young people's inpatient unit. The key measures remain as bed occupancy.

Section 75 Suffolk

A Section 75 Agreement remains in place with Suffolk County Council. This agreement means that the council delegates its legal duties in relation to the provision of social work services for adults experiencing mental health difficulties, to the Trust. This agreement is monitored by the S75 Partnership Review Group that meets quarterly. A joint mental health dashboard is produced for the review group to monitor performance but no formal targets are in place.

Public Health contract

Norfolk Public Health commission a substance misuse service in Norfolk. This service acts as a lead provider, and subcontracts elements of the provision for young people and local prisons. The service was not retained post 31 March 2018.

Financial review

This part of the Annual Report provides a review of the financial performance for the year ending 31 March 2018.

The Trust reported a surplus of £1.1m in the year to 31 March 2018. This is an improvement on the planned deficit of £1.1m as a result of additional non-recurrent Sustainability and Transformation cash Funding (STF) announced by NHS Improvement. The total STF funding received in year was £3.2m which, when removed, gives an underlying deficit of £2.1m.

A full set of 2017/18 accounts are provided as part of the Annual Report at the end of this document.

Going concern

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

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

Summary of financial performance

As at 31 March 2018, the Trust had delivered the following performance:

- A year-end surplus of £1.1m
- A finance and use of resources rating of 3
- Capital expenditure of £11.8m
- A cash balance of £14.6m

Income

The Trust's total income (turnover) for the year was £227.2m, of which £213.3m was for the provision of patient care activities.

The NHS financial settlement for 2017/18 resulted in a net 0.1% increase to funding received by the Trust from Clinical Commissioning Groups (CCG). This was made up of a 2.1% inflationary uplift and a 2% efficiency target on health care services contracts. There was also a 2.1% uplift from Suffolk CCGs for parity of esteem with further 4.5% investment secured from Norfolk CCGs for service developments.

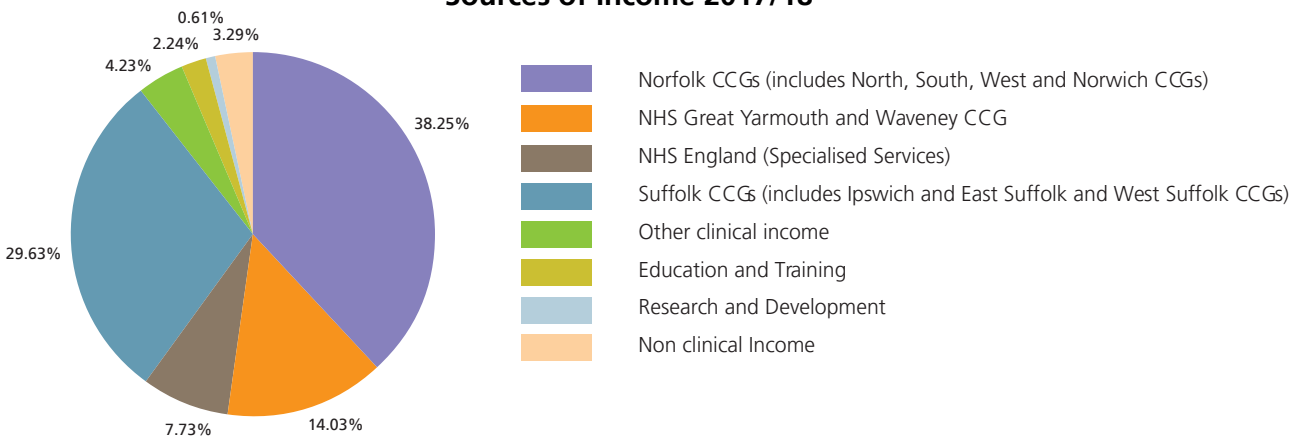
Research and development funding of £1.4m was secured in addition to education and training income of £5.1m.

This included £0.2m income from the National Apprenticeship Fund, which was used specifically for approved apprenticeship posts (both clinical and non-clinical) being introduced throughout the Trust. Funding for education and training is received via Health Education England and is given to NHS Trusts to support training placements for student and junior medical staff, nursing staff and other healthcare professionals.

The Trust's principal sources of income, as illustrated in the chart below, are from contracts for the provision of mental healthcare services for CCGs in Norfolk and Suffolk, and for secure services (both medium and low secure) and CAMHS Tier 4 for NHS England Specialised Services. The Trust received funding from NHS England of £3.2m as a result of Sustainability and Transformation Funding (STF). Of this, £1.3m was core STF for the delivery of the required control total, with additional STF of £1.9m received for accepting the 2017/18 control total and improving on the planned position.

(FR1)

Norfolk and Suffolk NHS Foundation Trust
Sources of Income 2017/18

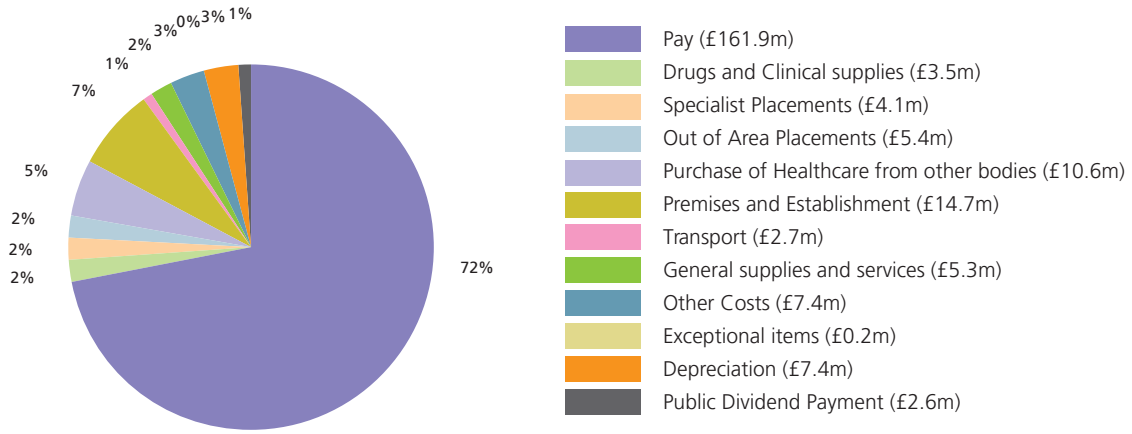


Expenditure

Total expenditure during 2017/18 amounted to £226.1m which is summarised by type of spend in the chart below.

(FR2)

Norfolk and Suffolk NHS Foundation Trust
Analysis of Expenditure 2017/18



The Trust delivered £10.0m cost improvement savings during the year with all schemes identified at the start of the financial year undergoing a Quality Impact Assessment by the Trust's Medical and Nursing Directors to ensure that any plans do not adversely affect patient safety or service quality.

Finances and use of resources segmentation

The Trust achieved a year-end rating of 3 in relation to finance and use of resources. Providers are allocated a rating of 1 to 4, where 1 reflects the strongest performance. The Trust is assessed on three main areas, which focus on financial sustainability, financial efficiency, and financial controls. It was difficult to achieve a higher rating without the Trust holding much larger cash reserves which would have adversely affected our commitment to direct all available resource to the benefit of our service users.

Capital expenditure and investments

The Trust's capital expenditure largely supports the buildings and facilities we utilise. The

Treasury has historically provided capital finance in the form of public dividend capital (PDC). As a result, the Trust is required to pay the Treasury dividends relating to that capital twice a year. These dividends amounted to £2.6m in 2017/18.

The Trust has limited access to new public dividend capital as it is expected to finance capital expenditure from internally generated sources (i.e. from operational surplus and depreciation charges) or to agree an interestbearing loan with either the Foundation Trust Financing Facility (FTFF) or a commercial lender. In 2017/18, however, the Trust was successful in securing additional PDC of £8.0m. This was for the Adult Acute Services reconfiguration in West Norfolk (£4.0m) and the establishment of an eight-bed Mother and Baby Unit on the Hellesdon site (£4.0m). In addition, a further bid in respect of IT resilience was awarded to the Trust of £0.6m for improvements to cyber-security and Wi-Fi rollout across the Trust as part of its ICT strategy.

The outstanding balance on loans from the FTFF was £9.0m as at 31 March 2018.

The capital expenditure plans were reviewed and revised on a regular basis throughout the year to ensure that emerging schemes, CQC compliance and patient safety requirements were prioritised over and above other originally planned expenditure.

There were two asset disposals during the year. These were in respect of a property on Drayton High Road and surplus land on the Northgate site. Both were deemed surplus to requirements for the provision of services.

Private Finance Initiative (PFI)

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

Liquidity and cash management

The Trust manages cash through the Government Banking Services arrangements.

Post balance sheet events

The Board of Directors confirms that there are no post balance sheet events applicable to the 2017/18 financial year.

Charitable funds

The Trust also administers the Norfolk and Suffolk NHS Foundation Trust Charitable Fund (Charity Number 1050441). These funds are used for the benefit of both patients and staff in accordance with the purpose for which the funds were either raised or donated.

Political and charitable donations

The Trust did not make any political or charitable donations from its revenue exchequer funds in 2017/18.

Financial outlook for 2018/19

The next year will be another challenging year for the Trust, as it will strive to deliver its financial targets whilst continuing to deliver on year three of the Five Year Forward View plans for mental health, in conjunction with its local commissioners. This will be against the backdrop of further financial investment already identified in order to meet CQC quality standards, and improvements to ensure that the Trust is able to emerge out of special measures.

The Trust will continue to work with partner organisations within the Norfolk and Waveney, and Suffolk and North East Essex STP footprints in an attempt to deliver financial balance across the NHS by 2020/21.

Environmental and social matters

Environmental matters and sustainability

Our Sustainability Policy and the Sustainability Development Management Plan (SDMP) are documents enabling the Trust to address all aspects of our environmental impact. The Board is actively involved in progressing the sustainability programme, with the Director of Finance taking primary responsibility. They lead on the vision for the Trust to over-achieve on the national carbon reduction targets and overall sustainability programme.

The government set NHS organisations a challenging target for 2021 to reduce carbon footprints by 25% from 2007/08 levels. The Trust has exceeded that target and has already hit the 50% reduction set for 2025.

Actions to address our environmental impact include a range of staff engagement activities:

- An intranet section about sustainability, enabling all staff to have access to key information and links to issue of interest and events
- An active programme of staff engagement through champions' meetings, ward / departmental meetings and information issued to each working area
- Frequent contributions to the weekly Trust newsletter, sharing good practice and news items
- Digital computer screen pop ups to promote NHS Sustainability Day alongside exhibition boards taken to staff engagement events
- Regular staff updates, focusing on personal health and wellbeing, supports the reduction of sickness absence. This allows for any requirements for additional resources, staffing or extended travel to be kept to a minimum, reducing associated sustainability impacts
- Information about the benefits of cycling to promote fitness and low-carbon travel
- Links to cycle purchase schemes and lift share sites for all areas
- Facilitate home working and local hub access to enable reduction in travel

Existing initiatives to improve the efficiency of energy consumption include sun pipes, ground source underfloor heating and PV panels on five properties. Further progress has been made this year with the sale of energy from Grange Lodge PV panels back to the grid and the continued roll-out of LED lighting. The Estates team has investigated alternative taps which reduce water wastage, and energy consumption has been reduced by 16% on last year's figures through a variety of initiatives, greater staff awareness as a result of increased publicity, the better use of existing premises, and energy monitoring.

The Trust has made significant changes in recycling of stock and equipment. Items no longer fit for purpose have been forwarded to charities both here and abroad. This has enabled the Trust to reduce our disposal costs and achieve a far more environmentally friendly solution, while also providing support to a variety of organisations. We also work with local charities providing anti-ligature furniture for refugee families and our own service users.

Waste management continues to be closely managed and we have maintained the rate of direct recycling at approximately 56% through extended recycling schemes across the Trust. The waste contractor has also contributed by filtering the general waste for other recyclates, with the remaining residue being bailed into refuse derived fuel. Clinical waste is sent to an 'Energy from Waste' site, which provides heat via steam for Ipswich Hospital and our own Woodlands site.

The Trust has implemented a trial scheme on three sites, where waste baskets have been replaced by larger central recycling points, encouraging an increase in direct recycling.

Throughout the procurement lifecycle, the sustainability and the carbon footprint of suppliers is reviewed to actively support those that demonstrate environmental credentials such as ISO14001, and those that address the requirements of the Modern Slavery Act within their policies.

These schemes will continue into the coming year, along with identifying other ways to reduce our carbon footprint and wider impact on the environment.

Social, community and human rights issues

With around 4,000 employees and a turnover of over £200m, the Trust is a significant employer in Norfolk and Suffolk. We aim to go beyond the requirements of our contracts and contribute to the wider wellbeing of the communities we serve.

In 2017/18 we supported a wide variety of community events. These included support for black and minority ethnic community festivals and events, LGBT History Month, Pride, Transgender Memorial Day, mental health and spirituality, and a wide-range of wellbeing initiatives.

Our public, service user and carer Trust Members, who number almost 13,000 have joined because of their interest in, and commitment to, mental health. The Council of Governors hosted two successful conferences for members and the wider public – one on talking therapies and one on social prescribing (in the widest sense). These two events were attended by over 300 people.

They provide an opportunity for Governors to raise awareness about important topics and to hear from local people, including Members and wider stakeholders.

We evaluate the effectiveness of many of our events by asking for delegate feedback. The events received very high satisfaction ratings and feedback enables us to plan future initiatives.

Human rights

The Trust has an important role to play in protecting human rights through its administration of the Mental Health Act (1983) (MHA) and oversight of the Mental Capacity Act (2005). The Trust issues and maintains a comprehensive set of policies which describe how we protect patients' human rights.

The Trust has a specialist team who promote good practice in the use of the MHA across its services.

The use of the MHA is monitored by the bi-monthly interagency Mental Health Law Forum (MHLF), which reports to the Quality Governance Committee. Use of the MHA and of Deprivation of Liberty safeguards is monitored and analysed for any significant themes. If issues are identified, then local services are asked to address these and progress is reported through the Trust's Performance Accountability Review Meetings.

The MHLF reviews and approves all policies related to mental health legislation.

During 2017/18 we have strengthened our work on improving access to advocacy, particularly for inpatients and those detained under the MHA. We work closely with our two local advocacy service providers (Voiceability and POhWER) and very much value their presence on our wards and the help they provide in ensuring that people's views and preferences are heard.

Where people who lack capacity have their liberty curtailed (in order to secure their safety and wellbeing), we apply to the local authority for an assessment under the DOLS (Deprivation of Liberty Safeguards) arrangements. Case law has changed the scope of DOLS and this has meant that local authorities are not always able to process DOLS applications in a timely way. We work closely with the DOLS teams in our two local authorities to prioritise this work and we have also introduced our own safeguard for anyone waiting more than six months, whereby specially trained Hospital Managers (as defined under the MHA) review the deprivations to support assurance that they are being kept to a minimum.

There are several policies that relate to the use of the MHA and MCA. The Quality Governance Committee receives detailed reports on the application of these policies via the Mental Health Law Forum. The Mental Health Law Forum analyses any breaches of policy reported through DATIX. The Board receives an annual report on the use of the Mental Health Act, including the work of the Hospital Managers and the Mental Capacity Act, including DOLS.

Anti-bribery

The Trust refreshed its Business Conduct Policy during 2017/18 to incorporate new guidance from NHS England (issued in June 2017) on declarations of interest. The Business Conduct Policy includes a section on the Trust's commitment to the Anti-bribery Act (2009). The policy sets out the definition of bribery and gives examples of how the risk might manifest in our Trust. Our policy states,

"The prevention, detection and reporting of bribery and other forms of corruption are the responsibility of all those working for the Trust or under our control.

All workers are required to avoid any activity that might lead to, or suggest, a breach of this policy.

Workers must notify the Counter Fraud lead as soon as possible if they believe or suspect that this policy may be breached."

Accountability report

Directors' report

Disclosures

Details of company directorships and other significant interests held by Directors can be found in the Directors' declarations of interest. See pages 33-36.

We publish all Directors' interests annually on the Trust's website as part of our Board papers (most recently on 25 January 2018 Item 18.09 Attachment A: nsft.uk/declarations-of-interest). A copy of the register of interests is available from the Company Secretary on request at any time.

Disclosures under the NHS Foundation Trust Code of Governance can be found on pages 49-51.

How the Trust has had regard to NHSI's well-led framework

Following the Trust's entry into special measures in 2015, the Trust received support from NHSI, including a limited scope well-led review using the well-led framework. This contributed to the review and improvement of our approach to risk management. The Trust then went on to carry out a self-assessment using the full framework, which was completed in November 2016. This formed the basis for a review of committee integrated governance (which was completed in January 2017) and fed into the priorities for organisation development and Board development for 2017/18.

The development areas identified from the self-assessment included the Board's quality culture and the Trust's approach to continuous learning. The review highlighted the need for clearer accountability (linked to the quality culture) and improved escalation processes for risks and issues. Data robustness and analysis were also identified as weaker areas. These themes were consistent with the concerns identified by the Care Quality Commission (CQC) following their inspection in July 2017, but whereas the self-assessment had rated these issues as amber and requiring improvement, the CQC findings showed that the weaknesses were more significant. This contributed to the rating of Inadequate for well-led.

The Board recognised that its self-assessment had been affected by optimism bias and the quality improvement plan reflected the need for systemic and cultural change in order to deliver the service standards required.

During 2017/18, significant changes were made to the Executive team following the publication of the CQC report.

For the second half of the reporting period the largely interim team provided stability and ensured that resources and governance were in place to deliver the changes required by the CQC S.29a letter. Recruitment to a permanent substantive Executive team will continue with a view to being completed by autumn 2018.

Further information about the 2017 CQC report and the subsequent regulatory action can be found in the Annual Governance Statement (on page A9) and the Quality Report (on page 73).

Summary of action plans to improve the governance of quality

Over the course of 2017/18 and in response to the CQC inspection report, the Trust reviewed its approach to the governance of quality and made changes to strengthen Board assurance. A Programme Management Office (PMO) approach was adopted and the Trust's internal PMO resources were strengthened to increase its capacity to support the improvement plan. Senior managers were released to work solely on the quality improvement plan and their posts back-filled. The Quality Programme Board was developed, is chaired by the Chief Executive and includes in its membership both a Non-executive Director and the NHSI Improvement Director. The Quality Programme Board is supported by a Quality Mobilisation Group, which is chaired by the Chief Operating Officer and which drives forward the detailed planning and implementation required to achieve the quality outcomes.

The plan reflected the initial detailed set of 25 "must / should dos" as set out in the S.29a letter, with a deadline of 11 March 2018. They were nested within a wider quality improvement plan which requires significant cultural change, which would take longer. The Trust's response to the S.29a letter was submitted on 9 March 2018. It set out the actions that the organisation

had taken to address the 25 "must/should dos" along with the evidence of progress. The CQC have indicated that they plan to re-inspect the Trust in the autumn of 2018.

Patient care

The Trust uses its foundation trust status to develop services and improve patient care through the work of the Council of Governors. Governors are involved in a wide range of initiatives. Governors:

- Represent the interests of local people in commenting on Trust service developments and on quality issues
- Triangulate information on quality by reading reports and listening to service users, carers and the wider public
- Hold the Non-executives to account for the performance of the Board of Directors

The Council of Governors' Planning and Performance Subgroup scrutinises a wide range of Trust activity that impacts on quality. During the reporting period the subgroup considered the Trust's annual plan and its strategic goals, the Trust's workforce plans, the use of out of area beds, feedback from the CQC inspection, and the development of local Sustainability and Transformation Plans (STPs).

Consultation with local groups and organisations / public and patient involvement activities

The Board of Directors has published a summary document describing its approach to consultation and involvement.

The relevant Trust documents / policies are:

- Our values…our behaviours…our future. Working together for better mental health (launched October 2015)
- Improving Services Together: Involvement and Engagement Strategy (launched October 2015)
- Membership Strategy (which is approved annually by the Council of Governors and the Board of Directors)

During 2017/18 the Trust held a series of initial meetings to present the Trust's Improvement Plan and to explore views and ideas about how we can involve service users and carers in helping to achieve sustained improvement in the quality and experience of our services.

Those invited included service users and carers; those with lived experience of NSFT services who use their experience to help others (e.g. peer tutors, peer support workers, expert by experience advisors, some NSFT Governors); representatives of stakeholder organisations that are directly involved in supporting, representing or advocating for people who use NSFT services; Governors; members of NSFT's Participation and Involvement Team; senior operational teams and Board of Directors.

Involvement of service users and carers

Information about how to get involved is published on the Trust website: www.nsft.nhs.uk/get-involved .

This section of the website explains the Trust's policy on involvement. The website lists the wide variety of opportunities that there are for service users and carers to get involved.

Key initiatives supporting involvement include:

Improving Services Together: Involvement and Engagement Strategy, launched in the autumn of 2015. A new reporting structure was developed and piloted in 2016 and implemented in 2017 to capture progress on the six commitments, which are:

1. Service users and carers will be able to have their say in Trust business
2. There will be opportunities for service users and carers to use their skills and experiences to improve services
3. We are changing the way we provide our services in line with our commitment to organisational change
4. We will strengthen links and create partnerships with other agencies and service user and carer-led organisations
5. We will reach out to diverse and other under-represented groups
6. Service users and carers will 'judge' whether this strategy is being delivered

Improving Services Together reports are reviewed by the Commitment Six Group, made up of service users and carers, working together with staff. The group uses the principles of co-production, and judges progress on the six commitments to identify areas of good practice as well as where more progress is required, making recommendations, as necessary.

In 2018 we will be establishing a rolling programme of Values Based Recruitment Training, empowering service users and carers to be more actively involved and able to influence staff recruitment. We will introduce a monitoring system to capture and report this activity within the Trust.

The Improving Services Together strategy will be reviewed in 2018/19 to make more explicit service user and carer involvement in Quality Improvement and alignment with Our Recovery Strategy.

Our Recovery Strategy: Our Recovery Strategy for 2017 to 2022 was launched in June 2017, and builds on the past four years of our Implementing Recovery through Organisational Change (ImROC). The strategy was informed by recommendations from the outcome of the 2016 Community Mental Health Service Users Survey and has at its core the following four priority goals:

- **Recovery at the core of every conversation:** This includes continuing to expand the Recovery College provision, co-developing and co-delivering training alongside tutors with lived experience of recovery from mental health problems. The Recovery College helps empower people overcoming serious mental health problems to develop the skills for achieving a more fulfilling, meaningful life and a positive sense of belonging in their communities
- **Co-production in decision making at all levels:** A solid foundation for this goal is embedding patient-informed quality improvement methodology in the Trust during 2018
- **Sharing responsibility for keeping safe:** Key actions that relate to this priority goal are the introduction of Formulation into clinical practice, and focusing on Triangle of Care standards within our community services. Both these initiatives commenced in 2017 and will be implemented in 2018
- **Develop partnerships to promote meaningful living:** The Recovery College already offers courses developed and delivered in partnership with local stakeholders. These include:

  - The Association of Suffolk Museums, which works to preserve and promote the county's rich and diverse heritage and increase access and learning in museums for the benefit of the people of Suffolk

  - Creative Heritage and Arts in Mind, a lottery funded project offering arts-based courses across four Suffolk museums

  - Equal Lives, who provide welfare benefits advice and advocacy to people who use mental health services

  We will continue to develop partnerships for the co-development and co-delivery of Recovery College courses

  Implementation of Our Recovery Strategy will be a major contribution to improving the experience of our services, and we expect to see this reflected in future responses to the Service Users Survey

Friends and Family Test: A new Friends and Family Test (FFT) card was developed and implemented in 2017. There was a short period during the year in which there was delayed delivery of the new cards. Additionally, the plan to increase the rate of returns from 2017/18 Q3 was temporarily put on hold due to the need to focus on the CQC Improvement Plan. These factors contributed to a 75% reduction in the number of cards received compared to 2016/17. However, the overall FFT score in 2017/18 is 89.8% which is a 1.9% improvement on the previous year and is now at or slightly above the national average. Following actions to raise the profile of FFT within the Trust, the number of participating teams has increased by 26% to 80%. We are well placed to increase the number of returns in 2018/19.

Patient experience informed quality improvements: Themes from FFT returns are triangulated with themes emerging from the Patient Advice and Liaison Service (PALS), complaints, NHS Choices and Healthwatch websites, surveys, engagement events and service user and carer forums to prioritise areas for co-designing quality improvement.

In 2017/18 we commenced implementation of best practice validated methodologies for service

user informed quality improvements and have lead staff in our Participation and Involvement Teams trained in facilitating Experience Based Co-Design and Always Events, validated patient-informed methodology in which quality improvements are co-designed with people who use services. The Trust is a signed up member of NHS England's fifth national Always Events provider cohort, which will provide further support for implementing Always Events in 2018.

Partnerships: In addition to more partnerships within the Recovery College, in 2018/19 we will continue to build on the good links already established with Healthwatch in Norfolk and Suffolk and other third sector organisations to explore more ways of working collaboratively for improving patient and carer experience and involvement. This will include working with Healthwatch Suffolk to help build community resilience and tackle mental health stigma through the Time to Change initiative.

With the focus on Triangle of Care standards in community teams in 2018/19 we will be undertaking more events in partnership with third sector carer support charities and public interest companies, including Suffolk Parent Carers Network, Suffolk Users Forum, Norfolk Family Carers, Family Voice Norfolk, Carers Matter and Care for Carers.

Involvement of Members and the wider community

Membership of the Trust is open to all residents of Suffolk and Norfolk aged 11 and over. Most Members opt to be kept informed about the work of the Trust and this takes place through Insight Magazine and a regular Trust Matters email newsletter. Members who wish to be more involved can attend engagement events and also stand for election as a Governor (if aged 16 or over).

Member involvement (and involvement with the wider public) by Governors is overseen by the Governor-led Governor and Member Development Subgroup which reports to the Council of Governors. During 2017/18 the Trust recruited a new Membership and Engagement Officer (0.5 WTE) who started in February 2018 and who ensures Trust representation at community events.

In addition to representing the Trust at a wide range of community events and networks, the Council of Governors hosts two large Member engagement events each year (one in each county) on a topical theme. In 2014 this was criminal justice and mental health, in 2015 it was young people's mental health, and in 2016 it was dementia. In March 2017 the topic was complex needs of people who use substances and in November 2017 it was talking therapies. Our most recent event was called Mind, Body and Soul and was held in March 2018. This was our most popular event to date attracting nearly 200 people to find out more about social prescribing.

Consultation

The Trust aims to ensure proportionate, meaningful consultation in line with S.242 of the NHS Act (2006) ('the duty to consult'). In all cases the impact on people who share protected characteristics as defined by the Equality Act (2010) will be considered.

This means that for proposed changes that impact on local areas or services (for example, changes to inpatient activity programmes) then consultation takes place via community / ward meetings so that those people affected are involved in decisions.

For proposals that involve changes to the configuration of services (for example, closing one service and opening a new one with a different focus as part of modernising services) wider consultation is required, which takes into account the impact, not just on people using services at the time, but future service users and carers. Depending on the nature of the change, consultation may be led by the commissioners.

In addition to formal consultations, we are broadening our approach to listening to and consulting with service users and carers and other stakeholders. From January 2018 we scheduled a series of Improvement Plan engagement meetings to share our CQC Improvement Plan and listen to views about where we need to focus improvements. The initial series of five meetings, one in each locality area, had a total attendance of 105. 50% were service users and carers, 25% representatives of stakeholder organisations and 25% NSFT staff.

A further series of engagements events to listen to the experiences of parent carers of children and young people was undertaken in March 2018 in partnership with Suffolk Parent Carers Network.

The themes emerging from these and subsequent meetings are then analysed to inform next steps, which include further engagement meetings with specific service line focus. These meetings have already resulted in one planned action for 2018/19 Quarter 1: the co-design of a participation newsletter and set up of a participation mailing list to support a direct route for keeping in touch with people interested in hearing about improvements (in the style of "You Said, We Did") and ways to be involved.

There are formal partnership arrangements with Staff Side to consult over changes that might impact on staff, largely via the Trust Partnership Meeting (TPM) and Local Negotiating Committee (LNC).

Interface with other consultative forums

Governors attend other consultative forums including Health Overview and Scrutiny Committees (HOSC), Healthwatch Norfolk, Healthwatch Suffolk and Health and Wellbeing Boards. The roles of each of these groups are different and while insights will inform Governor deliberations this exchange of information is a positive aspect.

The Trust's constitution prohibits a member of the HOSC from also being a Governor in order to avoid a conflict of interest.

Staff Governors have a specific role description to ensure that the role of Staff Governor and that of staff / union representative are differentiated.

Other disclosures

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay 95% of all invoices by the due date or within 30 days from receipt of goods or a valid invoice, whichever is later. This is summarised in the table below:

(DR1)

Performance by number	Non-NHS suppliers	NHS suppliers	Total
Paid within 30 days	17,871	658	18,529
Paid over 30 days	5,686	297	5,983
% paid within target	**75.86%**	**68.9%**	**75.59%**
Performance by value (£000)			
Paid within 30 days	£83,463	£20,595	£104,058
Paid over 30 days	£15,207	£3,215	£18,422
% paid within target	**84.59%**	**86.49%**	**84.96%**

The Trust did not make any interest payments under the Late Payment of Commercial Debts (Interest) Act 1998.

Statement of Disclosure to auditors (s418)

For each individual who is a Director at the time that the report is approved:

So far as the Director is aware, there is no relevant audit information of which the Trust's auditor is unaware.

The Director has taken all of the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

Income disclosures required by Section 43(2A) of the NHS Act 2006

The Trust has met the requirements of the NHS Act that the income from the provision of goods and services for the purposes of the health service in England was greater than any income from the provision of goods and services for any other purpose.

NHS England Emergency Preparedness, Resilience and Response Core Standards

Each year, all NHS providers are required to submit a self-assessment return recording compliance against the NHS England Emergency Preparedness, Resilience and Response Core Standards. In 2017, it was reported that against the 48 applicable core standard questions, the Trust was fully compliant on 44 standards and

partially compliant on four standards. Taking the NHS England criteria into account, this equated to a rating of substantially compliant, with no non-compliance. This submission was reported to NHS England. The areas of partial compliance concerned business continuity planning, lockdown planning for inpatient units, offsite evacuation planning for inpatient units and surge / escalation management. Significant progress has been made since with regard to offsite evacuation planning and surge / management. It is expected that the Trust will report an improved position for 2018/19.

Antek Lejk
Chief Executive

Date: 22 May 2018

Remuneration report – Annual statement on remuneration

Statement from Chair of Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is responsible for making Executive Director appointments and for determining their remuneration. The Committee ensures that pay levels are competitive and enable the Trust to recruit, motivate and retain high quality Executive Directors.

Appointments

During the financial year 2017/18 there were several changes to the Executive Director team and the table below sets out the Executive Director appointments that took place in the year.

(RR1)

Director of Operations for Suffolk*	Pete Devlin from 1 June 2017
Interim CEO	Julie Cave from 12 October 2017
Interim Director of Finance	Daryl Chapman from 9 October 2017
Interim Director of Nursing	Dawn Collins from 18 October 2017
Interim Chief Operating Officer / Deputy CEO	Josie Spencer from 2 January 2018

*non-voting Director

The Executive team and Board have also had professional advice and support from Mark Gammage in relation to Human Resources and from Paul Lumsdon in relation to quality and nursing.

During the reporting period the Committee oversaw the appointment of a substantive Chief Executive. The appointment was made through an open competitive process and included stakeholder panels that provided feedback for the interview panel to take into account. Following the selection process the Remuneration and Terms of Service Committee approved the appointment of Antek Lejk and this was then approved by the Council of Governors on 8 March 2018 by a majority vote. Antek Lejk will take up his position in May 2018.

Remuneration

No changes were made to Executive remuneration during the reporting period.

Senior management remuneration policy

There were no changes to the Trust's policy on senior management remuneration which follows Agenda for Change rates of pay.

Gary Page
Chair

Date: 22 May 2018

Future policy table

The Trust does not operate a bonus or performance related payment scheme for senior managers and has no plans to do so at present.

Payments above £150,000 pa

The Chief Executive is the only senior manager who is paid more than £150,000. The salary is determined by the Remuneration and Terms of Service Committee. The Committee took into account benchmarking information regarding CEO payment levels in trusts of comparable size. The salary is in line with the level of payment for trusts with a similar turnover and there has been no increase in salary since appointment. There are no additional performance related pay or bonus arrangements.

Service contracts obligations

Senior managers engaged on a contract for services basis sign a Contract for Services. This contract has been developed by the Trust's legal advisors. It includes terms setting out the Trust's obligations, in line with legal and NHS requirements, in respect of the following:

- Tax and national insurance liabilities
- Compliance with NHS standard employment checks
- Liabilities and indemnities
- Confidentiality
- Data protection

Policy on payment for loss of office

Executive Director contracts require Directors to provide six months' notice of resignation. In the event the Director receives notice from the Trust, this is also six months. The contract allows for all or part of this to be paid in lieu.

Senior manager contracts require senior managers to give three months' notice of resignation. In the event the senior manager receives notice from the Trust, the duration of notice increases with service, up to a maximum of 12 weeks.

In regard to both Executive Director and senior manager contracts, notice will not be paid where there has been gross misconduct. For Executive Directors, this is also the case where they become an 'unfit person' in accordance with Condition G4 of the Monitor License for Foundation Trusts.

Statement of consideration of employment conditions elsewhere in the Trust

Other than Executive Directors and doctors, all staff are employed on NHS Agenda for Change terms and conditions of employment. Doctors are employed on NHS terms and conditions for doctors and dentists.

The Remuneration and Terms of Service Committee receives an annual report on the pay for senior managers (Band 8c and above) and considers its relevance to the remuneration for Executive Directors to ensure an appropriate differential given the varying accountability levels.

There have been no changes to senior manager pay structures over the last year.

Annual report on remuneration

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is a Non-executive Director committee that oversees the appointment, remuneration and appraisal of the Trust's Executive Directors. It also reviews senior management pay. Senior managers' pay below Director level is set in line with the nationally negotiated Agenda for Change salary scales and therefore is not part of a separate negotiation or consultation process. No staff member is present at a committee meeting where their appraisal or remuneration is discussed.

The Committee is chaired by the Trust Chair and is made up of all Non-executive Directors. Members for 2017/18 are shown in the attendance list. The CEO is a member for the purpose of appointing Executive Directors and considering performance appraisal information (but is not party to discussions about CEO pay or performance).

The Remuneration and Terms of Service Committee receives reports from the CEO on Executive Director performance, and from the Chair on CEO performance.

Appointments

Appointments made in 2017/18 are listed on page 23.

(RR2) Remunerations and Terms of Service Committee attendance 2017/18

	5 June 2017 Stood down	28 Sept 2017 Re-scheduled	26 Oct 2017 Additional	30 Nov 2017 Additional	4 Dec 2017 Stood down	15 Jan 2018 Additional	6 March 2018
Gary Page (Chair)		✓	✓	✓		✓	✓
Marion Saunders (Deput Chair / SID)		✓	✓	✓		✓	✓
Brian Parrott (NED)		✓	✓	✓			
Ian Brookman (NED)		✓	✓	✓		✓	✓
Tim Newcomb (NED)		✓	A	✓		✓	✓
Tim Stevens (NED)		✓	✓	✓		✓	✓
Jill Robinson (NED)		✓	✓	✓		✓	✓
Adrian Matthews (NED)		✓	✓	✓		✓	✓
Julie Cave (CEO)*			✓	*		*	*

There were four dates which were additional or changed at short notice which affected the ability of some members to attend.

* The Chief Executive is a member of the committee but is not present when the CEO appointment, appraisal or remuneration are discussed.

A – Apologies received

Nominations Committee

The Nominations Committee is a Governor-majority committee that oversees the appointment, remuneration and appraisal of the Trust's Chair and Non-executive Directors (NEDs).

NEDs are appointed for an initial three-year term and may, on satisfactory achievement of objectives, be offered a second three-year term. However, a third term would normally only be offered through an open competitive process or subject to a business requirement. In all cases the NED must remain independent. The constitution also sets out how NEDs may be removed through a Governor vote at a Council of Governors' meeting.

The committee is chaired by the Senior Independent Director (SID) with the Lead Governor as vice-Chair.

There is an arrangement for Governors to elect representatives from their constituencies to become voting members of the Nominations Committee.

From January 2018 it was agreed that if there is no Partner Governor nomination then an additional seat is made available to the Public constituency not covered by the Lead Governor. For example, where the Lead Governor is from Norfolk, and there is no Partner Governor Committee member, then an additional seat will be made available to Suffolk Public constituency.

(RR3) Nominations Committee make up and voting Governors

Constituency	Seats	Nominated names
Norfolk Public	2	Sheila Preston Stephen Fletcher
Suffolk Public	2	Jane Millar (to 31 January 2018) Andrew Good
Staff	1	Howard Tidman
Service User	1	Malcolm Blowers
Carer	1	Mary Rose Roe (to 31 October 2017)
Appointed	1	Sue Whitaker (to 31 May 2017)
Lead Governor (automatic seat)	1	Catherine Wells

The Carer and appointed Governor posts were not replaced in year, as re-election took place in April/May 2018

Plus Non-voting Governors: Paddy Fielder (Suffolk Public Governor)

Appointment and re-appointment processes

The Committee ensures that a robust and transparent process is followed in relation to all appointments and re-appointments.

During the review period the Committee made one appointment, which was Adrian Matthews who took over from Brian Parrott. The Committee oversaw an open competitive process with a strong field and recommended that Adrian Matthews be appointed for three years from 1 September 2017. The Council of Governors considered this recommendation at their meeting on 31 August 2017 and approved the appointment. This allowed a three-month overlap with Brian Parrott who came to the end of this term on 31 December 2017.

The committee also recommended the re-appointment for a further three years of Marion Saunders and Tim Newcomb who came to the end of their first term on 31 August 2017. The Council of Governors approved the reappointment on 6 July 2017.

Remuneration

The Nominations Committee reviews the Chair and NED remuneration and expenses policies annually. No changes were made in the reporting period.

The remuneration for the Chair and NEDs are shown in the table on page 28.

Appraisals

The Committee received reports on the appraisals of the NEDs and Chair and provided assurance to the Council of Governors that the process followed had been robust. The Nominations Committee also comments on proposed objectives for the Chair and NEDs.

Other developmental work

The Committee carried out an annual review of its work, which it reported to the Council of Governors.

The Committee reviewed the role profiles for the SID / Deputy Chair.

(RR4) Nominations Committee voting member attendance

	2 May 2017 Stood down	12 Sept 2017 Stood down	14 Nov 2017	8 Jan 2018 Stood down
Marion Saunders (Deputy Chair / SID)	✓		✓	
Catherine Wells (Lead Governor)	✓		✓	
Stephen Fletcher – Norfolk Public	✓		✓	
Sheila Preston – Norfolk Public	✓		A	
Andrew Good – Suffolk Public	✓		✓	
Jane Millar – Suffolk Public	✓		✓	
Malcolm Blowers – Service User	✓		A	
Mary Rose Roe – Carer	A			
Howard Tidman – Staff	✓		A*	
Sue Whitaker – Partner	✓			
Gary Page – Chair	✓		✓	

* Due to a discrepancy on the agenda / calendar, Howard Tidman was unable to attend and would have done so but for this error.

A – Apologies received

(RR5) Directors' remuneration (subject to audit)

Name and job title	Salary and Fees (in bands of £5,000) 2017/18	All taxable benefits* (total to the nearest £100) 2017/18	All pension related benefits (in bands of £2,500) 2017/18 *****	Total (in bands of £5,000) 2017/18	Salary and Fees (in bands of £5,000) 2016/17	All taxable benefits* (total to the nearest £100) 2016/17	All pension related benefits (in bands of £2,500) 2016/17	Total (in bands of £5,000) 2016/17
Michael Scott Chief Executive To 2 October 2017 ****	85 to 90	-	-	85 to 90	170 to 175	-	17.5 to 20	190 to 195
Julie Cave** Director of Finance and Deputy Chief Executive To 11 October 2017. Interim Chief Executive From 12 October 2017	150 to 155	-	202.5 to 205	355 to 360	125 to 130	-	-	125 to 130
Bohdan Solomka Medical Director	135 to 140	-	20 to 22.5	155 to 160	135 to 140	-	30 to 32.5	165 to 170
Jane Sayer Director of Nursing, Quality and Patient Safety To 17 October 2017 ****	55 to 60	1,100	80 to 82.5	140 to 145	100 to 105	1,800	97.5 to 100	200 to 205
Leigh Howlett Director of Strategy and Resources To 18 October 2017 ****	55 to 60	-	50 to 52.5	105 to 110	100 to 105	-	62.5 to 65	165 to 170
Deborah White Director of Operations (Nor) To 31 January 2018	90 to 95	-	80 to 82.5	170 to 175	100 to 105	-	60 to 62.5	160 to 165
Peter Devlin Director of Operations (Suf) From 1 June 2017 to 31 January 2018 **	30 to 35	-	7.5 to 10	35 to 40	-	-	-	-
Daryl Chapman Interim Director of Finance From 9 October 2017	55 to 60	-	30 to 32.5	90 to 95	-	-	-	-
Dawn Collins Interim Director of Nursing, Quality and Patient Safety From 18 October 2017	45 to 50	-	132.5 to 135	180 to 185	-	-	-	-
Josie Spencer Interim Chief Operating Officer and Deputy Chief Executive From 2 January 2018 ***	30 to 35	-	5 to 7.5	35 to 40	-	-	-	-
Gary Page Chair	45 to 50	-	-	45 to 50	45 to 50	-	-	45 to 50
Brian Parrott Non-executive Director To 31 December 2017	5 to 10	-	-	5 to 10	10 to 15	-	-	10 to 15
Tim Newcomb Non-executive Director	10 to 15	-	-	10 to 15	10 to 15	-	-	10 to 15
Marion Saunders Non-executive Director	15 to 20	-	-	15 to 20	15 to 20	-	-	15 to 20
Ian Brookman Non-executive Director	10 to 15	-	-	10 to 15	10 to 15	-	-	10 to 15
Tim Stevens Non-executive Director	10 to 15	-	-	10 to 15	10 to 15	-	-	10 to 15
Jill Robinson Non-executive Director	10 to 15	-	-	10 to 15	10 to 15	-	-	10 to 15
Adrian Matthews Non-executive Director From 1 September 2017	5 to 10	-	-	5 to 10	-	-	-	-

* Other remuneration includes the benefit in kind received relating to the provision of lease cars

** Peter Devlin is a joint post between the Trust and Suffolk County Council and the Trust has contributed to his pension scheme in the year

*** Josie Spencer is seconded to the Trust from Coventry & Warwickshire Partnership NHS Trust and NSFT made a contribution to her pension scheme in the year whilst on secondment.

**** Remuneration for these Directors relates to the time they held this role although they continued to be paid by the Trust after that date as a result of secondments to other NHS Organisations. £174K in total.

***** Total remuneration for the Medical Director includes £16.6k in respect of his clinical role

NSFT currently has 27 Governors out of a possible 29 in place of whom 24 received expenses in the year. The aggregate expenses received by Governors for the financial year was £14.8k (2016/17 £19.1k).

Pensions

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

(RR6)

Name and job title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued penion at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017 (rounded to nearest £000)	Real increase in Cash Equivalent Transfer Value (rounded to nearest £000)	Cash Equivalent transfer value at 31 March 2018 (rounded to nearest £000)
Julie Cave Director of Finance and Deputy Chief Executive To 11 October 2017 Interim Chief Executive From 12 October 2017	10 to 12.5	20 to 22.5	60 to 65	165 to 170	951	204	1,165
Bohdan Solomka Medical Director	0 to 2.5	-	40 to 45	115 to 120	725	61	793
Jane Sayer Director of Nursing, Quality and Patient Safety To 17 October 2017	0 to 2.5	5 to 7.5	45 to 50	140 to 145	775	66	904
Leigh Howlett Director of Strategy and Resources	0 to 2.5	2.5 to 5	40 to 45	120 to 125	760	52	862
Deborah White Director of Operations (Norfolk) To 31 January 2018	2.5 to 5	5 to 7.5	40 to 45	115 to 120	689	111	829
Daryl Chapman Interim Director of Finance From 9 October 2017	0 to 2.5	-	0 to 5	-	11	8	28
Dawn Collins Interim Director of Nursing, Quality and Patient Safety From 18 October 2017	2.5 to 5	5 to 7.5	25 to 30	70 to 75	363	50	478

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Review of tax arrangements of public sector appointees (not subject to audit)

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

The Trust did not make any such engagements during the year.

Fair Pay Disclosure

The Trust is required to disclose the relationship between the remuneration of the highest-paid Director in the organisation and the median remuneration of the organisation's workforce. Remuneration includes the staff on the Trust payroll together with agency staff, including NHS Professionals. On certain agency invoices used in the calculation it is not possible to identify agency commission. In such cases a 25% deduction has been made from the agency bill as the assumed agency commission and is excluded from the calculation.

The banded remuneration of the highest paid Director in the Trust in the financial year 2017/18 was £150k - £155k (2016/17, £175k - £180k). This was 5.5 times (2016/17, 6.6 times) the median remuneration of the workforce, which was £27,124 (2016/17, £26,658). The median has increased due to inflationary and incremental increases within the financial year. The ratio has reduced due to the highest paid director fulfilling two roles in the year, including Chief Executive for only part of the year.

In 2017/18 three (2016/17, three) employees received remuneration in excess of the highest-paid Director.

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

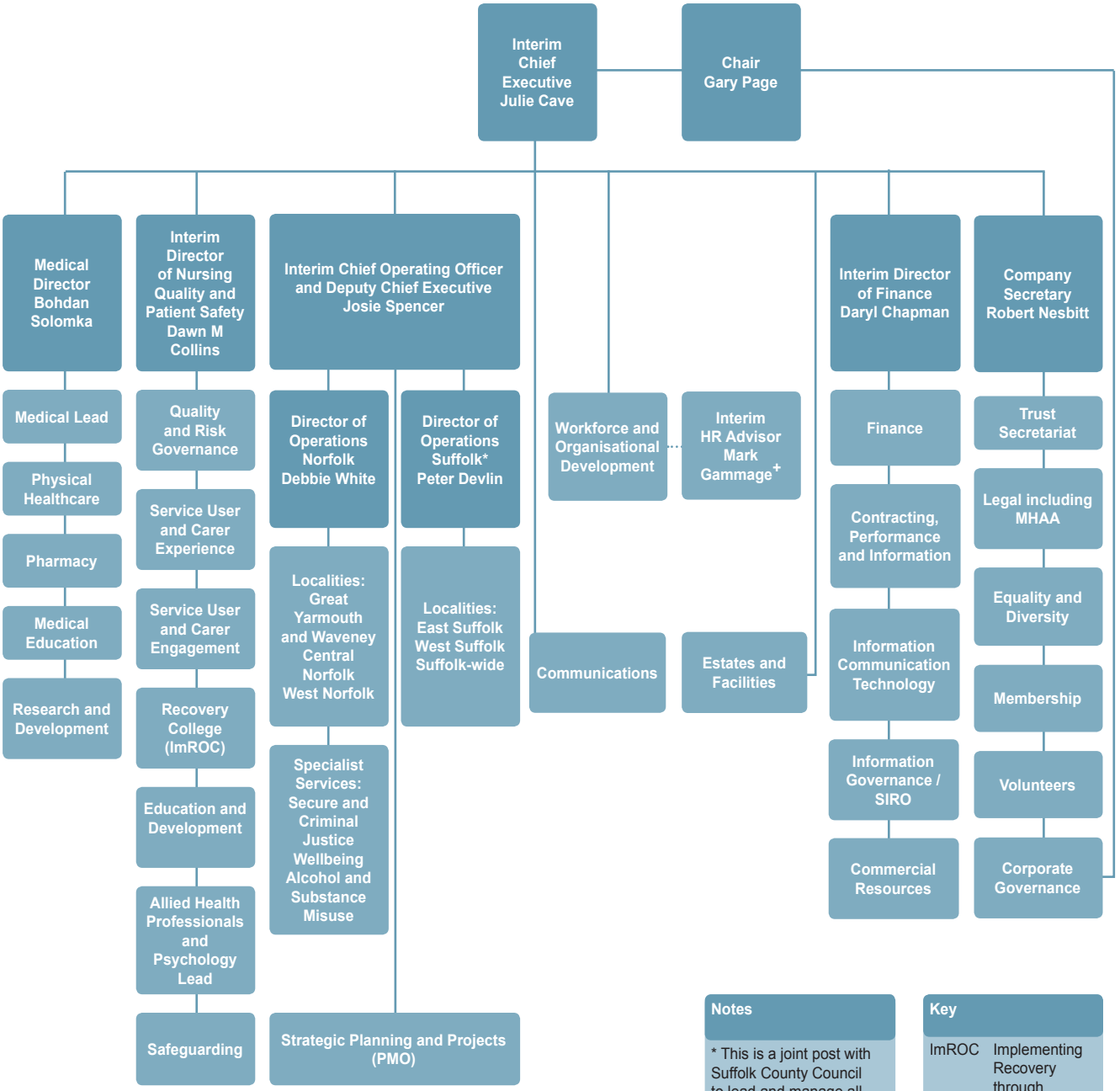
(RR7)

	2017/18 £	**2016/17 £**
Band of highest paid director (full year effect)	150,000-155,000	175,000-180,000
Median total remuneration	27,124	26,658
Ratio	5.5 times	6.6 times

Antek Lejk
Accounting officer

Staff report

(SR1) Management Structure



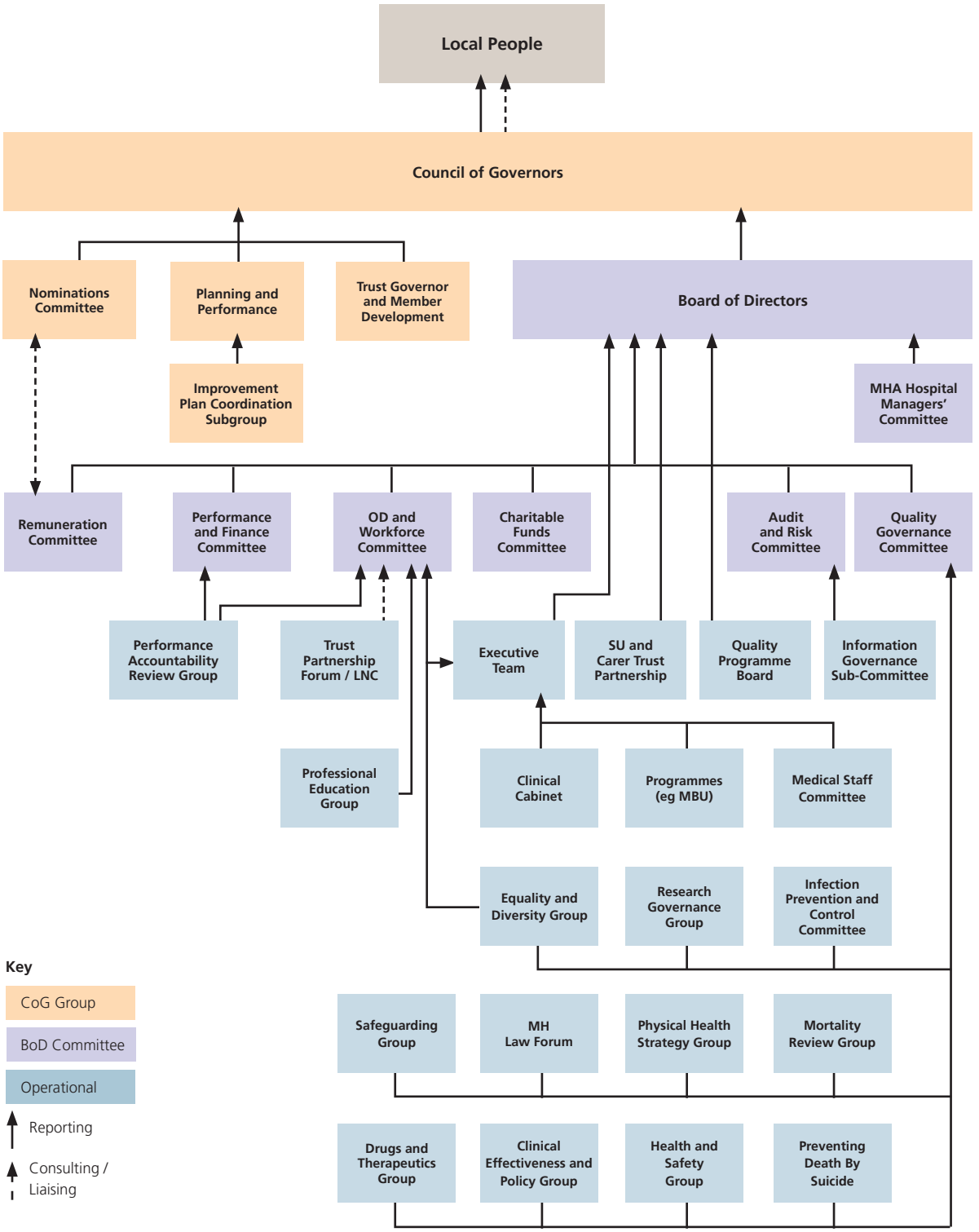
Notes
* This is a joint post with Suffolk County Council to lead and manage all of their mental health and learning disability services, together with the commissioning budget
+ Contracted Consultant

Key	
ImROC	Implementing Recovery through Organisational Change
MHAA	Mental Health Act Administration
PMO	Programme Management Office
SIRO	Senior Information Responsible Officer

During 2017/18 there were several changes to the executive team and the diagram above shows the position at 31 March 2018. The key changes were as follows:

- Michael Scott retired as CEO and Julie Cave (Director of Finance / Deputy CEO) became interim CEO
- Daryl Chapman was appointed as interim Director of Finance
- Jane Sayer resigned as Director of Nursing, Quality and Patient Safety and Dawn Collins was appointed as interim in this role
- Mark Gammage joined the Executive team in an interim contracted consultant capacity to provide advice on HR
- Leigh Howlett resigned as Director of Strategy and Resources

(SR2) Committee and Subgroup structure



Chair, Non-executive Director and Executive Director expertise and qualifications 2017/18

(SR3) Chair and Non-executive Directors (NEDs)

	Experience and Skills	Qualifications
Gary Page (Chair)	• CEO Global Markets for ABNAMRO BANK NV (2006-08). Career in financial services from 1986 • Chair of Trustees for a school in East London for boys aged 11-16 with social, emotional and behavioural difficulties (2008-10) • Chair of Trustees for the Hoffmann Foundation for Autism providing supported living and day services in North London for adults with autism (2010-16) • Member of the Supervisory Board and of the Audit and Risk Committee for Triodos Bank N.V., one of the world's leading sustainable banks (since 2017)	• BA (Hons)
Marion Saunders (Senior Independent Director / Deputy Chair)	• Non-executive Director UIA Insurance Ltd • IR and AAT Tribunals • Mental Health Tribunal (Specialist Member) • HCPC Partner Fitness to Practice • Governor of Sidestrand School • Health and Social Care Consultancy • Former Independent Chair of Lewisham Safeguarding Boards • Former Chair of Ealing PCT	• MSc HRD/OD • BA (Hons) • CQSW - registration with HCPC
Ian Brookman (NED / Chair of Audit and Risk Committee)	• Director of own accountancy and consultancy practice • Chief Finance Officer – The Bell Foundation • Trustee and Chair of Audit Committee – Ormiston Academy Trust • Trustee – Ormiston Trust • Formerly Managing and Audit Partner – regional accountancy firm	• Fellow of the Institute of Chartered Accountants in England & Wales (ICAEW)
Tim Newcomb (NED)	30 years in policing including: • 4yrs as Director of Intelligence – managing covert operations • 2yrs as Divisional Commander for Eastern Division – delivering mainstream community policing services • 2yrs as Assistant Chief Constable in Essex Police • Managed 2010 CSR Change Programme • Assistant Chief Constable in Suffolk Constabulary 2012 to 2014 • Hostage and Crisis Negotiator, including Kidnap / Extortion training • Strategic Public Order and Firearms (Gold) Commander Coach / Mentor	• Postgraduate Certificate in Business Excellence – Leeds University • Diploma in applied Criminology and Policing – Cambridge University Mst Programme • Level 5 Coaching Certificate

Tim Stevens (NED)	• Trustee of the Woolf Institute (2017) • Prelate of the Order of St John (2016) • Chair of Trustees of Common Purpose UK (2015) • Diocesan Bishop of Leicester (1999-2015) • Previously Member of House of Lords with Welfare Reform portfolio • Chair of Children's Society (2004 and 2010) • Governor of De Montfort University (2007-10) • Former Chair of Leicester Faith Leaders' Forum	• Cambridge MA • Oxford Dip Theol • Dip Mgt • Hon PhD Leicester University • Hon Phd De Montfort University
Professor Jill Robinson (NED)	• Recently retiring from her role as Faculty Executive Dean, retains a part-time position at the University of Suffolk as Professor of Healthcare Practice • Formerly a Non-executive Director for an acute trust • Over 10 years of senior leadership experience in health professional education and workforce development, stakeholder engagement, and quality improvement and assurance • Successful track record of nationally funded research and publication in the fields of health professional education, practice and university governance	• PhD in Applied Educational Research • NMC Registered Mental Health Nurse and Nurse Teacher • BABCP accredited Psychological Therapist • Graduate Member of British Psychological Society • Fellow of Higher Education Academy
Adrian Matthews (NED)	• 23 years working in the NHS as a senior manager and Executive Director (1991-2014) • Owner XE Associates Consulting (2015 to date) • Specialist Advisor to CQC (2016 to date) • Vice Chair and Chair of the Audit and Finance Committee of Diversa Multi Academy Education Trust (2017 to date) • Director of Diversa Trading Company Limited (2018 to date)	• Associate Chartered Management Accountant • Associate Chartered Global Management Accountant • Post Graduate Diploma in Board Direction (Institute of Directors)
Brian Parrott (NED to 31 Dec 2017)	• Former Director of Social Services and former Chair of small PCT • Social Care (Adults and Children), Health and Local Government Consultancy • Independent Chair, Safeguarding Adults Board – London Boroughs of Richmond and Tower Hamlets • Former Co-Chair of Association of Directors and Social Services Associates Network • Extensive experience of social services management and partnership working with NHS	• Certificate of Qualification in Social Work (currently registered)

(SR4) CEO and Executive Directors

	Experience and Skills	Qualifications
Michael Scott (Chief Executive to 2 Oct 2017)	• Over 35 years of experience across social care, the NHS and Department of Health, having worked in front line learning disability services, acute hospitals and commissioning organisations as well as mental health services • Held a Chief Executive position for over 16 years • Former chair of the NHS Confederation's Community Health Services Forum	• BA Oxon • CSS
Julie Cave (Director of Finance / Deputy CEO) (Interim CEO from 12 Oct 2017)	• Over 30 years of experience in the NHS in acute hospitals, health authorities and commissioning organisations as well as NSFT • Has held executive Director of Finance roles since 2004 • Has undertaken wider roles on performance, strategic change and leadership development • Has delivered major transformational change, established new networks for health care and managed large-scale building projects to improve health care facilities	• BA (Hons) • Fellow of the Chartered Association of Certified Accountants
Daryl Chapman (Interim Director of Finance from 9 Oct 2017)	• Held three previous Director posts in a variety of industries, including operational responsibilities • A variety of private and public sector experience, having worked at NSFT previously, and held the post of N&W STP Finance Lead prior to this role	• BA (Hons) • ACA
Leigh Howlett (Director of Strategy and Resources to 18 Oct 2017)	• Three previous director posts • Worked at Board level since 2004 • 33 years NHS experience across all areas of health care provision and delivery	• Diploma in management studies • Significant professional development in all areas of responsibility
Dr. Jane Sayer (Director of Nursing, Quality and Patient Safety to 17 Oct 2017)	• Extensive nursing leadership experience • Development of clinical career pathways • Research portfolio related to nursing workforce	• BA (Hons) • RMN • MSc • PhD
Dawn Collins (Interim Director of Nursing, Quality and Patient Safety from 18 Oct 2017)	• Qualified as a RGN in 1989 • Extensive nursing leadership experience, in Acute, Mental Health and Community Services • Development of Advanced Nursing Roles	• BA (Hons) • RGN • MSc
Dr. Bohdan Solomka (Medical Director)	• Qualified as a doctor in 1988 and joined the Trust in October 1994 as Senior Registrar in Forensic Psychiatry • Previously worked in Suffolk as a Consultant Forensic Psychiatrist from 1997 to 2007, then in Yarmouth and Waveney from 2007 to 2014 and the Women's Medium Secure Service from February 2014 • Lead Clinician in the Secure Service since January 2013	• Member of the Royal College of Psychiatrists

Josie Spencer (Interim Chief Operating Officer / Deputy CEO from 2 Jan 2018)	• Register General Nurse with 35 years of service to the NHS • Previous experience in acute hospitals, community services and specialist mental health trusts • Has held executive roles in Nursing and Operations for 15 years • Has delivered major transformational change in a number of provider roles • Has a national profile most recently working nationally on the 5YFV establishing new models of care for tertiary mental health services	• RGN • RNT • Dip Nursing Studies • BSc (Hons) • PGD (Adult Education) • MA (Research)
Debbie White (Director of Operations Norfolk and Waveney Board member to 31 Jan 2018)	• Qualified as a Social Worker in 1995 • Management of health and social care services since 2002, including Locality Manager and Associate Director within NWMHFT	• Diploma in Social Work
Pete Devlin (Operations Director MH & LD for Suffolk – Joint appointment with SCC from 1 June 2017 Non-voting Board member to 31 Jan 2018)	• Qualified as a Social Worker in 1998 • Over 19 years of experience working in public sector services • Since 2012 worked in integrated senior management and leadership position across health and social care	• Diploma in Social Work • BA Social Work • BA Mental Health Practice • HCPC member

The Nomination and Remuneration and Terms of Service Committee keep under review the balance and completeness of the skill and experience set for the Board. Person specifications take into account the current and future Trust needs.

(SR5) Board of Directors 2017/18 attendance

	27 Apr 2017	25 May 2017 (ARA)	29 Jun 2017	27 Jul 2017	28 Sep 2017	10 Oct 2017 (Private / AGM)	26 Oct 2017	30 Nov 2017	25 Jan 2018	22 Feb 2018	29 Mar 2018
Ian Brookman	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓
Julie Cave	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Daryl Chapman							✓	✓	✓	✓	✓
Dawn Collins							✓	✓	✓	✓	✓
Pete Devlin						✓	✓	✓	✓		
Mark Gammage								✓	✓	✓	✓
Leigh Howlett	✓	✓	A	✓	✓	✓					
Paul Lumsdon											✓
Adrian Matthews					✓	✓	✓	✓	✓	✓	✓
Robert Nesbitt	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tim Newcomb	✓	✓	A	✓	✓	✓	A	✓	✓	✓	✓
Gary Page (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Brian Parrott	A	✓	A	A	✓	✓	A	✓			
Jill Robinson	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓
Marion Saunders	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓
Jane Sayer	✓	✓	✓	✓	✓	✓					
Michael Scott	✓	✓	✓	✓	✓						
Bohdan Solomka	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
Josie Spencer									✓	✓	A
Tim Stevens	✓	A	✓	✓	✓	A	✓	✓	✓	✓	✓
Debbie White	✓	✓	A	✓	A	✓	✓	✓	✓		

A – Apologies received

The Board of Directors meets ten times a year in public in Ipswich and Norwich. A small number of items of business are confidential or commercially sensitive and are dealt with in private. Governors receive the agenda and minutes of the private Board papers. Details of meetings and public Board papers are available at: www.nsft.nhs.uk.

The Board of Directors is satisfied that the Non-executive Directors who served on the Board for the period under review were independent. The Chair had no other significant commitments. A summary of the background of each of the Directors along with their expertise is shown in the Directors' Report.

Board committees report on their work to the next available Board and include a review of performance against their terms of reference annually. Governors attend Board committees as observers and provide feedback to the committee chair and to the Chair of the Board of Directors.

The Executive Directors are appraised by the CEO who reports to the Remuneration and Terms of Service Committee. The CEO is appraised by the Chair.

The NEDs are appraised by the Chair, and the Chair by the Senior Independent Director (SID), on behalf of the Council of Governors. This is reported via the Nominations Committee to the Council of Governors.

The Board of Directors / Council of Governors hosts an annual Members' meeting at which the Annual Report and Accounts, plus any report from the auditors, are presented.

The Work of the Council of Governors

The Health and Social Care Act (2012) clarified the general duties of the Council of Governors:

S.151 (4)

"The general duties of the Council of Governors are:

(a) To hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors, and

(b) To represent the interests of the members of the corporation as a whole and the interests of the public."

The main duties include:

- To appoint or remove the Chair and other Non-executive Directors
- To approve the appointment of the Chief Executive
- To decide the remuneration and allowances, and other terms and conditions of office, of the Non-executive Directors (delegated to the nominations committee)
- To appoint or remove the Trust's auditor

Elections are held once a year with nominations opening in the autumn and the results being declared in December or January for Governors to take up their seats from 1 February each year.

Governors canvass the opinions of Trust Members and the wider public (including, for Partner Governors, the body they represent) in a wide-range of ways. They use informal and formal networks, attend community and Trust events and take account of service user and carer experience. They feed these insights back to the Board of Directors through the Council of Governors' issues log, by raising questions with Directors and by attending the Board of Directors' meeting. Governors use their insights to comment on the Trust's forward plan, objectives and strategic priorities.

A summary of the business carried out by the Council of Governors is shown below.

The Council of Governors met in public on the following dates in 2017/18. At each meeting, Governors present issues that they wish to highlight (often based on feedback from Members and the wider public) and the Trust undertakes to respond to these issues as fully as possible. The agendas include other standing items, including the reports of the subgroups. In addition to these standing items the following business was conducted. A full set of papers for each meeting is available at www.nsft.nhs.uk.

(SR6)

Date of meeting	Summary of business covered at sessions in public
6 April 2017	Membership Strategy 2017/18
	Non-executive Director recruitment planning
	Report on unexpected deaths
6 July 2017	Re-appointment of Marion Saunders and Tim Newcomb as NEDs for second, three year terms
	Update on annual account and report
	External audit report from KPMG LLP
	Bed review update
	Governor elections planning
31 August 2017 (additional)	Appointment of Adrian Matthews as NED for first three-year term
12 October 2017	Appointment of interim CEO – approval
	Staff Governor constitution proposals
	Update on service user and carer partnership developments
	Governor election dates and details
	Developing Member involvement
	Update on Allied Health Professionals conference
1 November 2017	External auditors' contract extension
11 January 2018	Update on Overview and Assurance Group
	Report from regional Governors' conference
	Board of Directors / Council of Governors joint agreement update
	Council of Governors' self-evaluation
	Governor publicity materials
	Community Service User Survey report
8 March 2018 (additional)	Appointment of CEO – approval
	Appointment of substitute Governor for Norfolk Public constituency

In addition to the meetings in public, the Governors hosted two member and public events during the reporting period. On 25 October 2017 the Governors hosted an event in Ipswich on Talking Therapies and on 23 March 2018 an event on social prescribing was held in Norwich.

Summary of changes to the constitution approved by the Council of Governors in 2017/18

Staff Governor constituencies – The Council of Governors voted to move to two constituencies (by county) in 2016/17. There was no Staff Governor election in year. The Council of Governors then reversed this decision at its meeting on 12 October 2017 and so there remains a single Staff Governor constituency.

There were no other changes to the constitution in the reporting period.

Register of interests

All Governors are required to declare any interests on the register at the time of their election or appointment and to keep this up-to-date. The full register is taken as an item at a public meeting once a year and is available for inspection by contacting the Company Secretary at NSFT, Hellesdon Hospital, Drayton High Road, Norwich, NR6 5BE.

Alternatively, call 01603 421104 or email: governors@nsft.nhs.uk.

(SR7) Council of Governors 2017/18 attendance

	Constituency	6 Apr 2017	6 Jul 2017	31 Aug 2017	12 Oct 2017	11 Jan 2018	8 Mar 2018	22 Mar 2018	
Mary Rose Roe	Carer – N	A	✓	A	✓				Re-elected 1 Feb 2016 (opposed) Stood down Oct 2017
Christine Hawkes	Carer – N						✓	✓	Elected 1 Feb 2018 (opposed)
Anne Humphrys	Carer – S	✓	A	✓	✓	✓	A	A	Elected 1 Feb 2016
Nigel Boldero	Public – N	✓	A	A	✓	✓	✓	✓	Elected 18 Feb 2016 (sub)
Stephen Fletcher	Public – N	A	✓	A	✓	✓	✓	✓	Re-elected 1 Feb 2016 (opposed)
Ronald French	Public – N	✓	A	✓	✓	✓	✓	✓	Re-elected 1 Feb 2017 (opposed)
Hilary Hanbury	Public – N	A	A	A	✓	✓	A	✓	Re-elected 1 Feb 2018 (opposed)
Sheila Preston	Public – N	✓	✓	✓	✓	A	✓	✓	Re-elected 1 Feb 2017 (opposed)
Clare Smith	Public – N							✓	Appointed 8 Mar 2018
Catherine Wells	Public – N	✓	✓	A	✓	✓	✓	✓	Re-elected 1 Feb 2016 (opposed)
Leonard Wellings	Public – N	*							Elected 1 Feb 2017 (opposed) Stood down May 2017
Kathleen Ben Rhaba	Public – S	A	A	✓	✓	✓	A	*	Re-elected 1 Feb 2017 (opposed) Formerly Partner Governor from Apr 2012
Paddy Fielder	Public – S	✓	✓	✓	✓	✓	✓	✓	Re-elected 1 Feb 2017 (opposed)
Ian Hartley	Public – S						A	✓	Elected 1 Feb 2018 (unopposed)
Andrew Good	Public – S	✓	✓	✓	A	✓	A	✓	Re-elected 1 Feb 2017 (opposed)
Jane Millar	Public – S	✓	A	✓	✓	✓			Re-elected 1 Feb 2015 (opposed) Stood down 31 Jan 3018
Guenever Pachent	Public – S	✓	✓	✓	✓	✓			Re-elected 1 Feb 2015 (opposed) Stood down 31 Jan 3018
Steve Roche	Public – S						A	*	Elected 1 Feb 2018 (unopposed)
Martin Wright	Public – S	✓	✓	✓	✓	✓	✓	A	Elected 1 Feb 2016 (opposed)
Ginnine Benedettini	Service User – N	✓	✓	A	✓	✓	A	✓	Elected 1 Feb 2016
Richard Gorrod	Service User – N	✓	✓	✓	A	✓	✓	A	Elected 1 Feb 2017 (opposed)
Malcolm Blowers	Service User – S	*	*	✓	*	✓	✓	*	Elected 1 Feb 2016 (opposed) Formerly Partner Governor from Feb 2015
Georgia Butler	Service User – S						A	A	Elected 1 Feb 2018 (opposed)
Paul Gaffney	Service User – S	A	✓	✓	✓	✓			Re-elected 1 Feb 2015 Not re-elected Feb 2018
Jill Curtis	Staff						✓	✓	Elected 1 Feb 2018 (opposed)
Nanayakkara De Silva	Staff	*	✓	A	*	*			Elected 1 Feb 2015 Stood down 31 Jan 2018
Marcus Hayward	Staff	✓	✓	A	✓	✓	✓	✓	Elected 1 Feb 2016
Howard Tidman	Staff	✓	✓	✓	✓	✓	✓	A	Re-elected 1 Feb 2018
Zeyar Win	Staff	A	✓	A	✓	✓	✓	✓	Elected 1 Feb 2016
Sue Whitaker	Partner – Norfolk County Council	✓							Appointed Jul 2013 Stood down May 2017
Tony Gordon	Partner – Suffolk County Council	A	A	*					Appointed 27 Jul 2016 Stood down Aug 2017
Richard Rout	Partner – Suffolk County Council			A	✓	*	*	*	Appointed 18 Aug 2017
Sian Coker	Partner – UEA	✓	A	A	A	A	A	*	Appointed 22 Feb 2016
Heather Passmore	Partner – UCS	A	A						Appointed 23 Jul 2015 Stood down Jul 2017
Heather Rugg	Partner – UCS			*	*	✓	*	*	Appointed 11 Aug 2017
Meghan Teviotdale	Partner – Norfolk County Council					✓	✓	*	Appointed 2 Jan 2018
Gary Page (Chair)	Trust Chair	✓	✓	✓	✓	✓	✓	✓	

A – Apologies received

* – Not attended, apologies not noted

The Work of the Audit and Risk Committee

The Trust has an Audit and Risk Committee which fulfils the responsibility of an audit committee on behalf of the Trust. The three members of the committee are all Non-executive Directors.

During the year the Committee met on five occasions. A Governor representative was in attendance at two of those meetings.

Two members must be present for the meeting to be quorate. All meetings achieved this status during 2017/18.

The Trust has an Internal Audit service which is provided by Grant Thornton UK LLP who were awarded this contract in April 2017. Internal Audit prepare and deliver a three-year, risk based, audit strategy which is translated into an internal audit plan each year. The plan takes into account the Trust's risk management framework, our strategic priorities and objectives and the views of senior management, the Audit and Risk Committee and the Board. Their work is undertaken in accordance with the Public Sector Internal Audit Standards (PSIAS) and NHS Internal Audit Standards. Each year the Head of Internal Audit prepares a statement on the effectiveness of the systems of internal control in delivering his / her annual internal audit opinion. The internal audit strategies and plans are approved by the Audit and Risk Committee, which also monitors progress and performance throughout the year. Any matters arising are reported to the Board of Directors by the Chair of the Committee. The Committee has assessed that the Trust received an appropriate level of service during 2017/18.

The external audit of the Trust's Annual Accounts and Annual Report, including the Quality Account is provided by KPMG LLP, following a competitive tendering process in 2014. The original contract term was three years, and this was extended for a further two years as approved by the Council of Governors. The contract value for 2017/18 was £64,400. During the year no non-audit services were provided by KPMG LLP.

The Audit and Risk Committee worked throughout the year in accordance with its Terms of Reference and best practice guidance. The Terms of Reference were developed in accordance with NHSI's Code of Governance for Audit Committees and Auditors. The Committee has a work programme for each financial year which covers:

- Annual Report and Accounts
- Board Assurance Framework
- Governance, risk management and internal control
- Counter Fraud work
- Internal audit work
- External audit
- Other assurance functions

In discharging its responsibilities in respect of the Annual Report and Accounts, the committee has reviewed:

- The Trust's accounting policies, with particular reference to any changes and compliance
- The accounts and disclosures
- Major judgement areas
- The accounting of Trust property, plant and equipment, and ensuring that independent, professional advice has been obtained in valuing the Trust's property portfolio
- All Internal Audit reports during the year, with specific attention on appropriate systems of control, and the effectiveness of these controls

Any issues identified by the Committee or by those charged with the responsibility of reporting to it, are monitored and followed up to conclusion or, where necessary, reported to the Board of Directors for their attention and action.

Should the external auditors identify any mis-statements in the accounts these are considered for their materiality and understanding of the accounts. These are reported to the Board of Directors and are listed by the external auditors in their report.

Each year, the effectiveness of the external auditors is assessed by the Committee and reported to the Board of Directors and Council of Governors.

(SR8) Audit and Risk Committee 2017/18 attendance

	19 May 2017 ARA	9 Jun 2017	4 Aug 2017	2 Sept 2017	8 Dec 2017	9 Mar 2018
Ian Brookman	✓	✓	✓	✓	✓	✓
Jill Robinson	✓	✓	✓	✓	✓	✓
Marion Saunders	✓	✓	✓	✓	✓	✓

ARA = Annual Report and Accounts meeting

Membership strategy summary 2017/18

Members must be over 11 years of age and Governors must be 16 or over.

We have consulted on and created the following membership constituencies:

- Public constituency
- Norfolk
- Suffolk
- Service User and Family Carer constituency

Anyone who has used our services within the last three years is eligible to become a Service User Member.

People who identify themselves as family carers of people who have been supported by our services are eligible to join as Family Carer Members. The term Family Carer Member is used to distinguish this group from paid carers. Family Carers do not have to be related to the person they care for.

The constituency classes are:

- Service User (Norfolk)
- Service User (Suffolk)
- Carer (Norfolk)
- Carer (Suffolk)
- Staff

Permanent contracted staff are automatically granted membership ('opted-in') although it is easy for any staff member to 'opt out', should they wish, by writing to the Company Secretary.

Members can only be a Member of one constituency at a time. If they become ineligible to be a Member of one constituency (they leave the Trust's employment), they can opt to become a Member of another constituency (a Public Member).

Eligible staff Members are not permitted to join another constituency.

The total number of Members is shown in the Membership Report. We have not made as much progress as we would have liked in building our membership because our membership officer post was vacant for much of the year, although the post has now been filled. Our focus for 2018/19 is on maintaining or increasing our membership and building meaningful engagement. Representation of BME members has made good progress over recent years.

This year, the Council of Governors has hosted successful member events on the topics of talking therapies and social prescribing.

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

Membership Office,
NSFT,
Hellesdon Hospital,
Drayton High Road,
Norwich NR6 5BE

We strongly encourage Members to receive information via email – about 90% of new Members do so.

(SR9) Membership report 2017/18

Membership	2017/18
Public constituency	
At year start (1 April 2017)	11,214
New Members	64
Members leaving	67
At year end (31 March 2018)	11,211
Staff constituency	
At year start (1 April 2017)	3,829
New Members	685
Members leaving	475
At year end (31 March 2018)	4,039
Patient constituency*	
At year start (1 April 2017)	1,547
New Members	43
Members leaving	13
At year end (31 March 2018)	1,577

Public constituency	Number of members	Eligible membership
Age (years)		
0 - 16	3	304,082
17 - 21	34	88,006
22+	9,468	1,254,004
Ethnicity		
White	10,388	1,521,213
Mixed	80	22,499
Asian or Asian British	145	26,148
Black or Black British	114	11,463
Other	26	4,728
Socio-economic groupings		
AB	2,902	90,768
C1	3,167	139,592
C2	2,521	115,112
DE	2,563	121,910
Gender		
Male	3,965	810,734
Female	7,128	835,358

Patient constituency	Number of members
Age (years)	
0 - 16	1
17 - 21	7
22+	1,376

* Here 'patient constituency' is that of Service Users and Carers combined.

Staff demographic data

Analysis of staff costs

The table shows the staffing costs by staff classification during 2017/18:

(SR10)

Staff Group	Permanent	Other*	Total
	£000s	£000s	£000s
Medical and dental	13,228	10,864	**24,092**
Administration and estates	31,562	3,481	**35,043**
Healthcare assistants and other support staff	20,856	7,456	**28,312**
Nursing, midwifery and health visiting staff	45,917	6,241	**52,158**
Scientific, therapeutic and technical staff	19,251	3,136	**22,387**
Total	**130,814**	**31,178**	**161,992**

* 'other' includes short-term contract staff, inward secondments, agency and other temporary staff.

Analysis of average staff numbers

The table below shows the average number of employees in the 2017/18 financial year, split by permanently employed and other staff:

(SR11)

Average number of employees (WTE basis)	Total	Permanent	Other*
Medical and dental	210	139	71
Administration and estates	983	885	98
Healthcare assistants and other support staff	1,126	861	265
Nursing, midwifery and health visiting staff	1,283	1,134	149
Scientific, therapeutic and technical staff	402	344	58
Total average numbers	**4,004**	**3,363**	**641**

* 'other' includes short-term contract staff, inward secondments, agency and other temporary staff.

Breakdown of male / female at year end

The male / female split for the Trust's workforce for the financial year 2017/18 is 71.7% female and 28.3% male.The proportion of women decreases to 52.9% at senior management level, but increases slightly to 57.1% at director level. The number of male / female staff in each group is set out below:

(SR12)

Annual report category	Female	Male	Total
Director	4	3	7
Senior Manager	27	24	51
Other employee	2,852	1,110	3,962
Total	**2,883**	**1,137**	**4,020**

Sickness absence data

The Trust's annualised sickness absence rate for the period January 2017 to December 2017 was 4.73%, (January 2016 to December 2016; 4.89%).

The average days sick per FTE employee was 10.8 days (11 FTE days in 2016).

The largest known reason for sickness absence is due to 'anxiety / stress / depression / other psychiatric illnesses', accounting for 31.9% of all absence (equivalent to 1.51% of days lost), (2016: 28.2%). The top five reasons for absence are:

- Anxiety / stress / depression / other psychiatric illnesses
- Other known causes – not elsewhere classified
- Cold, cough, flu – influenza
- Gastrointestinal problems
- Unknown causes / Not specified

Episodes of long-term absence (defined as being absence episodes of 28 days or more) account for 21% of all occurrences (2016: 22%) and short-term absence (defined as being absence episodes of 27 days or less) account for 79% (2016: 78%) of all occurrences.

Improving staff wellbeing and reducing sickness absence is a continued priority for the Trust. The Trust is continuing with a five-year Staff Wellbeing Strategy that was approved by the Board of Directors in June 2016.

Through this strategy we have provisionally received national recognition of the work we are doing to improve staff wellbeing.

A number of initiatives have been launched over the last year to positively impact stress related absences, including:

- Training and development of Trauma Incident Risk Management (TrIM) facilitators to support staff who are affected by significant incidents at work (e.g. assault, death of a service user)
- Training and development of Stress and Resilience at Work facilitators to provide support for staff who are affected by lower level but more sustained stress factors

Staff policies and actions applied during the financial year

Action on working with employees with a disability

In the last year, the Trust has been re-assessed as a 'Disability Confident' employer. The Disability Confident scheme supports employers to make the most of the talents that disabled people can bring to the work place.

The assessment is based on two themes:

Theme 1:
Getting the right people for our business:

- Actively looking to attract and recruit disabled people
- Providing a fully inclusive and accessible recruitment process
- Offering an interview to disabled people who meet the minimum criteria for the job
- Being flexible when assessing people, so disabled job applicants have the best opportunity to demonstrate that they can do the job
- Proactively offering and making reasonable adjustments, as required
- Encouraging our suppliers and partner firms to be Disability Confident
- Ensuring employees have sufficient disability equality awareness training

Theme 2:
Keeping and developing your people:

- Providing mentoring, coaching, buddying and or other support networks for staff
- Including disability awareness equality training in our induction process
- Guiding staff to information and advice on mental health conditions
- Providing occupational health services, if required
- Identifying and sharing good practice
- Providing human resource managers with specific Disability Confident training

Our policies that support this include:

- Recruitment and Selection Policy (including redeployment) (reviewed during 2017/18)
- Equality, Diversity and Inclusion Policy
- Disability Leave Policy
- Employment references (which was reviewed during the last year)

Equality and Diversity training is a mandatory requirement for all staff. We are part-way through a strategy to deliver higher level equality and diversity training to all staff. The focus of this level 2 training is on managing unconscious bias.

Our published Staff Wellbeing Strategy (2016/17) aims to support all employees, including disabled employees, to be the best they can be at work. To support this, we have introduced annual Wellness at Work Plans, which are developed between an employee and their manager and set out support needs and arrangements.

Action on providing information to staff

The Trust's Chair and Chief Executive regularly provide updates to staff on key issues and matters affecting the Trust, including those raised during listening events. Key vehicles of communication from the Chair and Chief Executive include:

- Staff Handbook
- Regular email updates
- Skype Broadcast events with key members of the Executive Team
- Newsletters – including a quarterly staff wellbeing newsletter

- Schedule of Executive Team visits and attendance at team meetings
- Induction

We issue a hard copy of the Staff Handbook to all new staff at the Trust induction session. An electronic version is available on the intranet for both existing and new staff. We continued to review our induction process within the last year to make it more engaging and have strengthened onboarding processes to ensure that all new staff feel ready and supported within their new roles.

Action on consulting with staff or representatives

We hold regular forums to consult with staff representatives. Trust Partnership Meetings (TPM) and Local Negotiating Committee (LNC) are monthly formal discussions between Executive Directors and trade union representatives. These meetings involve consultation and negotiation on matters affecting our workforce, including organisational change and performance.

Performance

Performance is reported to localities on a monthly basis via an Integrated Performance Report. This includes service, quality and workforce performance. Financial performance is reported separately each month to localities.

Monthly locality performance accountability review meetings, chaired by the Director of Finance, encourage localities and individuals within localities to take responsibility for their performance.

Daily performance can be monitored using the Trust's business intelligence system (Abacus). Abacus enables teams to examine their performance against targets, review waiting lists and keep up-to-date with reviews and contacts.

Providing information relating to health and safety performance and occupational health

All localities have use of the Datix dashboard, giving them up-to-the-minute charts on incident reporting trends.

Regular Health and Safety Committee meetings are held and have Staff Side representation.

Regular meetings are held with our occupational health provider and involve Staff Side and operational management representatives.

Information on key occupational health trends and issues are also discussed and plans agreed through the Staff Wellbeing Meeting, which is chaired by an Executive Director and involves Staff Side representatives and our Wellbeing Champions.

Providing information relating to countering fraud and corruption

The Trust has a Local Counter Fraud Specialist appointed, and our Anti-Fraud and Anti-Bribery Policy is in line with the NHS Counter Fraud Authority's national standards and guidance. The policy is regularly reviewed to ensure it is consistent with all current legislation and applicable guidance.

The Trust already has numerous procedures in place to reduce the likelihood of fraud and corruption including Standing Orders, Standing Financial Instructions, systems of internal control, and a system of risk assessment.

The Trust seeks to ensure that a risk awareness culture exists in the Trust (which includes fraud, corruption and bribery awareness), and is complying with Service Condition SC24 of the NHS Standard Contract in having appropriate counter fraud arrangements in place.

NHS Staff survey results

Approach to staff engagement

The annual national NHS Staff Survey is a mandatory requirement for NHS organisations. The Trust is committed to using the results as one element of our approach to understand the views of our staff and to inform improvements.

The most recent Staff Survey took place between October and December 2017, with results published on 6 March 2018.

Whilst our results from the previous year had demonstrated a significant year-on-year improvement, we are disappointed by our most recent results. These show a decline across a number of key findings. Only one score, relating to staff receiving appraisals, has increased compared to the previous year. We are committed to improving our results in all areas.

Response rates

55% of our eligible staff responded to the Staff Survey (2,096 staff). This is above the national average for Mental Health Trusts of 52%. Our response rate was 3% points below the previous year's response rate. The national response rate improved by 1.6%.

(SR13)	2017		2016		
	Trust	National Average	Trust	National Average	Change (+/-)
Response Rate	55%	52%	57%	50%	-2%

Summary of performance

Summary of the response rate and the five best and worst key findings for the Trust:

	2017		2016		
	Trust	National Average	Trust	National Average	Trust improvement (+) deterioration (-)
Response Rate	55%	52%	57%	50%	- 2%
Top five ranking scores: Our scores compare most favourably with the scores of our benchmark group in the following areas:					
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	20%	22%	20%	21%	No change
KF24. Percentage of staff/colleagues reporting most recent experience of violence	93%	93%	92%	93%	+ 1%
KF16. Percentage of staff working extra hours	72%	72%	72%	72%	No change
KF23. Percentage of staff experiencing physical violence from staff in the last 12 months	3%	3%	2%	3%	+ 1%
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	58%	60%	60%	59%	- 2%
Bottom five ranking score: Our scores compare least favourably with the scores of our benchmark group in the following areas:					
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.55	3.83	3.63	3.85	- 0.08
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.26	3.67	3.37	3.62	-0.11
KF8. Staff satisfied with level of responsibility and involvement	3.73	3.88	3.78	3.87	-0.05
KF6. Percentage of staff reporting good communication between senior management and staff	26%	36%	30%	35%	-4%
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	89%	93%	88%	92%	+1%

* National average scores are for mental health / learning disability trusts

Further information of the NHS Staff Survey response, including priorities and key areas for action, can be found on pages 79-81 of the Quality Report.

Future priorities and targets

During 2018/19 the Trust will use monthly Pulse Surveys to provide more immediate feedback to managers and Executives on morale.

The Trust will develop and agree a cohesive strategy for staff engagement and empowerment with the Trust values at the core of this work. Staff and service users / carers will be involved in the co-production of this strategy.

(SR15) Exit packages

A total of three redundancies were approved by the Trust in year and these were as a result of service and departmental restructuring. There were no other departure payments.

Reporting of compensation schemes - exit packages 2017/18

Exit package cost band (including any special payment element):	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	-	-	-
£10,001 - £25,000	1	-	1
£25,001 - 50,000	-	-	-
£50,001 - £100,000	1	-	1
£100,001 - £150,000	1	-	1
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**3**	**-**	**3**
Total resource cost (£)	£162,000		**£162,000**

Reporting of compensation schemes - exit packages 2016/17

Exit package cost band (including any special payment element):	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	1	-	1
£10,001 - £25,000	3	-	3
£25,001 - 50,000	1	-	1
£50,001 - £100,000	1	1	1
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**6**	**1**	**7**
Total resource cost (£)	£181,000	£54,000	**£235,000**

Exit packages: other (non-compulsory) departure payments

	2017/18		2016/17	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	1	54
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**-**	**-**	**1**	**54**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

NHS Foundation Trust Code of Governance

The Board of Directors has set in place governance arrangements that provide a review of the effectiveness of the system of internal control. This is described in detail within the Annual Governance Statement on page A8 of the financial statements.

Norfolk and Suffolk NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. All elements that are required can be found within this report.

The Audit and Risk Committee carried out a full review of the Trust's compliance against the Code in 2017/18.

(COG1) NHS Foundation Trust Code of Governance: Disclosures

A.1.1	The Board normally meets ten times a year in public and eleven times a year in private (an additional meeting being to approve the Annual Report and Accounts) and may vary this in order to carry out its business effectively. There is a scheme of delegation which sets out which matters are reserved to the Board. There is a joint working agreement which sets out how the Council of Governors (CoG) and Board of Directors (BoD) work together to fulfil their differing roles. The joint working agreement also sets out how disagreements will be resolved. The Annual Report includes narrative statements as to how the BoD and CoG operate and the types of decisions taken. These are reviewed annually.
A.1.2	The Chairperson, Chief Executive, Senior Independent Director and the chairperson and members of the Nominations, Audit and Remuneration Committees are set out on pages 25-28.
A.5.3	Details of the Council of Governors are set out on page 40. Records of the number of meetings of the CoG and the attendance of individual Governors are maintained and published on the Annual Report. The record of attendance is also summarised on the ballot statement of Governors standing for re-election.
B.1.1	All Non-executive Directors (NEDs) are considered independent as stated in the Annual Report. None of the factors that might compromise independence apply to the NEDs, other than the maximum six-year term aspect. The Trust's Constitution allows for NEDs to be appointed for up to nine years. NEDs links with other organisations are set out in the Annual Report. The Council of Governors has taken the view that the independence of NEDs is the primary concern and that this is not necessarily correlated with years of service. For recent appointments, a second three-year term would normally be offered on the basis of satisfactory completion of objectives and then for the third three-year term there would be market testing (with the incumbent being able to apply), unless there were over-riding factors why this would not be appropriate.
B.1.4	Each Director's skills and experience are listed within the Annual Report and the Report can be downloaded from the Trust's website: www.nsft.nhs.uk
B.2.10	Brief summaries of the Terms of Reference (TOR) for the Nominations and Remuneration and Terms of Service Committees are included in the Annual Report along with the work of the committees. This is available via the Trust website. The full TORs are available on request.

B.3.1	TThe process set out in the Code of Governance was followed for the appointment of the Chair in 2013 and reappointment in 2016, and there is a declaration of interests at both the BoD and CoG. The Chairperson is not a chairperson of another NHS foundation trust.
B.5.c	The responsibilities of the Chair are fulfilled through the committee and subgroup structures. All Directors and Governors have an induction process which, in the case of Directors, includes a range of stakeholders. NEDs have specific localities / services that they are aligned to. Directors have access to training and development opportunities funded by the Trust, where appropriate.
B.5.6	TThe opinion of Trust Members and the public is overseen by the CoG Planning and Performance Subgroup. Governors also attend a wide variety of meetings with Members and the public and use these insights to inform the Trust's planning. This is stated further within the Annual Report on pages 38-39.
B.6.1	The performance of the Board, its subcommittees, Directors and the Chair is included within the Annual Report.
B.6.2	Foresight Partnership undertook the evaluation of the Board in 2014/15. NHSI carried out a limited scope well-led review in 2016. PwC carried out an external governance review in Q4 2017/18 – Q1 2018/19.
C.1.1	The Trust's Annual Report is prepared in line with national requirements and includes the external auditors' statement. The report is written in Plain English and sets out an honest and balanced picture of the strengths and weaknesses of the Trust, including the challenges it faces looking ahead. The Annual Report includes an explanation of the approach to quality within the Quality Account.
C.2.1	The effectiveness of the Trust's risk management and internal control systems is overseen by the Audit and Risk (A&R) Committee in the reports it scrutinises and in the work it commissions from Internal Audit on specific issues to test controls assurance. The report from A&R Committee that goes to the BoD also goes to the Governors' Planning and Performance Subgroup and there is often a NED member of the A&R Committee in attendance at this meeting.
C.2.2	The Trust has an Internal Audit function and its function is set out in the Annual Report.
C.3.5	No situation has arisen where the CoG have not accepted the Audit and Risk Committee's recommendation in relation to external auditors.
C.3.9	The work of the A&R Committee is contained within the Annual Report. This includes an explanation of how the A&R Committee has assessed the effectiveness of external audit and the approach to appointment of the auditor.
D.1.3	Where Directors are seconded to another organisation they have received no additional remuneration above their Trust salary.
E.1.4	The main method of communication between Governors and Members is through Insight magazine, and for members who have provided email addresses there is a monthly update which includes Governor activities. The Trust coordinates Member events on behalf of the Governors to facilitate face-to-face discussions. As well as a Members' telephone contact number there is an email inbox: governors@nsft.nhs.uk monitored by the Membership and Engagement Officer and Company Secretary to ensure that Members are able to contact Governors easily. This is made clear on the public website and in the Annual Report. Governors have access to a closed Facebook group for informal sharing of news, events and thoughts.

E.1.5 The Annual Report includes many references to the views of Governors but specifically states, 'The Council of Governors and Board of Directors have approved a joint agreement that sets out how Non-executive Directors work with Governors to understand the views of members. Non-executive Directors attend Council of Governor meetings and are paired with link-governors whom they meet informally. Non-executive Directors also frequently attend Governor subgroup meetings and, on occasion, carry out joint service visits with them. Directors often attend public-facing events in the community or organised by Governors and Trust officers'.

E.1.6 The Board of Directors receives an annual report on membership which includes a demographic profile comparing membership to the population of Norfolk and Suffolk. The membership demographics are also reported in the Annual Report on pages 58-59. The Trust's Membership and Engagement Officer leads on recruitment and works with the Member and Governor Subgroup to promote membership to under-represented groups.

NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place.

Segmentation

Under the Single Oversight Framework, which is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding', NHSI now segment providers based on the level of support each provider needs.

The Trust has an overall segmentation rating of 4. This means that, "the provider is in actual or suspected breach of its licence (or equivalent for NHS trusts) with very serious / complex issues that mean it is in special measures". As a result of being in special measures the Trust receives targeted support.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

The Trust was rated a '3' throughout 2017/18 relating to the 'Finance and uses of resources' metric'.

See table overleaf for details of the calculation. This segmentation information is the Trust's position as at 24 April 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

(SOF1)

		2017/18 Scores				2016/17 Scores	
Area	**Metric**	**Qtr 1 Score**	**Qtr 2 Score**	**Qtr 3 Score**	**Qtr 4 Score**	**Qtr 3 Score**	**Qtr 4 Score**
Financial stability	Capital service capacity	3	3	3	2	4	3
	Liquidity	4	4	4	4	4	4
Financial efficiency	I and E margin	4	4	4	3	4	4
Financial controls	Distance from financial plan	1	1	1	1	1	1
	Agency spend	1	1	1	1	2	2
Overall score		**3**	**3**	**3**	**3**	**3**	**3**

The table (SOF2) explains the segmentation process in more detail. The table has been extracted from the NHS Improvement document entitled Single Oversight Framework:

(SOF2)

				Score			
Area	**Weighting**	**Metric**	**Definition**	**1**	**2**	**3**	**4**
Financial stability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	<1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus / deficit in comparison to Year-to-date plan I&E surplus / deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

Additional reporting

Equality reporting

Equality Act (2010) requirements:

The general duties are:

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it
- Foster good relations between people who share a protected characteristic and people who do not share it

The specific duties are to:

- Publish information to show our compliance with the (general) Equality Duty, at least annually
- Set and publish equality objectives, at least every four years

The Trust complies with the Equality Act through the NHS Equality Delivery System (EDS). The main purpose of the EDS is to help local NHS organisations to meet obligations under the Equality Act (2010). It works by ensuring that all of the work of the Trust is benefitting all protected groups in different ways.

The Board of Directors receives four reports a year on the Trust's progress against its objectives. A full year report is published in April each year.

In 2017/18 the focus was on:

- Continuing to mainstream equality and diversity work in line with NHS EDS objectives with focus on staff engagement and service improvement
- Workforce Race Equality Standard (WRES) action plan
- Preparation for the introduction of the Workforce Disability Equality Standard (which came into force in April 2018)
- Improving services by developing person-centred care planning and cultural competency
- Reporting on progress with the three step plan is part of the Trust's monthly Performance Accountability Review Meetings.

The Trust hosted a successful conference on equality and diversity – Stories of Inclusion in January 2018.

The Trust's gender pay analysis was published in March 2018 and is available on the Trust's website: www.nsft.nhs.uk/About-us/Pages/Monitoring-Data.aspx

Quality report

Part 1: Statements

2017/18 Statements of Directors' Responsibilities in Respect of the Quality Report.

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2017 to May 2018
  - Papers relating to quality reported to the board over the period April 2017 to May 2018
  - Feedback from commissioners, dated 17 May 2018
  - Feedback from Governors, dated 20 April 2018
  - Feedback from local Healthwatch organisations, dated 2 May 2018
  - Feedback from Overview and Scrutiny Committee, dated 23 April 2018
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 26 October 2017
  - The national patient survey, dated 15 November 2017
  - The national staff survey, dated 6 March 2018
  - The Head of Internal Audit's annual opinion of the trust's control environment, dated 18 May 2018
  - CQC inspection report, dated 13 October 2017
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

By order of the Board

Gary Page
Chairman Date: 22 May 2018

Antek Lejk
Chief Executive Date: 22 May 2018

Independent auditor's report to the Council of Governors of Norfolk and Suffolk NHS Foundation Trust on the Quality Report.

We have been engaged by the Council of Governors of Norfolk and Suffolk NHS Foundation Trust to perform an independent assurance engagement in respect of Norfolk and Suffolk NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- early intervention in psychosis (EIP}: people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral
- inappropriate out-of-area placements for adult mental health services

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

Respective responsibilities of the directors and auditors

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

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18*.

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

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

- Board minutes and papers for the period April 2017 to May 2018
- papers relating to quality reported to the board over the period April 2017 to May 2018
- feedback from commissioners dated 17 May 2018
- feedback from governors dated 20 April 2018
- feedback from local Healthwatch organisations dated 2 May 2018
- feedback from Overview and Scrutiny Committee dated 23 April 2018
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 26 October 2017
- the national patient survey 15 November 2017
- the national staff survey 6 March 2018
- the Head of Internal Audit's annual opinion of the trust's control environment dated May 2018
- CQC inspection report dated 13 October 2017

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Norfolk and Suffolk NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Norfolk and Suffolk NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially

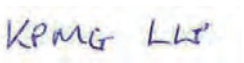
different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the nonmandated indicator, which was determined locally by Norfolk and Suffolk NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual ,and the six dimensions of data quality set out in the Guidance.



KPMG LLP
Chartered Accountants
Dragonfly House, 2 Guilders Way,
Norwich NR31UB
25 May 2018

Statement on quality from the Chief Executive, 2017/18

This has been a challenging 12 months for our Trust, and we recognise that the high quality standards in our services that we aspire to have not always been met, resulting in our being put back into special measures in autumn 2017.

In summary, the CQC report, and the subsequent Section 29A letter and its recommendations, highlighted the need to improve the safety of our services; to improve staff morale, staffing levels; patient and performance data; bed availability; and to improve leadership across our Trust.

We have been moving on from this setback and taking on board the advice and support we have been offered, focusing clearly on our quality improvement agenda.

Since the publication of the latest CQC report on our services, our Trust has increased the pace on its quality improvement work, with improving the safety of our services being a clear priority.

A large amount of work has already been done and some of the positive results of this are beginning to be seen.

Safe staffing levels and filling vacancies remains one of the most significant challenges to quality facing the organisation and is a top priority for NSFT. Sadly, due to these high levels of vacancies in some areas and the lack of available staff to recruit, our Trust has had to make the decision to temporarily close some of its beds in this year.

Plans are in place to action bringing these beds back into use as soon as it is safe and sustainable to do so, but these difficult decisions were made in the interest of patient and staff safety, upon which we will not compromise.

An extensive and intensive recruitment drive has been underway for some time, but where vacancies remain difficult to recruit to we are filling shifts to a safe level by using bank and agency staffing To do that we have to have well developed and well supported leaders and managers who are ready to listen and respond, as well as to lead.

As leaders we must take a positive approach to motivating our organisation to continue to get better; we must address the issues we encounter face on; encourage positive learning when things need to be improved; and we must ensure that we do not fall into a blame culture, but rather that we fully support our staff.

It is also vital that we draw attention to things that go right and thank our staff for their efforts, as an organisation which truly has quality improvement at its core and learns not only from its 'mistakes', but from its successes too.

We will be proud to celebrate and share our successes with our service users, carers and commissioners. We will continue to give full credit to our staff to motivate them to continue to deliver ever increasing levels of quality.

Once again, our staff were rated as 'Good' or 'Outstanding' in all services within the CQC's 'Caring' domain and on behalf of our Board, I would like to acknowledge their ongoing support and dedication.

Our Board will continue to keep quality as our central focus as we move into 2018/19. To that end we have developed and recruited to a new post of Head of Quality Improvement, responsible for embedding quality improvement across our Trust, while helping to map and share information on the quality initiatives already taking place.

Our Quality Improvement Plan and the Quality Priorities outlined below will provide us with the framework for our continued progress and ensure that we stay on track:

- Patient Safety / Physical Health
- Patient Experience / Service user and carer involvement
- Clinical effectiveness / Inpatient discharges

Some of the key quality improvements already underway and achievements we have made in 2017/18 include:

- Unexpected death numbers at NSFT have reduced from 184 in 2016/17 to 137 in 2017/18 – by around 25%. The Trust has introduced enhanced training for staff investigating serious incidents, and employed additional Investigation Improvement Managers to better support effective investigation and learnings
- £2.2 million has been invested into removing more than 1,000 ligature points across our Trust since 2016, and a further £1.2 million of improvement work began in January 2018 to further reduce any potential for self-harm in our inpatient and community buildings. Changes have also been made to make it easier to complete ligature risk assessments

so that we can further improve safety for service users

- Two Section 136 suites are currently being built and up-to-date seclusion rooms created to improve safe and secure environments for patients in crisis

- As around a third of the unexpected deaths tend to be due to physical (or natural causes / accidental death), NSFT is developing a Physical Health Strategy to deliver improved physical health outcomes for its patients, in collaboration with other healthcare providers

- Zero Suicide Ambition - NSFT officially joined the Zero Suicide Alliance (ZSA) which supports the ambition that one day we will live in a world where suicide does not exist

- An expansion of psychiatric liaison services based within A&E departments in Norfolk will be able to assist more people when they are in crisis, and refer them to our support

- An ambitious £4m rebuild project launched at in King's Lynn in March 2018 to create a new 16-bed inpatient mental health unit while also updating existing outpatient facilities, offering integrated services from one site

- Our Norfolk and Waveney Community Perinatal Mental Health Service launched in September 2017, providing specialist care to women with conditions such as severe postnatal depression, bipolar disorder and psychosis. A similar specialist service launched in Suffolk in February 2018

- NSFT is developing a £4m specialist inpatient unit for new mothers with serious mental health problems across the region. Kingfisher House, at Hellesdon Hospital, in Norwich is now being rebuilt to turn it into the eight-bed Mother and Baby Unit (MBU)

- The Trust's is currently running a £3.85 million redevelopment of all of its secure services. The first phase saw the opening of a redeveloped 16-bed ward in Norfolk in December. NSFT became the first NHS trust in the UK to introduce a blended service, bringing together low and medium secure beds for its female patients. £0.7m has been invested into extending low secure facilities for male secure patients at Foxhall House, in Ipswich, and five additional ensuite rooms have been opened there increasing beds from 11 to 16

- Service users in Norwich are now receiving community mental health services from more modern, easily accessible premises following a £0.6m refurbishment project. The work has seen a fully-functioning clinic room created as well as a large space for group therapy and training. Space has been allocated for patient consultations, while a new waiting room and reception area have been added.

- More people in east Suffolk are receiving a quick diagnosis and vital treatment for memory problems after the new-look Community Memory Assessment Service launched in November. The service will see up to 1,400 patients per year compared to around 1,200 previously, and aims to increase diagnosis rates so that patients can begin treatment more quickly while also benefiting from earlier access to post-diagnostic support

There is still much work to be done, and we must ensure that our day-to-day practices offer high quality, safe services which are the norm not the exception.

As we move into 2018/19 the safety and quality of our services remains our number one priority. We expect a further CQC inspection this autumn and we have a clear focus on demonstrating that NSFT has improving quality at its core.

We will to continue to listen to our service users, carers and staff and engage with all to continue to improve and raise the bar on quality to ensure we really are working together for better mental health.

Statement of Accuracy

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

Antek Lejk
Chief Executive Date: 22 May 2018

Part 2: Priorities for Improvement

Looking back at our quality priorities in 2017/18

The Quality Account published in 2017 identified three quality targets. This section demonstrates the progress that has been made in the past 12 months.

Patient safety / Reduce restrictive interventions

To ensure that 80% of inpatient service users with 'challenging behaviour' will have an individualised behaviour support plan informed by a recent holistic assessment.

Where we were:

In May 2017 the Trust appointed a lead for reducing restrictive interventions (RRI) as a ten month secondment to pull together the various strands of work already in progress in the Trust. The post holder has developed a strategy and implementation plan which includes providing information, support and guidance in developing Positive Behaviour Support Plans (PBSPs) across the Trust.

The strategy for reducing restrictive interventions; the *Promoting Positive Practice Strategy* was approved in February 2018.

Inpatient units have started to co-produce annual safety plans with their service users and will pilot and share various restraint reduction tools.

Support to launch Positive Behaviour Support Plans across the Trust, spreading the good practice already seen in secure and learning disability services is underway.

Considerable effort has been put into developing a data model to help us understand the impact of quality improvements including auditing Positive Behaviour Support Plans (PBSPs).

Where we are now:

The audit process for Positive Behaviour Support Plans (PBSP) has been amended after it was identified that the existing format contained a bias towards people being secluded for the first time. A random sample of cases is now taken from a population of all incidents of restraint, seclusion, rapid tranquilisation and long-term segregation. Each month a sample of at least 30 (selected from total number of cases) cases are audited to see whether a Positive Behaviour Support Plan was in place within seven days after the incident.

Some areas of the Trust were already using Positive Behaviour Support Plans but evidence of the use of any standard format was often difficult to locate. Training, audit feedback and electronic recording systems have been implemented to support teams that did not already have a system in place and this was piloted on a Psychiatric Intensive Care Unit (PICU) during December 2017 before rolling out to the rest of the Trust during January 2018.

Audit findings in March 2018 indicated that of the 50 incidents in which there was a restraint, seclusion or rapid tranquilisation given, 40 of the incidents involved a person who had a PBSP at the time of the incident or within seven days after. The compliance was, therefore, 80%. Monthly compliance reports will be completed during 2018/19 to ensure that improvements are sustained.

The Trust are currently recruiting to a substantive RRI Lead post to support the implementation of the *Promoting Positive Practice Strategy.*

Patient experience / Improve service user experience

To ensure that at least 50% of detained patients will report that they were offered information about Independent Mental Health Advocates (IMHAs).

Where we were:

The CQC report *Monitoring the Mental Health Act 2015/16* (2016) stated that little or no improvement had been found in relation to some issues that directly affect patients, including evidence that people had been informed of their right to an Independent Mental Health Advocate (IMHA). '*Advocates are an important safeguard, offering support to patients and enabling them to be involved in decisions about their care*'.

The Mental Health Act Administrators (MHAA) across the Trust report compliance with completion of MHA documents every two months. Specific criteria regarding providing information to patients was added to the

monitoring process early in 2018 in addition to the existing data collected, which was limited as to whether a patient has accessed advocacy services. No baseline data is, therefore, available prior to January 2018 but will be monitored from this date, collecting data regarding the provision of information in addition to whether the person has accessed advocacy services.

Where we are now:

A Rights and Advocacy poster has been produced and circulated to Trust-wide inpatient units which gives details of individual's rights as an informal or detained patient. It also contains contact details of advocacy services used in both counties across the Trust.

Information about advocacy services is available on wards and advocates regularly visit most inpatient services.

A meeting was held in January 2018 with the Trust's Suffolk services, Suffolk User Forum (SUF), and VoiceAbility to explore ways of increasing the profile of advocacy services further.

SUF has data to show that their informal advocacy lead has had over 400 patient contacts in nine months across the two Suffolk inpatient sites (that is excluding formal IMHA referrals). As the Trust already has an established network of Equality Leads, and as there is a clear overlap between human rights, advocacy and equality, the leads for VoiceAbility and POhWER (charities that provide information, advocacy and advice services) will be attending the Equality Leads meeting in January 2018. These meetings will provide an opportunity to explain more about the role of advocates and enlisting Equality Leads' help in ensuring that people who would benefit from advocacy services are identified and referred.

Data collected by the MHAA Team for February and March 2018 demonstrated that for 105 out of 196 newly admitted patients it was recorded that information was offered about IMHAs = 53.57%.

This data will continue to be reported to and monitored by the Mental Health Law Forum (MHLF).

Clinical effectiveness / Improve service user experience

Data reported monthly will demonstrate 95% compliance with core assessments, risk assessments and care plans.

Where we were:

The Care Programme Approach (CPA) is the framework that mental health services work within to ensure ongoing partnership working with service users and their carers / supporters. The application of CPA makes sure care and support is well organised, meets identified needs and stays up-to-date.

CPA requires that everyone involved communicates with the service user and with each other. All people with complex needs, who need support from a number of services, or who are at most risk, are entitled to CPA. Other service users, with more straightforward support needs, will still receive care from secondary mental health services, but the term non-CPA will be used. All service users with the exception of those accessing specific assessment services require a core assessment, risk assessment and care plan. The 2017 CQC inspection report indicated that in some services these core documents were not in place or had not been updated following multidisciplinary reviews and incidents.

Throughout the year several work streams have focused upon different aspects to improve skills, knowledge, and reporting methods within the Trust. These have included a revision of the Trust policy C98 Care Programme Approach (CPA) and Non-CPA, a CPA Task and Finish Group, allocating protected time for clinical staff, additional administrative support for Clinical Team Leaders, the development of a series of intranet resources to support staff and fortnightly reporting of compliance data.

Where we are now:

Data produced and distributed Trust-wide on 23 March 2018 indicated the following compliance:

- Core assessments in place: 73.55%
- Risk assessments in place: 83.87%
- Care plans in place: 92.75%

This data is extracted from the electronic patient record system fortnightly and is shared across the Trust for services to monitor their compliance. Data is obtained using a number of assumptions and is not reflective of quality.

Quality of the documentation is measured using the Trust-wide Quality of CPA audit which is carried out bi-annually. Results from Quarter 4 2017/18 are as follows:

- Core Assessment: 84%
- Risk Assessment: 88%
- Care / Crisis Planning: 84%

Documentation is also monitored through line management supervision and monthly Quality Checklists.

We have continued to monitor the following quality priorities identified in 2016/17 where the target was not met during the year.

Clinical effectiveness / Recording capacity

To ensure that 95% of service users have their capacity to consent to treatment on admission, recorded in the electronic record.

Where we were:

This issue has been raised by the Care Quality Commission (CQC) in their recent reports and a Trustwide plan was put in place. This included a Trust policy review, clear guidance and additional training / awareness sessions to ensure that adherence to the Mental Capacity Act (MCA) evidenced through documentation is being followed.

Where we are now:

Findings from an audit of capacity to consent to treatment published in September 2017 indicated a compliancy rating of 50% for clear documentation of capacity. This priority has been monitored throughout the year and improvements supported using local audit, Peer Reviews and central auditing.

Audit findings from end of March 2018 indicated that for the 56 newly admitted patient records analysed, 84% were compliant in documenting capacity to consent to admission and treatment.

Recording capacity to consent will continue to be monitored through Trust-wide audit as identified on the central audit schedule for 2018/19 and will be reported and monitored at the Quality Governance Committee and Mental Health Law Forum.

Clinical effectiveness / Section 17 leave

To ensure that Section 17 leave is managed in accordance with the Code of Practice, monitored by Mental Health Act (MHA) administration team.

Where we were:

Inspections of Mental Health Act (MHA) compliance by the CQC frequently identify that Section 17 leave forms and associated paperwork are not completed in accordance with the MHA 1983 Code of Practice. This failure may increase the level of risk for the service user if staff are not able to monitor the leave. The following compliance targets were not reached for 2016/17 and continue to be monitored weekly using the Trust Detained Patient Weekly Checklist and are reported every two months into the Trust Mental Health Law Forum.

- 95% of service users granted leave have a specific risk assessment carried out. In March 2017 the compliance was 80% as reported in our last Quality Account
- 95% of service users granted leave will be given a copy of the forms or it is documented that they refused a copy. March 2017= 77%
- 95% of carers will be offered a copy of the forms or it is documented that the service user has denied permission.
  March 2017 = 49%

Where we are now:

Re-audit in November and December 2017 indicated that;

- 97% of patients granted Section 17 leave had a specific risk assessment carried out

The MHA Administration Team reported the following compliance for January and February 2018:

- 68% of service users were given a copy of the forms or it is documented that they refused a copy
- 56% of carers were given a copy of the forms or it is documented that the service user has denied permission

Clinical teams have reflected upon the reasons for poor compliance, particularly with regards to giving copies of the forms to carers. In many cases the leave may be granted for short periods and with escorts without the opportunity to share documents with carers, some of whom live distances away from the ward. Teams are,

therefore, prioritising communication with carers about longer, unescorted periods of leave.

The Trust has agreed that administrative support will be provided for ward managers and 95% of these posts have been filled. Their duties will include checking compliance with MHA 1983 Code of Practice requirements and it is expected that compliance will improve as a result of this. Training is planned for 2018/19 to support this activity and will be provided by Matrons and MHA Administration Team members.

Compliance with the MHA 1983 Code of Practice and feedback on the impact of ward-based administration staff will be monitored by the Mental Health Law Forum.

Looking forward to our quality priorities in 2018/19

This is the section of the Trust's Quality Account that looks forward to 2018/19 and identifies our goals for improvement. The rationale for why these goals have been chosen and how progress will be monitored is described.

Our Trust has agreed a number of priorities which support our CQC Improvement Plan in response to the CQC inspection in 2017 and the following priorities were agreed by the Board of Directors for 2018/19. These quality are also reflected in the results of the national service user survey, local and national clinical audits and local feedback, including complaints and serious incident investigations.

Each of these priorities will be led by an Executive Director and progress will be reported to our full Board of Directors (BoD) four times a year.

Patient safety / Physical health

Physical health monitoring following rapid tranquillisation

Aim:

Audit will demonstrate that at least 95% of a sample of patients will have had their physiological observations taken post rapid tranquillisation complying with National Institute for Health and Care Excellence (NICE) guidance.

Background:

Drugs used for rapid tranquillisation carry risks of excessive sedation and loss of consciousness, loss of airway, and respiratory and cardiovascular collapse.

In accordance with National Institute for Health and Care Excellence (NICE) guidance; *NG10: Violence and Aggression: short term management in mental health, health and community settings* (2015) and as Trust policy C111: *Rapid Tranquillisation* stipulates, all patients who have received rapid tranquillisation will have their physiological observations recorded on the Early Warning System (EWS) Record Chart. Observations will be taken for a minimum of hourly for the first four hours post rapid tranquilisation to monitor the individual's physical health status. In situations where it is not possible to perform physiological observations, non-touch observations (alertness and respiration

rates) are required to be recorded on the EWS Record Chart.

This priority has been chosen after having been identified in the 2017 CQC Inspection Report as a concern.

Recognising our commitment to reducing restrictive interventions, it is expected that incidents involving rapid tranquilisation will decrease: however, robust monitoring of all incidents will continue.

Audit will examine all incidents of rapid tranquilisation during six week periods and findings will be reported quarterly during 2018/19.

Lead: Medical Director

Patient experience / Service user and carer involvement

Values Based Recruitment

Aim:

To monitor service user and carer involvement in interview panels and to report the percentage of interviews involving a service user or carer in 2018. The aim is to increase the percentage by at least 20% per year towards achieving a 90% target of service users or carers involved with recruitment to all posts that involve contact with service users.

Data will report that at least 20 service users and carers have participated in Values Based Recruitment training during 2018/19 and that at least four sessions were available for people to book onto.

Background:

The Trust's Recruitment and Selection Policy states *"14.6 Selection processes should involve a minimum of two staff and a service user or carer representative"*.

Currently, low numbers of service users and carers have been trained in Value Based Recruitment and are able to be included on interview panels. The Trust will, therefore, establish a roiling programme of interview training to ensure that training is provided to achieve the target of 90% service user and carer involvement over the next three years.

Lead: Director of Nursing

Clinical effectiveness / Inpatient discharges

Aim:

To achieve a 10% reduction in service users requiring readmission for clinical reasons within 28 days.

Background:

Reference to two key initiatives will support the Trust in developing an approach to this priority.

1. The King's Fund ***Quality Improvement in mental health*** (2017) document included an example of a key quality improvement initiative at Tees, Esk and Wear Valleys NHS Foundation Trust of the Purposeful Inpatient Admissions model, which was also described in the report of the ***Commission on Acute Adult Psychiatric Care*** (Crisp ***et al*** 2016). The key characteristics of the model were:

- Making service users' experience of care a core driver of change
- Replacing 'batched' decision-making processes (such as weekly ward rounds) with a more continuous flow (minimising service users' waiting times)
- Agreeing standardised processes for each step of the patient pathway
- Monitoring and measuring change

2. 'Red and Green Bed Days' are a visual management system to assist in the identification of wasted time in a patient's journey (NHS Improvement (NHSI) 2016). It is applicable to inpatient wards and the approach is used to reduce internal and external delays as part of the SAFER patient flow bundle (a practical tool to reduce delays for patients in inpatient wards). The approach requires teams to discuss for every patient whether the day ahead is 'red' (a day where there is little or no value adding care) or 'green' (a day of value for the patient's progress towards discharge). If 'red', action needs to be agreed by the team to create a 'green' day instead.

The Trust has appointed a Flexible Pathways Project Lead who will take up their post during March 2018 and will coordinate the number of strands involved to achieve this target.

The number of readmissions has been calculated over time and up until March 2018 a baseline number of 13 emergency readmissions within 28 days has been calculated.

Lead: Operations Directors

Statements of Assurance from the Board

The wording in the following statements is required in the Department of Health (DH) regulations for producing Quality Accounts. The statements are required nationally to enable the public to compare the performance of individual trusts and are therefore common across all Quality Accounts.

We have tried to provide some explanation of the terms used in the key, but if you would like any further explanation, please contact the Patient Advice and Liaison Service (PALS) on: Freephone 0800 279 7257.

1. Review of services

During 2017/18 the Trust provided and / or subcontracted eight NHS services: adult services, children's services, drug and alcohol services, improving access to psychological therapies (IAPT), learning disability services and older people's services. The Trust also provides forensic and Tier 4 Child and Adolescent Mental Health Services (CAMHS) commissioned by NHS England rather than local Clinical Commissioning Groups (CCGs). The Trust has reviewed all the data available on the quality of care in all eight of these services.

The income generated by the relevant health services reviewed in 2017/18 represents 95.3% of the total income generated from the provision of relevant health services by the Trust for 2017/18.

The quality of care the Trust has provided has been reviewed in a number of ways. This is via the collection of systematic performance data against NHSI, CQC and CCG quality targets as well as clinical audits, surveys, analysis of complaints and serious incident data, and informal feedback from service users and carers.

(QA1) Quality of care review methods

Data type	Lead	Reported to	Action
Clinical Audit	Audit Lead	Quality Governance Committee/ Accountability Review Meetings	Action plans developed and implemented by clinical team and / or audit sponsor as appropriate. This is then monitored by the audit department and a re-audit undertaken, as indicated, to demonstrate that the plan has improved the service. Locality governance dashboards incorporating audit compliance and audit results databases are updated monthly and shared with localities to enable them to compare their performance with other areas and to see, at a glance, where further action is required.
Complaints	Complaints Manager	Quality Governance Committee / Accountability Review Meetings	Action plan developed and implemented by relevant manager. Where there is learning for other areas, the action plan is shared through a variety of mechanisms including access to the plan and the production of themes that are shared with all areas, policy amendments and adjustments to training packages.
Feedback from visits	Executive and Non-executive Directors	Matrons and Ward Managers	Feedback shared with clinical teams and managers leading to development of an action plan to resolve any issues that arise.
Peer reviews	Head of Governance	Quality Governance Committee Matrons and manager	Peer reviews led by governance team to check compliance with fundamental standards are reported back to the teams and used to confirm the progress against Trust CQC Improvement Plan.

The Trust's quality monitoring systems ensures that data is reported, and that action plans for improvement are put in place where needed. Information is cascaded to all levels of the organisation via locality leadership and management supervision.

2. Participation in National Quality Improvement Programmes

During 2017/18, three national clinical audits and two national confidential enquiries* covered relevant health services that the Trust provided (in terms of collecting patient level data).

During that period, the Trust participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

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

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2017/18 were:

National clinical audits

1. The four national Prescribing Observatory for Mental Health – UK (POMH-UK): prescribing topics in mental health services were:

- Topic 1 and Topic 3 – Prescribing high-dose and combined antipsychotics on adult psychiatric wards
- Topic 15 – Prescribing valproate for bipolar disorder
- Topic 16 – Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour
- Topic 17 – Use of depot / long-acting injectable antipsychotic medication for relapse prevention

(The national Prescribing Observatory for Mental Health (POMH-UK) aims to help specialist mental health trusts / healthcare organisations improve their prescribing practice. POMH-UK, with its member organisations, identifies specific topics within mental health prescribing and develops audit-based Quality Improvement Programmes (QIPs). Organisations are able to benchmark their performance against one another and identify where their prescribing practice meets nationally agreed standards and where it falls short. Wide participation in QIPs creates a picture of prescribing practice nationally.)

2. National Clinical Audit of Psychosis

The National Clinical Audit of Psychosis (NCAP) is a three-year improvement programme which aims to increase the quality of care being provided to people with psychosis by NHS funded Mental Health Trusts in England and Health Boards in Wales. Commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England, the NCAP is the next phase in the development of the National Audit of Schizophrenia. The scope of the core audit included both inpatient and community care provided for people with a broader group of severe mental health problems. The audit focused on practice recorded within clinical notes.

3. The Early Intervention in Psychosis (EIP) Network

EIP Teams in England completed self-assessment between October 2017 and January 2018. This included data about expectations laid out in the *Implementing the Early Intervention in Psychosis Access and Waiting Time Standard:* Guidance document. This is the second round of data collection, the first took place in 2016/17.

National Enquiries

1. The mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide and Sudden Unexplained Death, by People with Mental Illness (NCISH)

2. National Confidential Enquiry into Patient Outcome and Death – Young People's Mental Health Study (NCEPOD)

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2017/18, are listed below, alongside the number of cases submitted to each audit or enquiry. POMH-UK national guidance does not specify the number of registered cases required within the terms of each audit.

(QA2) National clinical audits and inquiries

Name	Completed and status	Number of cases
National Clinical Audits		
Topic 1 and Topic 3 – Prescribing high-dose and combined antipsychotics on adult psychiatric wards	Report published in September 2017	NSFT sample 99
Topic 15 – Prescribing valproate for bipolar disorder	Data collection September 2017	NSFT Sample 57
Topic 16 – Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour	Result disseminated by POMH-UK in June 2017	NSFT sample 60
Topic 17 – Use of depot / long-acting injectable antipsychotic medication for relapse prevention	Result disseminated by POMH-UK in Dec 2017	NSFT sample 19
National Clinical Audit of Psychosis	Data submitted Nov 2017	NSFT sample 76
Early Intervention in Psychosis Network	Data Submitted Jan 2018	NSFT Sample Contextual Questionnaire = 3 Case Note Audit = 216
National Confidential Enquiries		
1) The mental health clinical outcome review programme: National Confidential Inquiry into Suicide, Homicide and Unexplained Death, by People with Mental Illness (NCISH)	Continuous audit	Total cases identified for the NCISH = 12
2) National Confidential Enquiry into Patient Outcome and Death – Young People's Mental Health Study (NCEPOD Young People's Mental Health)	Data submitted Aug – Oct 2017	NSFT sample Cases included = 9 Clinical Questionnaires returned = 8 Case Notes returned = 3 Organisation Questionnaires requested = 2 Organisation Questionnaires returned = 2

The reports of four national clinical audits carried out by the Trust were reviewed in 2017/18 and the Trust intends to take the following actions or has taken action to improve the quality of healthcare provided:

Actions following audit

(QA3) Actions following audit

POMH- UK: prescribing topics in mental health services (2017-18)	
Audits reported in 2017	**Actions in progress**
Topic 1g and 3d: Prescribing high dose and combined antipsychotics on adult psychiatric wards. (Feb – Mar 2017)	One page summary report prepared and disseminated to pharmacists, lead clinicians, participants in the audits, Medical Advisory Committee (MAC). Education and training at junior doctor's induction, consultants and Senior Associate Specialist doctor's mandatory training. Showed significant improvement compared to 2015. Discussed at Drugs and Therapeutics and Clinical Cabinet.
Topic 17a: The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention (May – Jun 2017)	One page summary report prepared. On agenda for discussion at Drugs and Therapeutics Committee in Mar 2018. Planned dissemination to participants, lead clinicians, pharmacists, members of Drugs and Therapeutics Committee.
Topic 15b: Prescribing valproate for bipolar disorder (Sept – Oct 2017)	Results yet to be published.
Topic 7 Monitoring of patient prescribed lithium. (February 2017)	Reported to Clinical Cabinet April 2017 (sample size = 63).

3. Trust clinical audit programme

The reports of 72 local clinical audits were reviewed by the provider in 2017/18 and the Trust intends to take the following actions to improve the quality of healthcare provided in relation to the five audit topics selected:

(QA4) Actions following Audit

Audit Title	Actions Taken
Health records audit	The Lorenzo Electronic Patient Record system was introduced to the Trust in May 2015. This audit focused on standards within the Trust's Health Records Policy and quality issues identified by the Systems and Business Change Manager. Following the 2016/17 Health Records Audit, staff were reminded to manually record the event date and time within all continuation notes; and compliance on these has improved by 8% for recording date and 11% for recording time. This issue is particularly important for determining whether records are contemporaneous or retrospective. All areas that failed to reach 95% compliancy in previous audits were required to take action to ensure that there was a signed Data Protection Act (DPA) form for all patients (scanned to Lorenzo). Compliancy has since improved from 32% in 2015/16 to 74% in 2017/18. Furthermore, compliance is now 100% for having the scanned DPA form signed by the patient or alternative.
Quality of referrals from primary care to the Norfolk Single Point of Access (SPoA) team (DCLL = Dementia and Complexity in Later Life)	This audit was a collaboration between Governance staff, nursing staff from the SPoA team, Clinical Team Leaders from Adult and Dementia and Complexity in Later Life (DCLL) community teams and a GP commissioner. The main objective was to reduce the number of referrals to the SPoA (safeguarding resources to meet clinical need requiring specialist mental health services). The audit involved the evaluation of 110 urgent referrals (120 hours) including both Adult / Youth and DCLL referrals, by the multi-disciplinary audit group. The audit found that the quality of referrals is a key issue in achieving the objective and has resulted in the development of an action plan, including the following themes: • Improving quality of referrals thereby reducing the time spent on history taking and time on call-backs • Evaluating the appropriateness of referrals from nursing / care homes • Evaluating risks and the related issues around referral rejection until risks are fully communicated • Investigating systems access issues • Actions and further evaluations to be determined by locality and service managers
Risk assessment for detained patients taking Section 17 Leave	The third round of the audit cycle was published in February 2018 and reported compliance of 97% for having a specific risk assessment for current Section 17 leave. This follows the February 2017 and March 2017 audit cycles which reported 80% and 73% compliancy, respectively. This was a quality priority for 2016/17 and was audited by ward-based staff completing the Detained Patient Weekly Checklist to which this additional item was added. By involving ward staff in the weekly audit of this aspect of care, the 95% standard has been exceeded. There has been a combined effort by the Mental Health Act team, matrons, ward Staff and the Clinical Audit team to ensure that this topic was audited on a weekly basis, advising staff when participation was not sufficient; all of which has resulted in the improvement in recorded practice.

The Quality of CPA and non-CPA documentation	In 2017/18 all clinical areas have been involved in a Trust-wide audit of the quality of CPA and non-CPA. Crucially, the audit requires the clinical staff involved in delivering the patient care to evaluate the quality of the completed documentation; providing an instant analysis of compliance and prompting for action planning, where needed. In 2016, 491 patient records were audited but in 2017 this has risen to 719 patient records; as the importance of this audit work is promoted across the Trust. Compliancy across all aspects of the audit (initial assessment, care planning, risk assessment etc.), increased from 78% in November 2016 to 83% in October 2017. Actions taken to achieve this improvement in compliancy included discussions during staff supervision and identifying training needs for completion of the CPA documentation and record keeping.
Medical staff audits	Medical staff have completed many audits throughout the year and participated in Trust-wide audits. Each report is distributed throughout the Trust and is accessible from the Trust intranet. Topics have included: • Compliance with Mental Health Act and Mental Capacity Act legislation • Recording medicines information in the health records • Bipolar disorder and teratogenic side effects • Medical seclusion reviews • Measuring compliance with Trust guidelines and NICE standards on the use of hypnotic medication • Quality and content of follow-up letters to GPs • Physical health - wellbeing and monitoring for community patients • Is prescribing of non-steroidal anti-inflammatory medication (NSAIDs), for all secure services in-patients within NSFT, safe and in-keeping with British National Formulary (BNF) guidance? • Re-audit - Measuring compliance with NICE standards in relation to the monitoring of obesity in a medium secure setting • Each audit has resulted in relevant actions for improvement

National Confidential Inquiry

The Trust participates in the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, with excellent compliance scores. Should the Trust have a serious incident resulting in a child's death or near miss, this would be referred to the Norfolk and Suffolk Safeguarding Children's Boards for consideration under the Serious Case Review (SCR) guidance as outlined in Working Together to Safeguarding Children 2015, and be reported in the three-year national report. For the period being looked at, there have been two SCRs involving children known to the Trust in Norfolk and Suffolk. As a member of the Norfolk and Suffolk Safeguarding Child and Adult Boards, the Trust will take account of all recommendations arising from SCRs and Safeguarding Adult Reviews (SARs), regardless of whether or not Trust services were involved. There has been one SAR completed in 2017 concerning a Norfolk service user known to the Trust.

4. Clinical research

1050 people receiving NHS services provided, or sub-contracted by, the Trust from April 2017 to March 2018 were recruited during that period to participate in national research approved by the Health Research Authority. This is the highest number of people recruited into Trust research since the creation of the Clinical Research Networks, and is an increase of 37% on last year's performance.

Research delivery

100% of studies received Confirmation of Capacity and Capability in the Trust within the 40 day target period. 100% of eligible studies also recruited their first participant within 30 days, compared to a target of 80%.

Over 10% of research participants took part in the Patient Experience Survey, and 98% of respondents Strongly Agreed or Agreed that they had a good experience taking part in research, and would recommend it to others.

10% of active research studies were audited by the Research Audit team. All studies showed a good level of management and oversight, and no critical research conduct findings related to patient safety or scientific integrity.

In 2017, Research and Development Department also underwent an Internal Audit, where the department was confirmed to provide 'Significant' assurance of oversight and processes related to research and research finances (Green rated), with only minor recommendations made.

Research development

All streams of the Research Development team have made significant progress in 2017/18. The Trust has been awarded major research grants, due to start in 2018, in the area of child and youth mental health services, mental health pharmacy and older people's services in collaboration with University of East Anglia and University of Cambridge. The Trust is also leading on the development of a large international research programme seeking to improve the experience of diagnosis for mental health conditions with Columbia University (NY) and Institute of Medical Science (Delhi), in consultation with the World Health Organisation.

Trust staff members have also authored over 50 research journal publications in 2017/18, including a significant increase in publications arising from research that the Trust has led on developing and conducting. This includes research where the Trust is a collaborating organisation on research with University of Cambridge, University of East Anglia, University of Sussex, and University of Kent.

There continues to be a high number of Trust staff undertaking research-based postgraduate and career development studies supported by our partner organisations.

5. Commissioning and Quality Innovation Goals (CQUIN) agreed with commissioners

A proportion of Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12-month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19

The Trust has a contract with Central Norfolk* CCG, West Norfolk CCG, Ipswich and East Suffolk CCG, West Suffolk CCG, Great Yarmouth and Waveney CCG and Cambridge and Peterborough CCG for the provision of mental

health services to the population of Norfolk and Suffolk, and with NHS England (specialist) Commissioning Group for the provision of Low and Medium Secure Services and Tier 4 Child and Adolescent Mental Health Service (CAMHS).

The Trust also has a contract with Ipswich and East Suffolk CCG, West Suffolk CCG, Central Norfolk*, West Norfolk and with Great Yarmouth and Waveney CCGs for the provision of Wellbeing services.

Central Norfolk, West Norfolk and Great Yarmouth and Waveney have eight national CQUINs which focus on NHS staff health and wellbeing, improving physical healthcare to reduce premature mortality in people with severe mental illness, improving services for people with mental health needs who present to Accident and Emergency Departments and improving transitions out of children and young people's mental health services. These account for 1.5% of the total contract value.

For the Norfolk Wellbeing services, two CQUINs applied. These account for 1.5% of the contract value and support increased service user access and engagement and the improvement of staff health and wellbeing and integration with acute hospital services.

Two further initiatives were applied to the Norfolk and Waveney, and the Norfolk Wellbeing contracts: the Risk Reserve, available to providers that delivered an agreed 2016/17 control total, and the Sustainability and Transformation Plan (STP). The STP CQUIN scheme has shifted focus from the local CQUIN indicators, seen in previous years, to prioritising STP engagement and delivery of financial balance across local health economies by encouraging providers and commissioners to work together to achieve financial balance, and to complement the introduction of system control totals at STP level. These initiatives account for the remaining 1% of the total contract values.

A total of three goals to improve quality were agreed for Secure Services and Tier 4 CAMHS services as commissioned by NHS England. Two goals applied to Secure Services and one to CAMHS. These were both nationally predefined schemes continuing from 2016/17.

In 2017-19 all CQUIN goals were pre-defined national priorities and covered the three domains of quality: patient experience, patient safety, and clinical effectiveness.

A commissioning decision between Suffolk CCGs and the Trusts Director of Finance resulted in no CQUINs being identified within the NHS Standard Contract between the Trust and Suffolk CCGs for this reporting period.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically on request from the Contracts Department.

The value of the CQUIN schemes represents 2.5% of the total contract value and approximately 80% compliance is estimated to be achieved in Norfolk and Waveney.

The income received, which was conditional upon achieving quality improvement and innovation goals in the main contracts 2017/18, is forecast to be £2,440,477. This compares with the income received in 2016/17 which was £2,615,669.

* Comprising South Norfolk, North Norfolk and City Clinical Commissioning Groups.

(QA5) CQUIN Schemes implemented across the Trust in 2017/18

Norfolk and Waveney Block Contract			
	Central Norfolk* CCGs	**West Norfolk CCG**	**Great Yarmouth and Waveney CCG**
Introduction of Health and Wellbeing Initiatives	✓	✓	✓
Healthy food for NHS staff, visitors and patients	✓	✓	✓
Improving the uptake of flu vaccinations for front line staff	✓	✓	✓
Cardio Metabolic Assessment and Treatment for Patients with Psychoses	✓	✓	✓
Collaboration with Primary Care Clinicians	✓	✓	✓
Improving Services for people with mental health needs who present to A&E	✓	✓	✓
Transitions out of Children and Young People's Mental Health Services	✓	✓	✓
Preventing Ill Health by Risky Behaviours – alcohol and tobacco	✓	✓	✓

Norfolk Wellbeing (Improving Access to Psychological Therapies-IAPT) Contract			
	Central Norfolk* CCGs	**West Norfolk CCG**	**Great Yarmouth and Waveney CCG**
Increasing Service User Access and Engagement	✓	✓	✓
Improvement of Staff Health and Wellbeing	✓	✓	✓

(QA6) NHS England (Specialist) Commissioning 2016/17 CQUIN

Secure Services CQUIN Schemes	**CAMHS Tier IV Services CQUIN Schemes**
Recovery Colleges for Medium and Low Secure Patients	CAMHS Inpatient Transitions to Adult Care
Reducing Restrictive Practices within Adult Low and Medium Secure Services	

* Comprising South Norfolk, North Norfolk and City Clinical Commissioning Groups.

6. Statements from the Care Quality Commission (CQC)

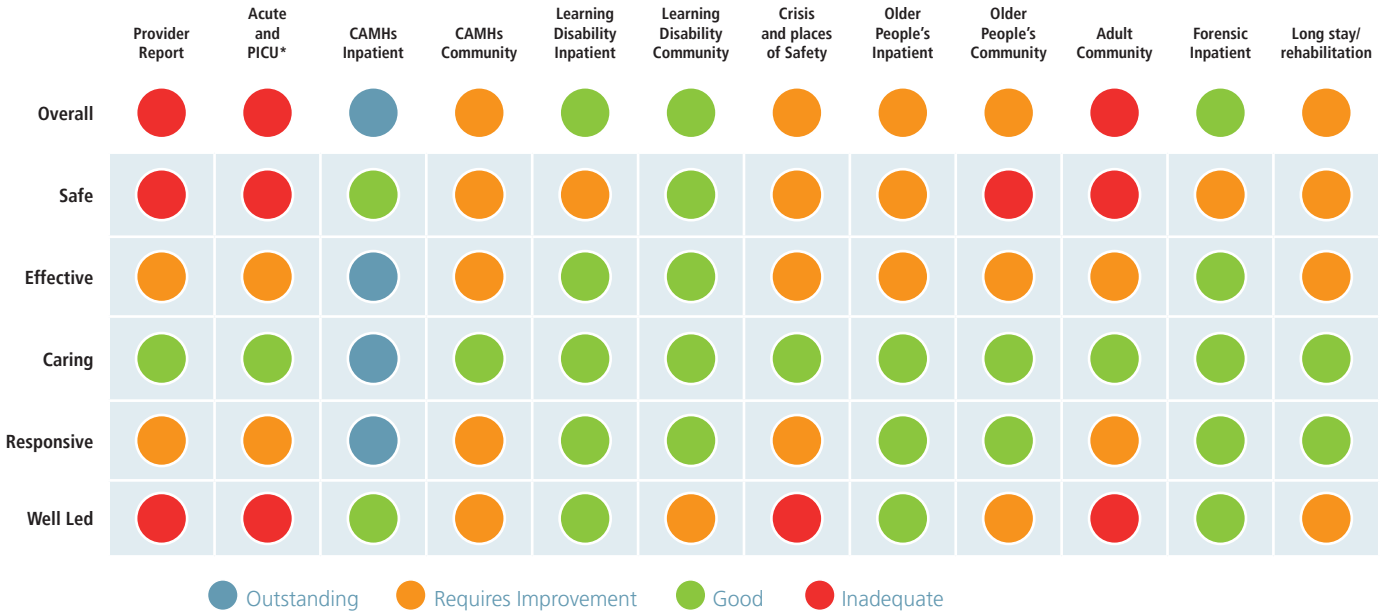
The Trust is required to register with the Care Quality Commission (CQC). Its current registration status is 'registered to provide assessment or medical treatment for persons detained under the Mental Health Act 1983 and 'treatment of disease, disorder or injury'.

Following an inspection in July 2017 the CQC took enforcement action against NSFT and in October 2017 the Trust was rated 'inadequate' and placed into special measures. The CQC issued a section 29A letter (Health and Social Care Act 2008) requiring the Trust to make improvements by 11 March 2018.

The Trust responded to the CQC within the required timeframe setting out the improvements already made and those that will be completed in the near future. Some areas of concern included national issues, such as, staffing and the Trust response to the section 29A letter sets out mitigating actions for all areas that cannot be resolved.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period. All of the CQC reports are available at: www.cqc.org.uk

(QA7) Table showing the ratings received by the Trust in 2017



*PICU = Psychiatric Intensive Care Units **CAMHS = Child and Adolescent Mental health Services

The Trust is disappointed by the rating and has implemented a robust system of improvement and monitoring. Service line leads have been appointed to lead on the action plans which are Trust-wide, ensuring consistency and continued progress. Plans are monitored weekly at Quality Performance Board and support for the process is provided by the Project Management Office (PMO).

The Trust is also supported by an Improvement Director and an Interim Chief Operating Officer / Deputy Chief Executive.

A recent review by NHS Improvement (NHSI) found that some improvements had been made, for example, awareness of management of and removal of fixed ligature points in inpatient settings: and provision of emergency and lifesaving equipment in both inpatient and community settings but that there was still work to do.

This work is ongoing and includes both short-term and longer-term objectives.

CQC Mental Health Act monitoring visits

During 2017/18, the CQC undertook 16 visits to the Trust to check compliance with the Mental Health Act for people detained within inpatient services. A number of themes have been identified and these are being monitored through the production of a 'heat map' which shows areas of non-compliance and also Trust-wide clinical audits through review of care against standards.

Key themes identified for continued improvement include:

- Patient / carer involvement in care planning
- Section 132 rights
- Documentation of discussion with patients regarding consent to treatment / medication
- The requirements for the recording, monitoring and reviewing episodes of seclusion and segregation
- Assessing for leave and recording outcomes of leave
- Copies of Section 17 leave forms being given to patients and carers
- Information regarding the right to access and referral to an IMHA

7. Duty of Candour

The Trust continues to apply the Duty of Candour in accordance with statutory and contractual direction. Promoting a greater openness and candour when safety incidents occur, the Trust applies a number of actions including notifying an individual or their representative when an incident of moderate harm or above occurs. There follows a discussion of the incident with an apology for its occurrence. Where identified, further investigation is undertaken with the intention to maximise learning which is then confirmed with the individual or their representative. These actions are confirmed in writing.

During this year the Trust applied the Duty on 182 occasions.

Part 3: Review of quality performance

Quality indicators

Data quality

The Trust will be taking the following actions to improve data quality. Excellent data quality is essential to the delivery of excellent quality care. The Trust will continue to ensure data quality improvements are made to support services through provision of easily accessible performance reporting through Abacus, the Trust's business intelligence reporting system, overseen by the Data Quality Group.

This system provides daily updates which are accessed by business support staff. Any data quality issues can be passed to the appropriate staff member for correction. A monthly data quality meeting is held and attended by a wide range of staff to discuss data quality issues, new updates, where applicable, and Information Standards Board changes which may affect reporting and therefore data quality. Data quality is also mentioned in staff job descriptions, ensuring that staff are held accountable for the quality of the data that they submit. The Trust submitted records during 2017/18 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS number was 99.4% for admitted patient care in March 2018:
  - Not applicable for outpatient care
  - Not applicable for accident and emergency care
- Which included the patient's valid General Medical Practice Code was 100% for admitted patient care in March 2018:
  - Not applicable for outpatient care
  - Not applicable for accident and emergency care

The Trust's information governance assessment reports the overall score for 2017/18, submitted in March 2018, was 93% and was graded 'satisfactory' (green) under national information governance rules.

The Information Governance Risk Register, and also information governance related incidents that are reported through the Trust Datix reporting system, are continuously reviewed and reported quarterly to the Information Governance Committee for action.

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

The Information Governance Toolkit is available on the NHS Digital website: www.igt.hscic.gov.uk

The Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

National indicators

Seven day follow up

This indicator is described as "The percentage of patients on CPA who are followed up within seven days after discharge from psychiatric inpatient care".

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

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

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

- Business Support Managers checking the systems and liaising with clinical staff to check any data that appears to be outside normal parameters
- Data is discussed at local management groups as well as Trust-wide performance groups

(QA8)

Prescribed information	Related NHS Outcomes framework domain	2015/16	2016/17	2017/18
The percentage of patients on CPA who were followed up within seven days after discharge from psychiatric inpatient care. This is a national definition reported to Monitor. **Target 95%**	Preventing people from dying prematurely Enhancing quality of life for people with long-term conditions	89.42%	95.90%+	96.27%

+ Improvements can be attributed to improved business processes and data extraction through the electronic patient record implemented within 2015/16

The latest available data produced by NHS England shows that the national average score for the period October to December 2017 was 95.4%. The highest performing area scored 100% and the lowest area scored 66%.

Gatekeeping by Crisis Resolution and Home Treatment Teams (CRHT)

This indicator is described as "The proportion of inpatient admissions gate kept by the crisis resolution home treatment teams".

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

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

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

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

(QA9)

Prescribed information	Related NHS Outcomes framework domain	2015/16	2016/17	2017/18
The percentage of admissions to acute wards for which CRHT acted as gatekeeper. This is a national definition reported to NHSI. **Target 95%**	Enhancing quality of life for people with long term conditions.	60.62%	97.00%+	97.86%

The latest available data produced by NHS England shows that the national average score for the period October to December 2017 was 98.5%. The highest performing area scored 100% and the lowest area scored 83.3%.

Readmission rates

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

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

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

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

(QA10)

Prescribed information	Related NHS Outcomes Framework domain	2015/16	2016/17	2017/18
The percentage of patients aged 0-15	Helping people to recover from episodes of ill health or following injury	No re-admissions	7.14% (accounting for one readmission to Dragonfly CAMHS Unit which opened in September 2016)	9.09% (Definition 28 days, only emergency readmissions excludes out of area stays. This relates to 1 out of area placement)
16 or over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust.		8.33%	8.79%	8.51% (Definition 28 days, only emergency readmissions excludes out of area stays)

(QA11)

Key Performance Indicator	2014/15	2015/16	2016/17	2017/18
Patient safety				
Seven-day follow up of service users following their discharge from inpatient services.	98.57%	89.42%	95.90%	96.27%
Target 95%				
Absconsions of detained patients from adult wards as a ratio of 100 detained patients.	5.72	8.16	6.43	8.22
Target 4.1				
Ratio of inpatient serious untoward incidents (e.g. suicide) per 10,000 occupied bed days.	4.19	3.40	3.02	3.81
Target 3.8				
Clinical effectiveness				
Access to crisis resolution and home treatment services.	98.92%	60.62%	97.00%	97.86%
Target 95%				
Delayed transfers of care, relating to other support needs (like housing) following discharge from hospital.	4.61%	3.39%	4.33%	5.66%
Target <7.5%				

Readmission rates:				
Age 0-15	No admissions	No re-admissions	7.14% (accounting for 1 readmission to Dragonfly CAMHS Unit which opened in September 2016)	9.09% (Definition 28 days, only emergency readmissions excludes out of area stays. This relates to 1 out of area placement)
Age 16+	7.87%	8.33%	8.79%	8.51% (Definition 28 days, only emergency readmissions excludes out of area stays)
Inappropriate out of area placements for adult mental health services.	New metric - no previous data	New metric - no previous data	New metric - no previous data	748 (average for the number of bed days in each of the 12 months)
Patient Experience				
CPA patients having formal review within 12 months. **Target 95%**	96.71%	69.24%	92.79%	96.06%
Waiting times. The number of people waiting 18 weeks or greater.	78	280	120	387
Number of under-18 year old admissions to adult acute ward.	12	5	2	8
Number of under-16 year old patients admitted to adult acute wards. **Target 0**	0	0	0	0
Meeting commitment to serve new psychosis cases by early intervention teams. **Target 95%**	131.76%	118.24%	150.00%	120.4%
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral. **Threshold 50%** Data indicates referrals to existing 14-35 year olds to early intervention services.	New metric - no previous data	New metric - no previous data	Q1 44.68% Q2 60.42% Q3 56.50% Q4 62.35%	Q1 59.74% Q2 67.53% Q3 66.30% Q4 62.82%

Improving access to psychological therapies (IAPT):				
- proportion of people completing treatment who move to recovery **Threshold 50%**	New metric - no previous data	New metric - no previous data	New metric - no previous data	Q1 46.77% Q2 42.53% Q3 39.97% Q4 44.64%
- people with common mental health conditions referred to IAPT programme will be treated within 6 weeks of referral **Threshold 75%**			Q1 94.24% Q2 92.97% Q3 93.10% Q4 93.17%	Q1 93.96% Q2 93.78% Q3 92.68% Q4 89.62%
- people with common mental health conditions referred to IAPT programme will be treated within 18 weeks of referral **Threshold 95%**			Q1 100.00% Q2 99.68% Q3 99.80% Q4 99.86%	Q1 99.90% Q2 99.92% Q3 99.89% Q4 99.98%
Cardio-metabolic assessment and treatment for people with psychosis in:				
- inpatient wards	New metric - no previous data	New metric - no previous data	New metric - no previous data	Data not available until June 2018
- early intervention in psychosis services				13.64%
- community mental health services (people on Care Programme Approach)				Data not available until June 2018

1. NHS Staff Survey

The annual national NHS Staff Survey is a mandatory requirement for NHS organisations. The Trust is committed to using the results as one element of our approach to understand the views of our staff and to inform improvements. The most recent NHS Staff Survey took place between October and December 2017, with results published on 6 March 2018.

Whilst our results from the previous year had demonstrated a significant year on year improvement, we are saddened by our most recent results. These show a decline across a number of key findings.

Only one score, relating to staff receiving appraisals, has increased compared to the previous year. We are committed to improving our results, across the board.

55% of our eligible staff responded to the NHS Staff Survey (2,096 staff). This is above the national average for Mental Health Trusts of 52%. Our response rate was 3% points below the previous year's response rate. The national response rate improved by 1.6% points.

(QA12) Summary of the response rate and the five best and worst key findings for the Trust

	2017		2016		Trust Improvement (+) Deterioration (-)
	Trust	National Average*	Trust	National Average*	
Response rate	**55%**	**52%**	**57.7%**	**50.4%**	**- 3%**
Top five ranking scores. Our scores compare most favourably with the scores of our benchmark group in the following areas:					
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	20%	22%	20%	21%	No change
KF24. Percentage of staff / colleagues reporting most recent experience of violence	93%	93%	92%	93%	+ 1%
KF16. Percentage of staff working extra hours	72%	72%	72%	72%	No change
KF23. Percentage of staff experiencing physical violence from staff in the last 12 months	3%	3%	2%	3%	+ 1%
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	58%	60%	60%	59%	2%
Bottom five ranking scores. Our scores compare least favourably with the scores of our benchmark group in the following areas:					
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.55	3.83	3.63	3.85	- 0.3
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.26	3.67	3.37	3.62	-0.11
KF8. Staff satisfied with level of responsibility and involvement	3.73	3.88	3.78	3.87	-0.14
KF6. Percentage of staff reporting good communication between senior management and staff	26%	36%	30%	35%	-9%
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	89%	93%	88%	92%	+1%

* National average scores are for mental health / learning disability trusts

We are disappointed in the deterioration in our staff engagement rating (on a scale of 0 to 5, with 5 being 'highly engaged').

	2017		2016		
	Trust	National Average*	Trust	National Average*	Change (+/-)
Staff engagement	3.55	3.79	3.62	3.77	-0.07

This has been a difficult year for staff, particularly with the Trust entering special measures.

Our priorities and plans

We are committed to making improvements and will be focusing on the following areas:

Continuation of our CQC quality improvement plans. This includes ensuring that the improvements we have made across areas such as appraisals, supervision and mandatory training are embedded and sustained.

Engagement. We will use pulse surveys within our services to identify the current state and to implement focused and timely plans, using the surveys monitor impact. Additionally, we will implement listening into action, translating staff feedback and ideas into solutions.

Quality improvement. We will move forward with our quality improvement plans, engaging and coaching staff to develop solutions using quality improvement tools and techniques.

Local focus. Results vary between services. Localities will engagement staff in the development and implementation of improvement plans.

Staffing. We will review our inpatient staffing levels using recognised methodology and we will review the number of direct reports for our managers to ensure these are reasonable.

Wellbeing. Following a successful pilot, we will extend the scope of our Trauma Risk Management programme. We will also roll out a Stress, Retaining Resilience at Work programme to sit alongside our existing Healthy Worker programme.

Management. We will refocus our Leadership Fundamentals programme to a leadership programme that is a pre-requisite for new managers and will also be undertaken by all existing managers.

Communication. We have introduced a number of new forms of communication recently. The Executive Skype broadcasting sessions have proved popular and will continue. Recently introduced team briefings will also continue.

The progress of these plans will be monitored and measured in various ways, with our Organisational Development and Workforce Committee taking an overview. We have a workforce dashboard that measures a range of key performance indicators which will help us assess impact, as well as feedback from the pulse surveys that we will be running and the quarterly Staff Friends and Family results.

We are currently recruiting to a number of positions on our Board which will support increased direction and stability for our staff. We are undertaking a series of Executive-led listening sessions within our localities and have recently launched new internal communications channels.

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

2. Community Service User Survey

The Trust commissions an outside agency, Quality Health, which is an 'approved provider' to undertake the survey

- The Trust commissions an outside agency, Quality Health, which is an 'approved provider' to undertake the survey

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

- Undertaking an analysis of results by locality and sharing with community managers and clinical leads to discuss with their teams
- Mapping other initiatives and improvement plans to identify actions likely to have a positive impact on future survey results (to minimise duplication of effort)
- Joining NHS England's fifth cohort of Always Events® network in order to use this methodology to further improve future results

('An Always Event is a clear, action-oriented, and pervasive practice or set of behaviours that: Provides a foundation for partnering with patients and their families; ensures optimal patient experience and improved outcomes; and serves as a unifying force for all that demonstrates an ongoing commitment to person- and family-centered care'. (NHS England 2018))

It should be noted that the breakdown by locality of each year's results is only available in Quarter 3 with the survey for the following year distributed from Quarter 4. We would, therefore, not expect to see any improvements as a result of the action plan in the next survey, but would expect to see these improvements in subsequent surveys. This is consistent with our Trust objective to maintain an improving trend that is greater than the national average over successive years.

QA13

Prescribed information	Related NHS Outcomes Framework domain	2015	2016	2017
The Trust "patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker.	Enhancing quality of life for people with long-term conditions Ensuring that people have a positive experience of care	7.4	7.2	7.6

Range of scores: 6.4-8.1 The scores achieved are from a maximum possible score of ten.

3. Incident reporting

Staff continue to be encouraged to apply an open culture of reporting incidents and near misses as they occur. The Trust is identified through the National Reporting and Learning Service (NRLS) as one of the highest reporters of incidents which staff report via the Datix incident reporting system:

- All incident reports are reviewed by the risk management team and clinical managers are required to investigate and sign off each incident before closing the event
- Health, safety and security audits are carried out on all Trust premises which include a review of incident reporting trends
- These are subject to discussion in a range of monitoring groups including the Patient Safety Group and Health & Safety Committee

Serious incidents are managed in accordance with national guidance.

(QA 14) Table showing the ratings received by the Trust

Related NHS Outcomes Framework domain	1 October 2014 to 31 March 2015	1 April 2015 to 30 September 2015	1 October 2015 to 31 March 2016	1 April 2016 to 30 September 2016	1 October 2016 to 31 March 2017
Treating and caring for people in a safe environment and protecting them from avoidable harm.	4400 incidents reported	4822 Incidents reported	4620 incidents reported	4405 incidents reported	5146 incidents reported
	58.9 incidents per 1000 bed days**	64.54 incidents per 1000 bed days**	66.51 incidents per 1000 days**	65.21 incidents per 1000 days**	77.55 incidents per 1000 days**
	2 incidents (0.0%) led to severe harm. National average 0.4%	2 incidents (0.0%) led to severe harm. National average 0.3%	5 incidents (0.1%) led to severe harm. National average 0.3%	3 incidents (0.1%) led to severe harm National average 0.3%	3 incidents (0.1%) led to severe harm National average 0.3%
	8 incidents (0.2%) led to a death. National average 0.7%	16 incidents (0.3%) led to a death. National average 0.7%	10 incidents (0.2%) led to a death. National average 0.8%++	25 incidents (0.6%) led to a death National average 0.8%++	20 incidents (0.4%) led to a death National average 0.8%++
	** The reporting rate of 58.9 incidents is rated 10th out of 54 mental health organisations and puts the Trust in the top 25%	** The reporting rate of 64.54 incidents is rated 8th out of 55 mental health organisations and puts the Trust in the top 25%	** The reporting rate of 66.51incidents is rated 7th out of 55 mental health organisations and puts the Trust in the top 25%	** The reporting rate of 65.21 incidents is rated 10th out of 55 mental health organisations and puts the Trust in the top 25%	** The reporting rate of 77.55 incidents is rated 5th out of 54 mental health organisations and puts the Trust in the top 25%

++ During this period routine cross checking of Trust coding with NRLS coding methods have led to an adjustment in uploading data related to incidents leading to death at an earlier stage, accounting for an increase in the number of incidents reported.

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

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

Differences between the NRLS data for deaths and the figure for serious incidents are due to the different reporting requirements. NRLS guidance requires that only deaths of suspected suicide are reported to the system, whereas Serious Incident reporting will include all forms of unexpected death (e.g. incidents where information suggests it may be due to an accidental overdose).

4. Evaluation of patient safety

The Trust continues to report all serious incidents on receipt of an initial report. This is reported as good practice by the National Patient Safety Agency.

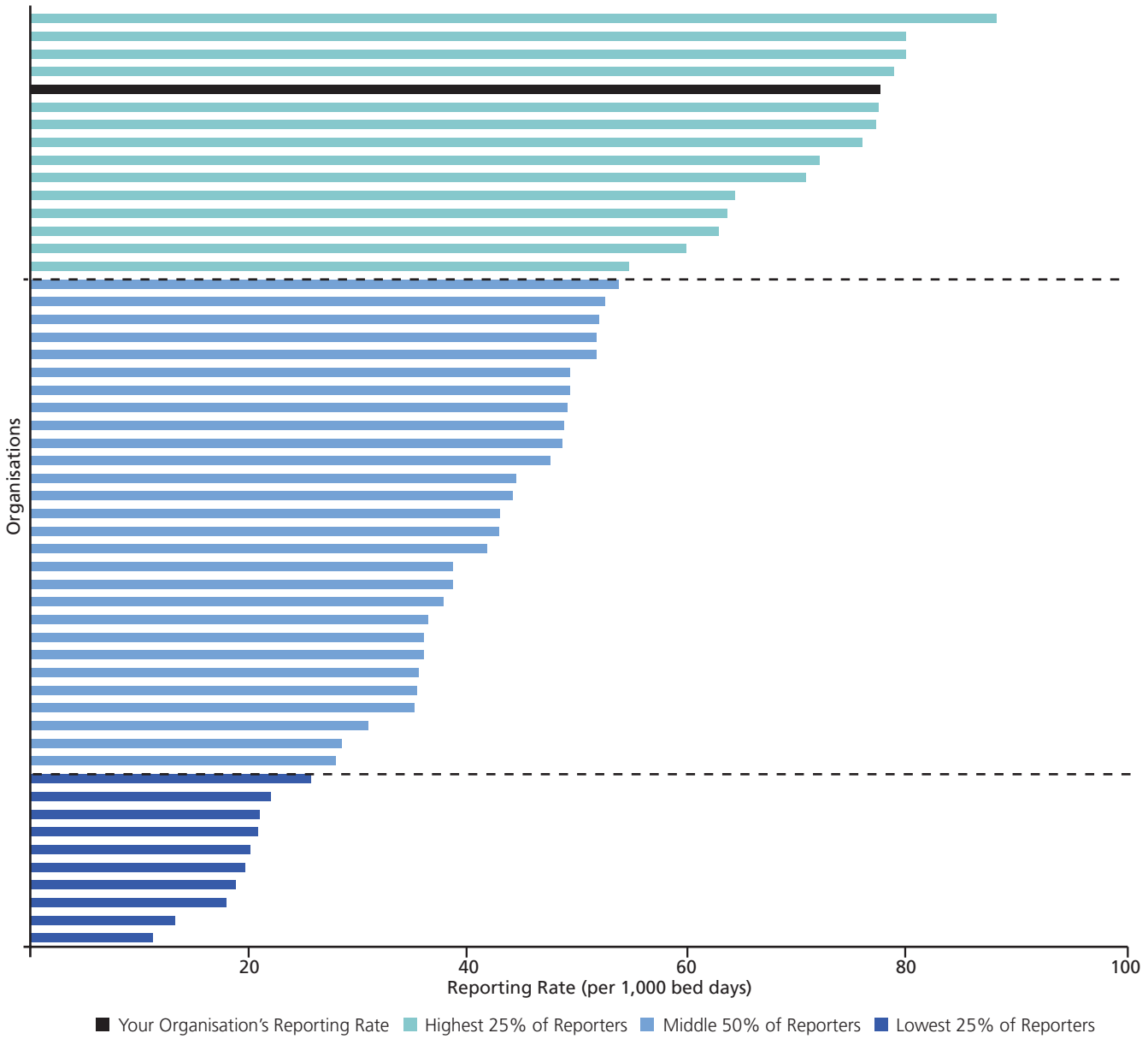
The latest report from the National Reporting and Learning System for the period 1 October 2016 to 31 March 2017 (published March 2018) shows that the Trust is the 5th highest reporter of 54 mental health trusts in that period.

(QA15) NRLS Graph

Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by NHS organisations to the National Reporting and Learning System (NRLS) occuring between 1 October 2016 to 31 March 2017. Your organisation reported 5,146 incidents (rate of 77.55) during this period.

Figure 1: Comparative reporting rate, per 1,000 bed days, for 55 Mental health organisations.



The median reporting rate for this cluster is 42.45 incidents per 1,000 bed days.Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

5. Learning from deaths

The following section will contain a series of figures and statistics set by a national template. It is to be remembered these represent people who were loved by family and friends and were part of their local community.

Providing respectful, sensitive and compassionate communication with families and carers when someone has died is important to the Trust. At times families may have questions, and/or concerns they would like answers to in relation to the care and treatment their loved one received. If you are reading this as a family member of someone who has recently died, and has received care from our Trust and you have anything you would like to discuss, you can contact the Patient Safety Team at 01603 421914 or via email to nsft.si@nhs.net.

The Trust, alongside all NHS providers, has made significant changes in seeking to learn from deaths during this year. Aided by national guidance, the Trust has introduced a number of actions to develop structures by which increased understanding and learning may be made. These have included formalising a policy on learning from deaths leading to the introductions of structured judgement reviews and mortality reviews, strengthening data and information, embedding the work of the mortality review group supported by two county groups and working with other local providers of care.

The Trust recognises this work is still in its infancy, continuing to work collaboratively with other providers to share and pursue learning with the common goal of seeking to make positive improvements to the care of our users.

During 2017/18, 560 of the Trust's patients died (including those open to the Trust at time of death and up to six months post discharge). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 136 in the first quarter
- 124 in the second quarter
- 158 in the third quarter
- 142 in the fourth quarter

By 5 April 2018, 9 case record reviews and 126 investigations have been carried out in relation to the deaths indicated above.

In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 38 in the first quarter
- 31 in the second quarter
- 33 in the third quarter
- 33 in the fourth quarter

No cases representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been compiled using the structured judgement reviews and serious incident investigations in accordance with national guidance.

23 case record reviews and 61 investigations completed during the year 2017/18 which related to deaths which took place before the start of the reporting period.

No cases representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using structured judgement reviews and serious incident investigations.

No cases representing 0% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

These actions have led to a range of insight and learning promoting action by the Trust. Reported within quarterly reports to the Trust board, areas of learning have included:

- Physical health problems are the most frequent cause of premature death, seen across age ranges, geographies and services the Trust provides. During this year the Trust has published its Physical Health Policy and from April 2018 its hospitals have moved to become smoke free areas. This is intended to support users have equitable access to assessment and information that will support their physical health
- Clinical curiosity has been identified as a theme requiring further understanding. Actions have included improving the level of completeness and quality of risk assessment and care planning. This is to meet the aim of clear, bespoke, co-produced care plans that are easily accessible. The Trust has commenced an improvement programme to establish the process of formulation within all levels of practice. Formulation is an integral part of understanding a service user's needs and communicating it. Whilst the care

plan lists the interventions, the formulation provides a reasoning that can help teams respond more accurately in a crisis or indeed prevent a crisis

Evaluation of clinical effectiveness

The Trust has formally adopted an approach to reviewing NICE guidance that ensures all new guidance relevant to the Trust is considered by its lead clinicians representing each locality. A group of senior clinical staff chaired by the Medical Director consider and review relevant guidance centrally for Trust-wide implications and attending lead clinicians relay issues and necessary actions back to their localities' clinical strategies.

This approach provides a route of reporting to the Trust Board and external partners such as commissioners.

Technology appraisals are discussed by our Drug and Therapeutics Committee to ensure that medicines are available when recommended by the prescriber.

The Trust is registered as a stakeholder in the development of several NICE guidelines and has actively participated in reviews of guidance including dementia, decision making and mental capacity and depression in adults.

NICE guidance published since April 2017 included:

- New guidance on eating disorders covering assessment, treatment, monitoring and inpatient care for children, young people and adults. It aims to improve the care people receive by detailing the most effective treatments for anorexia nervosa, binge eating disorder and bulimia nervosa
- An update on their guidance on managing hip fractures, and on head injuries
- New safeguarding guidance helping staff spot and respond to child safeguarding concerns

NICE newsletters and published NICE Bites summaries are shared with staff through email bulletins to help staff keep up-to-date with notices, reviews and publications.

Gap analysis by Trust teams as well as audit, such as, through Prescribing Observatory for Mental Health UK (POHM-UK) help us to establish the Trust's compliance against NICE guidance.

For example, a review with the Trust's lead on Learning Disabilities and Autism found that implementing new guidance on mental health problems in people with learning disabilities would be further supported by the planned Learning Disabilities Core Skills Framework. A multi-agency group already established was in place to develop training packages for staff.

A POHM-UK national audit on prescribing high dose antipsychotics showed how our acute adult wards performed better than average on minimising above British National Formulary doses of antipsychotics.

A POHM-UK audit on rapid tranquillisation showed the difficulties both nationally and locally recording physical health observations following rapid tranquillisation. A working group was established involving medical, nursing and pharmacy colleagues to look at what policy changes might support staff to overcome these problems. A new observations form, specifically for rapid tranquillisation, has been designed and will be piloted to see if it is effective.

NHSI identifies a number of measures of clinical effectiveness, including access to crisis resolution and home treatment teams before a person is admitted to hospital, and ensuring service users are followed up within seven days of discharge from an inpatient ward.

These are reported to NHSI and the Trust is pleased to report an improvement in performance this year acknowledging the improvements in business reporting systems.

Evaluation of patient experience

Service user and carer involvement and participation

The Trust values the role played by service users and carers and is committed to the principles of coproduction, involving service users and carers in a meaningful way in everything we do, enabling them to use their experiences and skills to improve and develop services.

The Trust works very closely with a number of service user and carer groups and forums across Norfolk and Suffolk with a service user group in each of the localities, with each having a service user or carer co-chair.

The groups and forums vary in format, ranging from structured meetings to 'drop in' type meetings but the overarching aim of the

groups is to provide an opportunity for service users, carers, family and supporters to receive information about the work of the Trust and be able to use their experiences to support improvements.

We also encourage service users and carers to tell us about their experiences of services and about personal recovery, directly or indirectly (for example, via Governors representing interests of their constituency members). These personal experiences are presented in various formats, including first person accounts, written, or through audio and video recordings, and will be used for staff education and quality improvement.

Improving Services Together – Capturing service user and carer views, experiences and feedback

Our service user and carer involvement and participation strategy, 'Improving Services Together' was launched at the end of 2015. The strategy clearly sets out six clear commitments about how we will work together with services users and carers to make sure that we listen to their experiences.

Commitment 1: Service users and carers will be able to have their say in Trust business.

Commitment 2: There will be opportunities for service users and carers to use their skills and experiences to improve services.

Commitment 3: We are changing the way we provide our services in line with our commitment to organisational change.

Commitment 4: We will strengthen links and create partnerships with other agencies and service user and carer-led organisations.

Commitment 5: Reach out to diverse and other under-represented groups.

Commitment 6: Service users and carers will 'judge' whether this strategy is being delivered.

Service User and Carer Locality Hubs were piloted in 2016, implemented in all localities in 2017 and are now established. These locality hubs report into the Service Users and Carers Trust Partnership Meeting for which membership increased during 2017.

In 2017/18 Q4 we conducted an initial series of CQC Improvement Plan engagement meetings for service users and carers that attracted over 100 attendees, with 50% identifying themselves as services users or carers. The outputs from these meetings will inform further actions to improve how we engage with service users and carers during 2018.

These actions include:

- Establish a mailing list and a co-designed Involvement and Participation Newsletter
- A system to award a co-production stamp of approval for documents and policies produced within the Trust
- Introduce a service user and carer informed quality improvement methodology (e.g. Always Events®) to improve the user experience of our clinical services and pathways
- Participation and Involvement team delegation, including service user and carer representatives to visit East London NHS Foundation Trust to learn how they have embedded service user and carer involvement as part of achieving a CQC rating of 'Outstanding'

Triangle of Care and carer involvement

As a requirement, the Trust has submitted Triangle of Care self-assessments, as a carer involvement benchmarking exercise, to the Carers Trust for evaluation. The Trust received its first gold star award in relation to work in stage one of the implementation.

In 2017 stage two submission was completed, which involved submitting self-assessments for all community services. A representative from our Participation Team along with an NSFT carer lead presented our stage two plans to the Carers Trust on 2 March 2018. This resulted in the Trust being awarded a second gold star for continued engagement with the Triangle of Care initiative.

At the end of 2017 a Trust carers survey was undertaken with the results being analysed in 2017/18 Q4 which will inform further actions to improve the experience of carers in 2018/19.

Friends and Family Test (FFT)

Both the Francis report, regarding Mid Staffordshire NHS Foundation Trust (2013), and the Berwick Report, 'Improving the safety of patients in England' (2013), highlighted the need for patients to be more engaged and their voices to be heard regarding the service they receive within the NHS.

The Friends and Family Test (FFT) was devised to address this, and to determine patient satisfaction with NHS services. Our Trust implemented the FFT in October 2014.

The FFT aims to:

- Gather feedback from patients immediately – or soon after – care has been received
- Provide a broad measure of patient experience that can be used alongside other data
- Identify areas where improvements can be made and practical action can be taken
- Empower patients to make informed choices about their care

The FFT consists of one key question: 'How likely are you to recommend our service / team to friends and family if they needed similar care or treatment?' with responses ranging from 'extremely likely' to 'extremely unlikely'. Service users also have the option to answer 'don't know'.

Cards have been designed to capture responses to the FFT and each team indicates their unique reporting code on the cards they distribute to enable them to review their specific responses and to implement changes following feedback. The cards are filled out at the point of discharge or transfer from inpatient services, and intermittently for all community based services.

In April 2017, following feedback from service users, a revised Standard Read card and a new Easy Read version of the FFT card were launched.

The total number of responses received from service users in 2017 was 1741 from 72% of participating teams in comparison to 2229 in 2016 from 52% of participating teams.

The temporary fall in responses in 2017 was due to teams running out of the old card design while awaiting the new cards to be received from the printers. However, the 20% increase in participating teams compared to 2016 provides evidence that actions to increase awareness and use of FFT have been effective. This has put us in a good position to now increase returns in 2018 to well above that in previous years. January and February 2018 received 366 returns which is the highest number of returns for these two months since FFT commenced in 2014, and 15% more than for the same period in 2017.

Reporting shows that we have not only maintained a score of 91% (responses rating extreme likelihood or likelihood of recommending the service) for community teams, but increased the percentage of those who choose 'highly likely' by 15%. Our overall FFT improvement is driven by an improving score for inpatient teams of 82% (responses rating extreme likelihood or likelihood of recommending the service) compared to 77% in 2016).

Overall, this shows the following changes during 1 March 2017 to 28 March 2018 compared to the same period the previous year.

- Number of returns: -24%
- Satisfaction (% selecting extremely likely or likely): +2.5%
- Dissatisfaction (% selecting unlikely or extremely unlikely): -1.2%
- Participating teams: +23%

The target outcomes for 2018/19 are to:

- Maintain an overall FFT score of 89% or more
- Increase number of returns by 60%+ to between 2,500 and 3,000 (or more)
- Increase participating by at least +8%, to 80% or more

Mental Health Community Service Users Survey 2017

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is by asking people who have recently used health services to tell us about their experiences
(CQC 2017)

The CQC requires trusts to undertake national service user surveys each year and this year's mental health community service user's survey involved 58 providers of NHS mental health services in England (including combined mental health and social care trusts, foundation trusts and community healthcare social enterprises that provide mental health services).

People aged 18 and over were eligible for the survey if they were receiving specialist care or treatment for a mental health condition and had been seen by the Trust between 1 September 2016 and 30 November 2016.

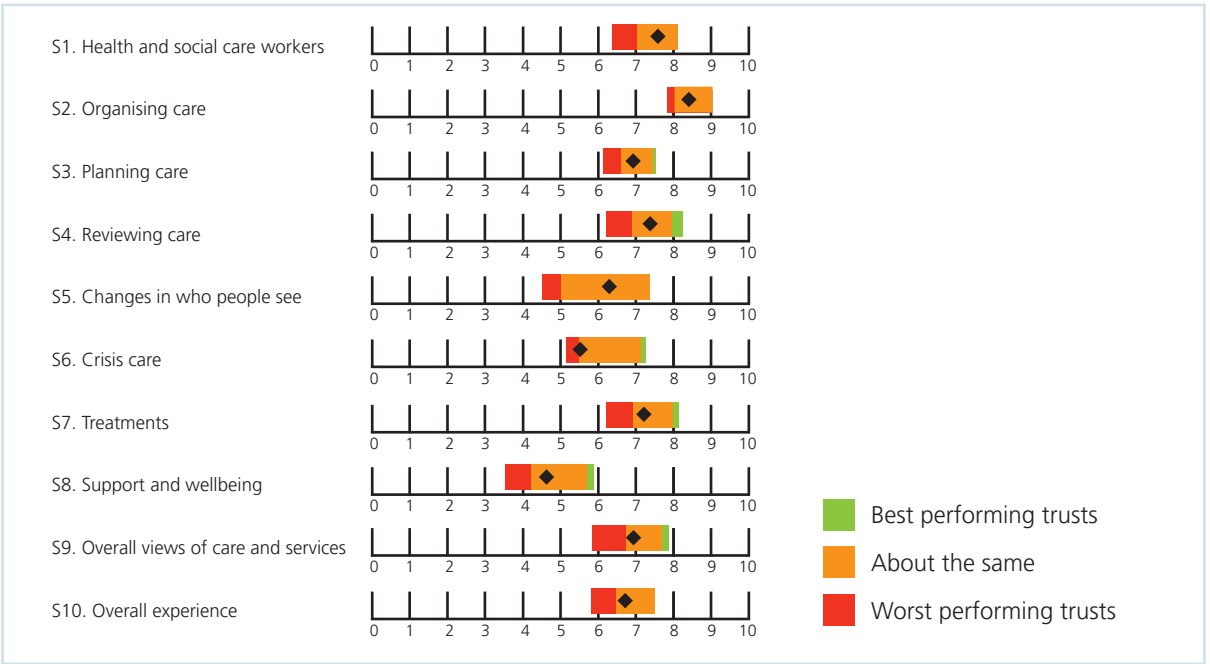
The survey has undergone two major redevelopments ahead of the 2010 and 2014 surveys to reflect changes in policy, best practice and patterns of service which means that the 2017 survey is only comparable with the 2014, 2015 and 2016 surveys.

A response rate of 30% was achieved – the national average was 26%. This compares with a Trust response rate of 30% in the 2016 survey; the national average was 28%.

Further information about the survey can be accessed via the CQC website on: http://www.cqc.org.uk/publications/surveys/community-mental-health-survey-2017 or type 'service user survey' into the CQC website search box.

This national survey enables the Trust to be benchmarked against other mental health trusts. The survey questions are grouped into nine sections and the table below shows the Trust scores compared to other mental health trusts.

(QA 16) Section scores



◆ denotes the score for the Trust compared to the range of scores achieved by all trusts taking part in the survey. The black diamond shows the score for our Trust. The graph is divided into three sections:

- If the Trust's score lies in the orange section of the graph, its result is 'about the same' as most other trusts in the survey
- If the Trust's score lies in the red section of the graph, its result is 'worse' than would be expected when compared with most other trusts in the survey
- If the Trust's score lies in the green section of the graph, its result is 'better' than would be expected when compared with most other trusts in the survey.

The text to the right of the graph clearly states whether the score for your trust is 'better' or 'worse'. If there is no text the score is 'about the same'.

The Trust was disappointed by the results of the 2016 survey, particularly as we were in the fourth year of our Implementing Recovery Through Organisational Change (ImROC) project. This has overseen the establishment of our successful Recovery College and achieving approximately 30 Peer Support Worker posts in our secondary services across Norfolk and Suffolk (with the same number employed within our Wellbeing services).

However, we welcomed the recommendations made by our survey provider, Quality Health Ltd, in response to the 2016 survey results, which provided renewed impetus and helped to further inform our co-produced Recovery Strategy that was launched in June 2017.

The strategy has helped to increase awareness within our community services of the recovery principles that would help to improve results of future surveys.

Compared to 2016, our 2017 survey results showed overall an improved score in 24 of the 32 rateable survey questions and a worse score in just four questions. The rate of improvement on a 10-point scale averaged 0.35 per rateable

question. This has improved our relative position compared to the average of other Mental Health Trusts.

We accept that we need to do more, but this result is consistent with our objective to achieve a sustained improvement over the five years following on from the 2016 results.

Other quality indicators

1. Infection Prevention and Control (IPAC) activities

The work of the IPAC service is detailed in the Trust annual plan. This programme of activities is devised against the priorities described in key documents and national best practice guidance; including The Code of Practice on the Prevention and Control of Infections and Related Guidance (revised July 2015).

Key achievements resulting from implementation of the IPAC plan for 2017/18 have been:

- The Trust staff succeeded in maintaining a low rate of Health Care Acquired Infections (HCAIs). The Trust has a target of nil cases of Clostridium difficile infection in patients aged two and above, which was achieved in 2017/18. No ward closures were required during the year due to diarrhoea and / or vomiting infections. Nil occurrences of MRSA blood stream infection within NSFT inpatients
- The Trust continues to embed the IPAC link worker programme. All of the inpatients wards have at least one local IPAC link practitioner, with 84 link staff receiving annual update training
- Continued close working with the acute Trusts' IPAC teams has enabled early communication of any organisms of concern identified through laboratory reporting
- The Trust has run a successful vaccination campaign of Trust staff to protect them and our service users from influenza. This year the vaccination uptake rate for frontline staff was 50.46% this year's vaccination campaign saw a further 714 frontline staff vaccinated compared to the previous year
- A Legionella awareness project with ward staff was commenced with introduction of a software system recording flushing of low use water outlets

Priorities for improvement for 2018/19 are:

- To build on the success of the flu vaccine campaign, seeking to increase the number of staff vaccinated to meet the Public Health England target of 75%
- To continue to monitor 'alert organisms' (a specified list of micro-organisms/infections), and advise clinical areas accordingly
- To work with prescribing colleagues and the pharmacy team to continue to improve compliance with best practice for antibiotic prescribing and support national initiatives related to the reduction of infections caused by gram negative bacteria
- Improve compliance with IPAC training and education which is being managed through the mandatory training programme, through a range of learning and assessment opportunities
- To embed a programme of mattress cleanliness and integrity monitoring
- The IPAC team will continue to work with staff to ensure water safety and quality as per legislative requirements and national best practice guidance

2. Physical health

The Trust aims to provide holistic care including monitoring, maintaining and improving the service users physical health in line with available evidence and supporting care provided by other key stakeholders.

The service user's physical health is seen as being inextricably linked to their mental health and as such should have equal importance. NSFT staff have unparalleled opportunities to help service users improve their physical health alongside their mental health, both in inpatient settings and in the community.

To stand by the principles of holistic care physical health will be part of a package of care that seeks to; reduce health inequalities, promote 'Integrated care pathways' between the service user, their care team and with their GP and to increase knowledge and participation in health promotion activities.

Key achievements for 2017/18 have been:

- Through consultation and collaborative working a single use electronic physical health form was developed and implemented in April 2017. The form is continuously reviewed with the aim that subsequent versions are versions tailored to specialist services
- Formation of the Physical Health Strategy Development Group who undertook a series of focus groups for service users/carers and staff. Feedback from sessions has underpinned the first draft of the five year Physical Health Strategy 2018 – 2023
- Improvement in achieving the CQUIN 2017/19 Improving Physical Healthcare to reduce premature mortality in people with Severe Mental Illness – focus has been on developing physical health screening in the community through:
  - Revised ***Physical Healthcare Policy*** – with clear direction and clarity for staff on NSFT responsibility for physical health screening for first 12 months of service user initiated antipsychotic medication
  - The formation of physical health community team meetings in every locality to enable focus on implementation of revised ***Physical Healthcare Policy***, identifying barriers to implementation, shared learning across the Trust and embedding solution focus approach
  - Improved partnership and local communication channels with GP Leads, CCG and Public Health in the development of a shared integrated care pathway regarding physical health checks for people with Severe Mental Illness (SMI)
- A *Smokefree Policy* has been developed followed by a consultation period for service users, carers, staff and other key stakeholders and was implemented in April 2018
- Development of the Nicotine Management Working Group (NMWG) chaired by the Medical Director with members from Public Health, specialist stop smoking servicers, and fire officers was formed to respond to the themes that emerged from the consultation and which have helped to form the basis and direction of the Trust's Smokefree initiative
- Development of the Wound Assessment Treatment (WAT) internal training programme to support Trust-wide reduction of avoidable pressure ulcers, which included the development of 'safety huddles' on later life wards
- Trust-wide education event entitled Vital Signs Fundamental Aspects of Care which focussed on management of the deteriorating patient with external speakers and workshops e.g. sepsis, wound management and diabetes

Priorities for improvement for 2018/19 are:

- Partnership with our service users:
  - Implementation of the Physical Health Strategy 2018–23 to support holistic personalised services to service users
  - Focus on self-care and prevention linking with recovery focused approaches. Information available in a variety of formats to cater for different ages and cultural backgrounds and intellectual abilities
  - Sources of physical health information and guidance available and easily accessible for service user and carer use
- Partnership with our staff:
  - Introduction of new post, Health Promotion Lead Nurse, to embed health promotion into clinician's role
  - Enabling a cultural shift by improving staff knowledge of the impact and benefits of improving service user's physical health and promoting holistic care to achieve the best possible physical health outcomes
  - Sources of physical health prevention/ promotion information and guidance available and easily accessible for service user and carer use utilising other mediums of communication for example, video
  - To achieve year-on-year improvement across a range of physical indicators for our service users (for example, smoking, obesity, alcohol consumption) screening for modifiable cardiovascular risk factors; CQUIN 2018/19 Improving physical healthcare to reduce premature mortality in people with SMI
  - Introduction and sustainability of the Smokefree Initiative Trust-wide incorporated CQUIN 2018/19 preventing ill health by risky behaviours; alcohol and tobacco
  - Physical health practices reviewed regularly in all practice governance forums and locally through inpatient and community physical health meetings

- To work at producing meaningful data for audit purposes to support the Physical Health form being used as a routine part of clinical practice

Partnerships with Primary Care / GPs / Public Health

- Collaborate, coordinate and integrate care across organisations to deliver joined up physical and mental health care integrated care pathway guidelines to define responsibilities and communication channels
- Utilise local public health expertise
- Work with health promotion providers so that they understand how having a mental health problem affects service users' abilities to engage with their programmes and tailor them appropriately
- Advocate for information and equity in the provision of prevention activities across the boroughs where our patients live

3. Sign Up to Safety plan

The Sign up to Safety campaign supports the ambition of the Secretary of State for Health of halving avoidable harm in the NHS over the next three years. The campaign aims to incorporate three key principles to improve patient safety:

- **Listen** – to patients / carers and staff
- **Learn** – from what they say when things go wrong
- **Act** – take action to improve patient safety when things go wrong

By making the commitment in Signing Up to Safety, the Trust will:

- **Put safety first** – committing to reduce avoidable harm within the Trust, making both the safety goals and plans available to the public
- **Continually learn from safety incidents and share that learning to prevent similar occurrences** – by developing a culture of learning and development that strengthen the Trust's ability to safety and risk
- **Promote an open and honest culture for those who work in our services and use our services** – by being transparent with both those who use our services and work in our services and supporting people if something goes wrong
- **Collaborate** – with services and teams to ensure learning is shared
- **Provide support to individuals** – to understand why things go wrong and how to put them right and also celebrate improvements

The Trust has identified five key initiatives to improve safety and have set the following ambitions for each of the priorities.

The five safety priorities:

Reduce the number of restrictive interventions used within the Trust by 25% by 2018

The Trust continues to work towards this target through implementation of actions such as Safewards.

- Reduce the number of assaults by 25% within the Trust by 2018

Also linked to the Safewards work, this work involves reviewing trends and identifying actions for sustained implementation.

- That no falls result in severe harm

The Trust uses Root Cause Analysis methodology to identify learning from events that can have a positive influence in future provision of care.

- Provide an environment that reduces the risk of harm so that all inpatient areas comply with current same sex accommodation standards and all ligature points are removed or mitigating actions put in place

The Trust continues to examine its environments for potential risks, investing in ways that the risk can be addressed or mitigated.

- To ensure the Trust embeds a safety culture based on openness, transparency and learning from previous incidents that have caused harm. This ensures that individuals feel supported and safe to report incidents and when things go wrong and improvements are made to prevent future occurrence

The Trust promotes an open culture where staff can report incidents. During this year the Trust has invested in the Putting People First Freedom to Speak Up Guardian role in order to further enhance staff confidence and support to raise key matters (see page 98)

4. Positive and proactive care

In April 2014 the Department of Health published the report 'Positive and Proactive Care' focusing on the need to reduce the use of restrictive interventions (restraint) by staff in mental health trusts.

'Restraint' describes any restrictive intervention involving direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.

In 2015, as part of the Trust's commitment to implementing the Department of Health's guidance, a target to reduce the number of restrictive interventions incidents reported by 25% was set. The Trust has subsequently reviewed its programme with a lead for restrictive interventions appointed to refresh the strategy. The strategy *Promoting Positive Practice* was ratified in February 2018 introducing a range of measures to reduce restrictive interventions. As part of this, and following nationally accepted practice, the Trust has added the monitoring of rapid tranquilisation to the programme.

> *'We have set an ambitious three year target to reduce the use of restrictive interventions by 25%. We will measure this against a baseline figure of 3,752 reports in the calendar year 2016. The baseline figure is calculated by adding together 2,448 restraints, 641 seclusions, 630 uses of rapid tranquilisation and 33 long term segregations. Our aim is that in the year from April 2020 to March 2021, there will be fewer than 2,814 such reports.'*
>
> Promoting Positive Practice, Reducing Restrictive Interventions Strategy, April 2018 to March 2021 NSFT

New detailed data reporting for each ward will enable staff to analyse practice to lead to improvements. The Trust has a culture of high levels of reporting and the data is also demonstrating that a significant amount of restraints are related to planned and supportive safe holding to provide personal care for older patients with dementia. Some areas have very successfully introduced restrictive intervention reductions – in particular Secure Services who have reduced restrictive interventions to fewer than half the number in 2014/15.

5. Serious Incidents (SIs)

The Trust continues to report all Serious Incidents (SI) in accordance with national guidance.

Incidents may subsequently be stood down if an explainable cause is identified i.e. if a death is found to be as a result of natural causes, and will not be subject to a coroner's inquest.

From April 2017 to March 2018, 190 SIs were reported by the Trust (2016/17, 242 were reported), of which 137 were unexpected deaths (2016/17, 184 were unexpected deaths). At the time of reporting, 22 have been determined due to a natural / physical cause (2016/17, 47 due to natural / physical cause).

The remaining involved service users who were accessing a range of inpatient and community services across the Trust. They were engaged with services at the time of their death or had been discharged within the previous six months.

Our Trust uses Root Cause Analysis methodology to consider the timeline and factors that influenced an incident. Through group review the analysis identifies learning actions. A number of serious incidents have strengthened oversight through the engagement of Executive and Non-Executive Directors in setting the terms of the investigation and agreeing the final report.

6. Complaints

Our Trust is committed to using complaints to learn and improve our services. Our Trust considers complaints in an open and transparent way.

At the time of reporting (April 2018), our Trust had received 620 complaints during April 2017 – March 2018 (661 in 2016/17). The majority of complaints related to all aspects of clinical treatment (57%), followed by attitude of staff (18%).

At the time of reporting (4 April 2018) 413 complaints have been responded to. Of these complaints 10% were upheld, 39% were partially upheld and 51% were not upheld by our Trust. 11% of complaints were stood down for reasons including confidentiality form not signed by the service user or confirmation of the complaint returned.

Across the year, data has been analysed for themes arising from complaints, along with learning that can be used to improve services.

These are highlighted below.

A number of people cited delays in receiving care or treatment; this is a theme that also emerged during 2016/17. It was particularly relevant to both the south service and the Wellbeing service in Norfolk, especially, where complaints highlighted this issue. However, this concern is reduced in community mental health teams, which had been highlighted last year. It is considered that the structural changes to the community teams and recruitment undertaken have affected this positively. For the teams where people waiting for treatment is still an issue, lessons are learned around how to support people's expectations from the outset, and how people can make contact if they feel their health is deteriorating. Giving people information about the team's duty systems, along with any third sector organisations who can offer interim support, will assist in this area.

Accuracy of recording by clinicians has also been highlighted as a concern, with complaints being recorded in some specific areas. Generally, this featured allegedly inaccurate information being stated in assessments or reports. Recommendations were made to sense check what was being recorded with the person during the assessments and interactions. Teams have responded well to this feedback with complaints dramatically reducing in this area.

Carers have raised that the support provided by the Trust for their loved one could be improved. The feedback is on a range of issues including communication and treatment pathways. Supporting the principles of Triangle of Care learning is provided to clinicians on listening to, and engaging carers' as much as possible within their loved ones care.

During the review of the annual complaints report in October 2017, the Trust Board set a direction to increase the level of contact with complainants during the investigation phase. Adopting this direction, the complaints team are using Quality Improvement science to guide the necessary actions. Actions have included creating the measurement framework of the improvement, forming the theory of change and, with the help of a small group of service users, carers and staff, creating ideas of how the process and content of contact with complainants may be enhanced. The implementation stage is now in progress with evidence of improvement aimed for September 2018.

The Trust has been informed that following the response to a complaint, the Parliamentary and Health Service Ombudsman opened investigations into 11 complaints this year. The Ombudsman concluded 17 complaint investigations (including those opened in previous year). Ten of the complaints investigations have not been upheld, five partially upheld and two upheld.

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

7. Patient Led Assessments of the Care Environment (PLACE)

PLACE assessments take place annually, and results are reported publicly to help drive improvements in the care environment across the NHS and show how providers are performing against their peers both nationally and locally.

PLACE assessments were undertaken across nine inpatient sites and involved staff, current service users, ex-service users, Healthwatch and Governors to assist with the audits.

There are five main areas of assessment (Cleanliness; Food and Hydration; Privacy, Dignity and Wellbeing; Condition, Appearance and Maintenance; Dementia and Disability). The Food element has an overall score but is also split into Organisational Food, covering the general provision and food service, and Ward Food which covers the actual quality, taste, aroma and texture. The Trust performed as follows:

(QA 17)

Criteria	2017 National Averages	Trust Overall score 2017
Cleanliness	98.38%	98.93%
Food	89.68%	94.93%
Organisational Food	88.80%	90.56%
Ward Food	90.19%	97.99%
Privacy Dignity and Wellbeing	83.68%	92.48%
Condition Appearance and Maintenance	94.02%	97.47%
Dementia	76.71%	90.49%
Disability	82.56%	93.30%

The Trust has scored higher than the national average in all aspects. NSFT individual site scores attained were as follows:

(QA 18)

Location	Cleanliness		Food		Organisational food		Ward food	
	2017	2016	2017	2016	2017	2016	2017	2016
Wedgwood	99.90%	100%	95.53%	96.54%	90.58%	91.77%	99.33	100%
Carlton Court	98.28%	98.91%	96.11%	97.98%	90.29%	94.61%	99.49%	100%
Fermoy Unit	99.52%	98.88%	96.58%	96.52%	92.96%	94.91%	98.89%	97.44%
Hellesdon Hospital	97.58%	97.96%	95.67%	97.54%	89.18%	94.85%	100%	100%
Woodlands	99.83%	99.33%	94.68%	94.33%	90.00%	91.77%	98.54%	96.16%
Foxhall House	99.49%	99.74%	97.67%	98.06%	95.23%	95.14%	99.38%	100%
The Julian Hospital	98.79%	98.91%	90.15%	97.82%	91.51%	94.61%	89.37%	100%
The Norvic Clinic	98.88%	98.53%	95.97%	95.76%	90.11%	94.61%	99.72%	96.41%
Northgate Hospital	98.94%	96.24%	96.69%	96.15%	92.96%	97.22%	98.63%	95.56%

Location	Privacy, Dignity and Wellbeing		Condition, appearance and maintenance		Dementia		Disability	
	2017	2016	2017	2016	2017	2016	2017	2016
Wedgwood	85.86	92.20%	98.27	97.21%	88.84	91.43%	87.40	90.09%
Carlton Court	94.96%	89.01%	97.34%	99.25%	97.31%	97.45%	95.94%	96.81%
Fermoy Unit	90.38%	81.46%	99.24%	96.69%			97.40%	90.60%
Hellesdon Hospital	95.04%	90.97%	97.03%	98.21%			98.58%	96.60%
Woodlands	93.52%	90.74%	94.90%	95.96%	85.05%	91.39%	82.72%	87.38%
Foxhall House	95.43%	83.59%	97.66%	95.08%			96.28%	88.87%
The Julian Hospital	94.84%	91.56%	98.28%	98.59%	96.96%	100%	98.77%	98.68%
The Norvic Clinic	92.02%	89.56%	99.38%	97.48%			97.78%	85.16%
Northgate Hospital	89.65%	83.10%	97.48%	94%			92.14%	92.20%

(Note: grey sections indicate those areas not providing dementia services)

The Trust has scored above the national average in all aspects. We are also performing well nationally against other NHS Trusts that specialise in solely providing care to patients with mental health and learning disabilities and against the other NHS Trusts in Norfolk and Suffolk.

At an individual site level there are mixed results where some areas have improved on 2016 results but some have deteriorated slightly (it should be noted there were changes by NHS England to questions and scoring methodology).

There are areas to improve on for certain individual sites around standards of cleaning, some internal and external maintenance issues. Work has been completed to offer a wider range of hot foods, more choice where there are specific dietary needs and menus are available in a range of languages.

Quality initiatives

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

Key performance and developments during 2017/18

This section allows the Trust to highlight quality matters from 2017/18 in more detail or that have not been addressed elsewhere in the report.

The examples are reported using the three key components of 'High Quality Care for All' where quality is placed as the organising principle in the NHS. Quality is defined in relation to three domains: patient safety, clinical effectiveness and patient experience.

Patient safety

Promoting Positive Practice Strategy

Our strategy Promoting Positive Practice which launches in April, brings in a number of new initiatives in the fields of leadership, workforce development, use of data to drive quality improvement, restraint reduction tools, service user roles and debriefing to reduce our use of restrictive interventions. All of our wards are writing safety innovation plans, where possible in collaboration with service users. The Patient Safety Team has developed new Statistical Process Control charts to monitor the impact of ward safety plans. All wards are now using Positive Behaviour Support Plans. We have created a central register of blanket restrictions to reduce the number of general rules on our wards.

Service users have been involved in writing the strategy and will also be more involved in day-to-day risk management of the wards, through community meetings. A number of teams have introduced daily safety huddles and reviewed the way that they manage handover periods. Our board will be involved in Executive walk arounds, aimed at quickly helping wards to resolve issues as they emerge. Our Recovery team is working with service users who have experienced restrictive interventions on our wards to produce a video, known as Experience Based Co-Design (EBCD), which will become part of an e-learning package to compliment Prevention and Management of Aggression training.

Suicide prevention

The Trust's Suicide Prevention Strategy was launched as a five-year strategy in February 2017 and focuses on five key domains. There have been many achievements indicating progress with the strategy:

- Clinical Pathways: work continues to review the safety of internal, third sector and external clinical pathways and safer prescribing

  The Trust has hosted a Men's Mental Health Day with another event planned for June 2018. The events aim to contribute to other strands of work that will link support organisations and resources together to increase the availability of male specific interventions

  An external review of serious incidents involving younger people has been undertaken which has enabled learning to be shared and quality improvement initiatives to be developed. Work in mapping out access to supporting services for those in crisis is being carried out

  The Trust is connecting with Public Health in Norfolk and Suffolk to consider ways to engage with gypsy and travelling communities
- Working with family and carers: the Trust facilitated a Suicide Prevention workshop in February 2018 for carers and family members. A pilot project has been initiated in Great Yarmouth and Waveney to implement learning and feedback from the workshop
- Supporting staff with the most up-to-date skills and knowledge: bespoke training sessions have been developed and delivered by the Suicide Prevention Lead to several teams across the Trust. The content of future sessions is being reviewed by Trust educators, clinical staff and service users and carers. Mandatory training is also currently being reviewed
- Innovations: Norfolk MIND and Samaritans in Suffolk are making follow up contact with people who have experienced acute distressing events which have had a single or brief contact with Trust services e.g. acute liaison services
- Plans are progressing for a Crisis Hub to be opened in Norwich into which the Trust Recovery College and Crisis Teams will input and offer support and services

- A trial in Suffolk will begin during 2018 of a Staying Alive app enabling people in crisis access to safety plans (a written list of coping strategies and sources of support for people who are at hig risk for suicide)
- Working with others: the Trust continues to be an active part of both Norfolk and Suffolk Suicide Prevention Steering Groups

Mortality Review

In line with the guidance laid out in the *Learning from Deaths* framework, published by the National Quality Board in March 2017, The Trust published it's Learning from Deaths policy in October 2017 and now informs the process of learning using Serious Incident and Structured Judgement Reviews.

As a trust we are learning as much as we can from other trusts and organisations: our Director of Nursing attends the National Mortality Group and will continue to inform the Trust of the latest guidance. The Medical Director and Director of Nursing have attended meetings and workshops with Mazars, a national consultancy group, in an effort to understand and compare figures, processes and responses. Mazars are working with us to explore local mortality trends, specifically focusing on trends in physical causes, and we will be planning a multi-agency workshop to address issues across the sector.

The Trust is also participating in the Learning Disabilities Mortality Review Programme (LeDeR) which is commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England within 2017. This programme was one of the recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities aiming to provide greater scrutiny and to identify improvements in health and care services. The LeDeR tool is now reporting into the Mortality Review Board (MRB).

The MRB reports to the Quality Governance Committee and the Medical Director reports quarterly directly to the Board of Directors. The main themes of learning are:

- Physical health problems as the most frequent cause of premature death
- Clinical Curiosity is lacking at times during assessment or response to risk
- Education and development: opportunity and time to learn, influenced by workload & capacity

The following actions are currently in place in response to the themes arising from the deaths as discussed in local SI groups and the Mortality Review Group. Progress on themes is monitored in these groups:

- Physical health:
  - ***Physical Health Policy*** C84 has undergone extensive consultation and review, with clinical, operational, service user, carer and IT involvement. The policy was signed off by Board of Directors 22 February 2018. The purpose of the policy is to put in place practice that will have a long-term impact on the length and quality of life in our service users
  - ***Smokefree Policy*** implementation (The Trust will be fully tobacco free) from April 2018 will reduce premature deaths in the long-term
- Clinical curiosity:
  - Improving the level of completeness and quality of risk assessment and care planning. Clear, bespoke, co-produced care plans easily accessible through electronic patient records is at the core of the CPA policy and review of training
  - In order to reduce the number of missed opportunities for engaging a potentially suicidal person in a preventative intervention, the full range of available interventions needs to be known. An Asset Mapping exercise is being conducted across agencies to capture the full range of groups and activities organised by informal, volunteer and third sector. This asset map will allow primary and mental health services to recommend and access a wider range of options that take account of rurality and different styles of engagement. A report will be ready for the May Mortality Review meeting
  - Formulation is an integral part of understanding a service user's needs and communicating it. While the Care Plan lists the interventions, the Formulation provides a reasoning that can help teams respond more accurately in a crisis or indeed prevent a crisis
- Education:
  - Lead Clinician with early intervention expertise to present the Thematic Review into youth deaths to the Child, Family and Young Person Service Education Group
  - Medical Director will send Root Cause Analysis (RCA) / Serious Incident Review Group (SIRG) / Mortality Review findings to the Training Department for incorporation into course content
  - Lead Clinician for Drug and Alcohol services and Service User representatives to provide input and content regarding dual diagnosis training

– Medical Director to send the themes from SIRG and MRG to CTLs, operational managers and lead clinicians for them to be discussed at team meetings and locality governance meetings

Ligature assessments

The Trust approach to ligature risk management has been changed, supported by our 'buddy trust' East London Foundation Trust to an evolving clinically-led and locally owned strategy with corporate services supporting safe care.

Assessments of all ward areas were completed in 2017 and following the agreement of the Trust Executive Team that all fixed and higher rating risk ligature points have either been removed or replaced with anti-ligature fittings or local management protocols have been put in place by clinical staff. The assessments are all accessed on the Trust intranet as live documents that can be accessed by Matrons and Clinical Team Leaders whose responsibility it is to update and modify the assessments directly as part of their management protocols for the identification and management of fixed ligatures. Completion dates are agreed with the Estates and Maintenance teams and included in the assessment so all staff are fully aware of any remedial works. Floor plans remain in place for each ward clearly indicating the high, medium and low risk areas to enable staff to ensure they are fully aware of the risk areas.

Within community bases, work to minimise risks specifically in toilet areas has been prioritised and will be completed by July 2018.

Putting People First Freedom to Speak Up Guardian (PPFFSTUG)

Sir Robert Francis stated in the Freedom to Speak Up Review Report (2015); 'The Boards of all NHS organisations should ensure that their procedures of raising concerns offer a variety of personnel, internal and external, to support staff who raise concerns including:

> A person (Freedom to Speak up Guardian FTSUG) appointed by the organisation's chief executive to act in a genuinely independent capacity'.

The Trust appointed a substantive FTSUG in March 2017. The Guardian is accessible to all staff including, temporary and agency staff, volunteers and students. The primary function of the role is to facilitate improvements to patient care where concerns are raised. Each organisation is mandated to appoint someone to the role but they are free to develop it in a way that works best for their circumstances. So far in the Trust's development this role has raised more issues around how staff work together as opposed to concerns of poor clinical practice.

Cases for 2017/18 numbered 48 up to the end of February 2018. This is broken down into themes for recording purposes:

- 10 x Attitudes and behaviours
- 8 x Staffing levels
- 1 x Staff safety
- 7 x Bullying and harassment
- 7 x Systems, procedures and processes
- 4 x Patient safety and quality
- 3 x Patient experience
- 1 x Performance, capability
- 6 x Leadership and management
- 1 x Other

These themes denote the category the case is raised in and is not an indicator of eventual outcome.

Individuals can contact the PPFFTSUG via email, phone, in person or via confidential answerphone where disclosures can be made anonymously. Only one case has been made anonymously in 2017/18 which is an encouraging indicator that staff have confidence in making contact and that their identity will be kept confidential when requested.

Clinical effectiveness

Early Intervention in Psychosis Service

Over 50% of people with suspected first episode of psychosis are able to access treatment within 14 days from referral as per national guidance since the expansion of the Trust's Norfolk Early Intervention in Psychosis Services. Services have been extended to support people aged up to 65 after receiving additional funding from Norfolk's five clinical commissioning groups (CCGs).

Previously, patients aged between 35 and 65 with suspected psychosis would be referred to the Trust's adult service which does not offer a specialist Early Intervention in Psychosis approach. The additional funding has also allowed the

teams to increase provision of NICE approved interventions such as CBT for psychosis, family interventions, physical health monitoring and employment support.

Crisis service

From the beginning of April 2017 a new out-of-hours crisis service designed to give children and young people across Norfolk and Waveney better access to specialist mental health support during evenings and weekends was launched. The crisis teams are made up of mental health practitioners, nurses, social workers, occupational therapists, assistant practitioners, with support from an on call psychiatrist to carry out out-of-hours assessments when patients with mental health issues arrive at their local A&E.

Its aim is to provide children and young people who are facing a mental health crisis outside of normal working hours with the right help and support, in turn preventing an admission to a mental health inpatient unit. The new service operates between 8am and midnight, and expands on the existing service which provides care during the working day between 9am and 5pm.

Following a successful trial in Great Yarmouth, the service will also run at weekends and bank holidays between 9am and 1pm. Outside of these times, young people will be offered support by mental health workers from the Trust's adult teams.

Norfolk and Waveney Perinatal Service

The Norfolk and Waveney Community Perinatal Mental Health Service was formally launched at the end of September 2017. The team includes two consultant psychiatrists, clinical team leader, nursing staff, psychologists, an assistant psychologist, occupational therapist, social worker, nursery nurse and administrators.

NSFT has been awarded nearly £2.5m by NHS England to develop the service over the next three years. By the third year, it will aim to offer specialist care to 525 pregnant women and new mothers from Norfolk and Waveney with serious mental health difficulties, as well as providing support for the rest of the family.

The service provides care for mothers with conditions such as severe post-natal depression, severe anxiety disorders and obsessive compulsive disorder, bipolar disorder and psychosis. The specialist perinatal service will also offer pre-conception advice about medication and the support needed by woman with a known severe mental illness wishing to conceive. Women will be able to stay under the care of the team until their child is a year old, where appropriate, and can then receive ongoing support from NSFT's community teams if necessary.

The successful application for funding was made jointly by the Trust and the five NHS clinical commissioning groups (CCGs) in Norfolk and Waveney.

The service has been developed in partnership with maternity services at the Norfolk and Norwich University Hospital, Queen Elizabeth Hospital and James Paget Hospital, as well as Cambridgeshire Community Trust, which provides health visiting services and nursery nurses.

The funding was awarded to the Trust after figures showed an estimated 360 women in Norfolk and Waveney have severe perinatal mental health needs and were not able to access specialist perinatal mental health care. It is estimated a further 3,000-5,000 mothers have mild to moderate mental health needs. The specialist perinatal mental health team will also be offering training to professionals in universal services including GPs and primary care, health visitors, maternity services, as well as IAPT and mental health teams to improve the mental health care for mothers, babies and families.

Suffolk Perinatal Service

New mothers from across Suffolk are able to get targeted help for severe post-natal depression and other complex mental health issues as the Trust launched its new specialist perinatal service in February 2018. The East and West Suffolk Perinatal Mental Health Clinic offers specific help to pregnant women with pre-existing conditions as well as those who develop mental health issues following their child's birth.

The service has been commissioned by NHS West Suffolk and Ipswich and East Suffolk Clinical Commissioning Groups and will be delivered in partnership with Ipswich and West Suffolk Hospitals. The Trust team will work closely with midwifery staff at both hospitals, as well as health visitors in the community and other stakeholders such as social services, to coordinate care so that women receive joined-up services. The service is run by a consultant psychiatrist and two senior nurses who will provide a range of support and interventions to women with serious mental illness for up to twelve months following

the birth. The team will also work closely with colleagues within the community who provide perinatal care, while also helping them to identify women who may be at risk of presenting with mental health difficulties.

Learning Disabilities Child and Adolescent Mental Health Service

A specialist service for young people in Suffolk expanded in summer 2017 to support children and young people who have a learning disability to benefit from a wider range of targeted support for mental health problems. The expansion will allow the team to support people aged under 18 to remain at home, in school or within the community, improve their quality of life and maximise their potential. New recruits to the team include clinical psychologists, a behaviour therapist, specialist senior and community practitioners, support workers and administrative staff, will significantly increase capacity in the service. It will also mean the team is able to offer a greater range of specialist assessments and bespoke interventions which have been tailored to meet each service user's needs. At the same time, the service is also developing a specialist behavioural element, which means it will be able to offer targeted functional assessments and intervention for the most high risk cases.

The expansion has been made possible thanks to an investment from NHS West Suffolk and NHS Ipswich and East Suffolk Clinical Commissioning Groups. These improvements follow the commitment of both CCGs, working with partners, to deliver the countywide Children and Young People's Emotional Wellbeing Transformation Plan which, over the next four years, will deliver better services and outcomes and for young people with learning disability and mental health needs. This new development is also a key strand of the Special Educational Needs and Disabilities (SEND) action programme and is responding to issues raised by CQC and OFSTED inspectors in December 2016.

Patient experience

Green Light

The Green Light Toolkit from the National Development Team for Inclusion is an audit tool, setting standards to improve mental health services and ensure that the needs of people with learning disabilities and / or autism are met. The toolkit identifies standards to ensure reasonable adjustments are in place to provide fair and equitable services. An annual audit is undertaken to monitor compliance with the standards and in 2017 this demonstrated that the Trust had improved on 24 of the 27 standards in a 12 month period and were above the national average of other mental health trusts in 25 of the 27 standards.

The Green Light Toolkit advocates that Green Light Champions are recruited within every team as people who have expertise in caring for people with LD and / or Autism and wish to volunteer to drive changes within services. Currently there are 140 Green Light Champions within the Trust, 14 within linked external agencies, eight service users, and two parents / carers.

The Green Light Toolkit also ensures that the Trust is compliant with the NHS England Accessible Information Standards. Work undertaken includes:

- Launch of an Accessible Information policy
- Access to Easy Read leaflets on Trust intranet
- Easy read care plan and appointment letters available on the electronic patient record
- Recording service user communication needs on the electronic patient record to ensure a person's preference is documented
- Currently there are 100 Green Light Champions trained to create Easy Read information
- An Easy Read group has been established including service users

The Trust LD / Autism Strategy entitled '*Green Light for Mental Health Services 2017-2020'* was launched in December 2017. The purpose of the Green Light Strategy is to continue to drive forward improvements in clinical practice. The strategy is monitored through the Making It Happen Strategy Oversight Group (MIHSOG). The membership of this group is multi-agency and has service users, parent and carer involvement.

Recovery College

The recovery college is now in year five (2017/18). It has continued to expand the number of courses offered and student places available.

(QA19) Recovery College provision and uptake

Year	No. of courses on offer	No. of places available	No. of students booked	Average attendance
Year 3	269	3,216	3,078	43%
Year 4	294	3,654	3,019	56.3%
Year 5 term 1	117	1,742	1,467	61%

Our current term, (January - March 2018) has 38 different courses on offer across our five localities. The college has 45 peer tutors supporting the co-development and co-delivering of courses, and who are also involved in promotional events, enrolment sessions and other college activities.

On average, 25% of students attending the college are current staff members. Benefits reported by staff from attending include: improving their own clinical practices, for their own wellbeing, to further develop understanding and knowledge and to support their service users.

We have established a Recovery College within our secure services, with courses being offered at the Norvic Clinic, a regional medium secure unit. We are looking to expand these into our other secure wards and units during this coming year.

The Recovery College receives exceptionally positive feedback through our internal evaluation forms, the Friend and Family Tests and additional research projects. From a sample of over 1,200 students, 99% would recommend the college to a friend or family member.

Work to increase availability and accessibility across all services including those for older people, people with dementia and younger people under 25 years is underway. An Easy Read timetable has been developed to improve accessibility to courses for people with learning disabilities. Shortened courses have been provided to acute wards and regular taster sessions / bite size courses are offered.

Enrolment sessions take place across all localities before each term, providing students with an opportunity to complete an individual learning plan (ILP) to help plan their journey through the college.

A patient reported outcome measure (PROM) called 'Hope, Agency and Opportunity' has been introduced which students complete at the start and end of their college experience.

The Recovery College are committed to increasing opportunities to work with partner agencies, charities and third sector organisations to help support the delivery of new courses. Current work with museums and benefit and employment support agency is in progress and future work with local art projects, housing support and housing agencies and a local horticultural / gardening group is planned.

The Recovery College is proactively looking at opportunities to increase accessibility and opening up our eligibility by working with external agencies on project pilots. These will be evaluated and the results used, when appropriate, to explore any additional funding revenue.

Equality and diversity initiatives

Our three stepped approach in implementing the Equality Delivery System (EDS2) across the Trust has made some progress. Most of our localities have now recruited equality leads and have started their initial equality assessments and developed action plans as part of their local equality objectives. This will remain a continuing process and is now being monitored through our Accountability Review Meeting (ARM).

The next step will require localities to engage with both local service users and carers as well as staff to take part in the EDS grading. This will enable local services to understand how well they are performing against their equality objectives and where they need to improve after consulting with its stakeholders.

Our first Diversity conference "Sharing stories of Inclusion" was co-developed by service users and staff and was held in January 2018. The event was over-subscribed and feedback was very positive. It helped promote equality and diversity, through stories of inclusion shared by staff and service users. The aim was to help staff understand the power of inclusion in supporting

us to achieve an engaged workforce and to deliver a person-centred service to our local population.

During the year 2017/18 the Open Mind group which consists of service users and staff worked alongside the Ipswich Hindu Community Centre to raise awareness in mental health. A series of workshops which were co-developed by staff and service users working alongside the Recovery College and Wellbeing service were facilitated at the community centre. The sessions covered a series of talks and presentations ranging from the types of mental health issues, to what services are available and how they can be accessed.

The group is keen to reach out to the wider Black and Minority Ethnic (BME) communities. The group is now focusing on new recruits of service users and carers and making links to wider BME communities and voluntary community organisations including the Suffolk Refugee Support forum.

The group remit is to also act as a critical friend to the Trust and help provide meaning to BME data in relation to access to services, restraint, seclusion and detention.

A group of equality leads have been volunteering in facilitating equality and diversity training across our organisation. This has been very well attended and feedback has been very positive. This is three yearly training and we have so far trained approximately 70% of our workforce. This means we are well on track to reach 100% compliance by 2019.

Out of Area Placements (OoA)

The Trust has experienced a long period where service users have needed to be placed in OoA beds, particularly older people and adult service lines. Out of Area placements are used both for clinical reasons, that is, where a specialist placement is required and non-clinical reasons, that is, where the Trust does not have an available bed.

The total number fluctuates from month to month and significant resources have been dedicated to reducing the number; however, the issue has persisted and there has not been a consistent period where there were no service users in OoA placements for some time. The numbers are reported on the quality dashboard and have ranged from 12-30 adults of working age and 2-6 older people during the 2017/18 financial year.

Recognising this challenge, the Board set an objective for 2017/18 to make sustained progress towards meeting the national 2020 Five Year Forward View target of ensuring no inappropriate Out of Trust placements aiming for a 50% reduction of Out of Trust placements compared to 2016/17 activity. We were unable to achieve this for many and complex reasons attributed to resourcing challenges within the health and care system, including lack of residential and nursing care beds in the community, funding agreement delays, delays in social worker allocation, changes in admission criteria for low secure services (impacting on acute services) and lack of rehabilitation facilities in the community.

(Within our Trust we refer to OoA as Out of Trust as, while we can place people in a local facility so they do not have to travel long distances, they are not within our wards and under our care.)

The Trust is working with Norfolk County Council, CCGs, acute trusts and other agencies to reduce length of stay and delays in transfers of care to improve flow of care and reduce the number of service users needing to be sent to Out of Trust placements.

These joint initiatives include; funding social worker posts, social care assessors attendance at Board Rounds on admission wards*, clear governance and oversight within Trust and escalation processes with social care directors, commissioning of step down and admission prevention beds and implementation of Red to Green Bed Days systems as described on page 63.

* Board rounds are 'a summary discussion of the patient journey and what is required that day for it to progress. They identify and resolve any waits or delays in the patient's hospital stay. This enhances patient experience and reduces the risk factors associated with a prolonged hospital stay' (NHSi 2018)

National / Regional awards

Electroconvulsive Therapy Accreditation Service

All three of the Trust Electroconvulsive Therapy (ECT) Clinics (Wedgwood House, Woodlands and Julian Hospital) are currently accredited as 'Excellent'.

The Electroconvulsive Therapy Accreditation Service (ECTAS) works with electroconvulsive therapy (ECT) services to assure and improve the quality of the administration of ECT. We engage staff in a comprehensive process of review, through which good practice and high quality

care are recognised and services are supported to identify and address areas for improvement. Accreditation assures staff, service users and referrers, commissioners and regulators of the quality of the service being provided.

Enabling Environment Award

Our Trust's Wensum Assessment and Treatment service at HMP Wayland has achieved an Enabling Environment (EE) award, conferred by the Royal College of Psychiatrists' Centre for Quality Improvement, following a panel meeting of their Special Committee on Practice and Ethics.

The Assessment and Treatment service is one of three national PD Pathway contracts held by our Trust, the other being the HMP Wayland Psychologically Informed Planned Environment (PIPE), which also had its existing EE status reconfirmed, and a community consultation service with the Probation Service.

The services also received a boost in October, following an HMIP inspection report which described them as "excellent".

Enabling environments are those where participants feel safe enough to develop relationships and to share experiences and ideas with others; they are places where everyone can get involved in helping to decide on matters that affect them.

EE status requires a service to demonstrate that it meets ten core standards, designed to promote best practice within public-focused services. Success is achieved by the production of a portfolio of evidence and confirmed via an inspection by Royal College assessors.

The award represents two years of work by staff and residents to develop the service and portfolio.

European Psychiatric Association Scholarship

A Specialist Registrar at Norfolk and Suffolk NHS Foundation Trust (NSFT) has become the only psychiatrist in the UK to win a prestigious scholarship from the European Psychiatric Association (EPA).

Dr Yasir Hameed, who is based at the Julian Hospital in Norwich, has become one of just five specialists to receive the Early Career Psychiatrist Scholarship after demonstrating exceptional clinical practice, leadership, research innovation and management skills.

The EPA will now fund his attendance at the International Congress of Psychiatry, which will be held in Italy in April 2018, and focuses on subjects such as parental mental health, adolescent psychiatry and personality disorder. Dr Hameed hopes to use the visit to share learning while also bringing back best practice from across Europe which could benefit service users locally.

APT-DICES® Award for Excellence in Risk Assessment and Management

Matt Wilding, Community Mental Health Nurse for the Youth Pathway Bury South Integrated Delivery Team (IDT) and Sheryl Parke, Assistant Psychologist at Wedgewood House, West Suffolk Hospital have received an APT-DICES® Award for Excellence in Risk Assessment and Management 2017 from the Association for Psychological Therapies.

These annual awards were established to keep people enthused and thinking about how they can apply training in risk assessment and management in their practice.

Their entry described the setting up of a DICES risk assessment and management clinic as a way of promoting the use of DICES risk assessment and management plans. The aim of the clinic is to provide a time for clinicians - with or without experience and training in DICES - to discuss cases that are causing them concern at present. From this discussion the relevant DICES forms are completed and a risk management plan is developed.

Early Career Award from the British Psychological Society's (BPS) Division of Clinical Psychology's Faculty for Children, Young People and their Families

A Specialist Clinical Psychologist with Norfolk and Suffolk NHS Foundation Trust (NSFT) who was involved in delivering an innovative service to help the victims of child sexual exploitation has been presented with a prestigious award in recognition of her work.

Dr Romana Farooq received the Early Career Award from the British Psychological Society's (BPS) Division of Clinical Psychology's Faculty for Children, Young People and their Families during its annual conference in September 2017. The award is presented to clinical psychologists who have shown significant skill within five years of qualifying.

Dr Farooq leads the Trust's input into Norfolk's Harmful Sexual Behaviour Team, which is a partnership with Norfolk Youth Offending Team. This service provides professionals who work with children and young people with specialist training to identify the signs of sexualized behaviour with the overall aim of reducing offending and protecting vulnerable young people.

She received the award in recognition of work which took place shortly after she qualified in 2015, which saw her set up a community-based therapeutic service in Rotherham for children and young people at risk of, or currently subject to, sexual exploitation. The service was developed following the abuse scandal in 2014, and Dr Farooq was nominated for the accolade by a local councillor.

Commissioner and stakeholder comments

Trust Governors

The Council of Governors appreciate the opportunity to review and comment on the Norfolk and Suffolk Foundation Trust's 2017/18 Quality Account.

The Quality Account for 2017/18 reflects a challenging year for the Trust which was placed into Special Measures for the second time following a CQC Inspection in November 2017. This outcome led to a highly in depth review of personnel, processes and procedures and to a multifaceted programme for improvement. This initially addressed and reported on the key issues of concern identified by the CQC, but it set in train a revised methodology for assuring quality in all aspects of the Trust's business.

The governors took part in the CQC inspection and have been active within the subsequent improvement process. Whilst a number of issues of concern had been regularly raised by the governors, including staffing, serious incidents, unexpected deaths, out of area placements, IT and the service user and carer involvement the governors had encountered a positive bias in the responses given. This has led to our increased focus on evidence of quality, and to sub committees ensuring that the progression suggested has been achieved. The governors have closely monitored the Trust Improvement plan and commend the Trust on making significant changes to recognise and eliminate unsafe practice. They accept however that long term improvement is required which requires a change of culture throughout the organisation against a backdrop of financial constraint.

Quality priorities 2017/18

The Quality Account identified three quality targets which focussed on patient safety, patient experience and clinical effectiveness. Patient safety was a key, overarching concern of the CQC report and the Governors note the work undertaken to reduce restrictive interventions, especially prone restraints. However it appears that information on Independent Mental Health Advocates was only provided to half of the detained patients. Although compliance with the care programme approach is increasing this has been an on-going issue throughout the year. Section 17 leave did not reach its required target and will continue to be monitored. Although there are some improvements the statistics given remain confusing and fail to fully assure progression.

Quality priorities 2018/19

The governors support the emphasis on patient safety and the continuing work stream regarding rapid tranquilisation. Service user involvement and discharge monitoring are systemic issues about which the governors consistently express concern, these will be closely monitored within the Council's business throughout the year.

Staffing:

The Council of Governors is informed by the four staff governors and by undertaking visits and events with the Trust's staff. They were particularly concerned by the results of the NHS staff survey although they recognise that the timing, the rating of special measures and the national shortage of qualified staff impacted on this. The Governors commented frequently on the poor evidence regarding appraisal, clinical and managerial supervision and are pleased to see this being addressed with a greater emphasis on accountability. There is also a significant reduction in the time to hire. Staffing remains a key issue for the Trust which has demonstrated that it will close facilities if the safety of service users would be compromised by failing to retain and recruit sufficient qualified staff. In a period of national shortage it is important that more innovative and outward facing initiatives to effect recruitment are undertaken. Governors consider that staffing will remain a significant and serious issue for the Trust in both the short and medium term.

Patient Safety:

The Governors commend the emphasis on improving patient safety in all areas of Trust responsibility.

Despite lessons being learned the number of unexpected deaths continues to cause Governors concern and this is and will be closely monitored. The Trust has focused initially on safety within the inpatient domain and the governors welcome the initiatives which are starting to occur within the community.

Service user and carer involvement:

Service User and Carer Governors across the two counties report their concerns about their constituents having difficulty accessing Trust services, the seeming lack of co-production on initiatives and the existing system of locality meetings. The governors acknowledge that the Trust is making this strand of service delivery a strategic aim within both the Improvement plan and the 2018/19 Annual Plan, and we endorse this decision as it places service users and carers at the centre of the organisation.

Out of area placements:

The Governors remain concerned at the number of out of area and out of Trust placement used throughout the year. This situation impacts significantly on the service user and their family, as well as on the quality of care received elsewhere. The need to close some beds, underpinned by the CQC requirements for safe practice, exacerbates the problem. The Governors support the activity which the Trust is undertaking to monitor admissions and lengths of stay and to ensure there is a process to support service users who are placed in OOA or OOT beds. The delay in establishing the crisis café initiative is unfortunate and the Governors would like to see more collaborative working to achieve this area of support.

Throughout the document the Governors remain concerned that there appears to be a failure to produce coherent and readily understandable performance data. There is also a lack of clarity in defining and identifying key performance issues. A comprehensive system for data collection and analysis which more clearly defines the process of objective solutions and change should assist everyone involved in the Trust's future progression.

Despite many areas of concern within the Trust the Governors recognise that the organisation has been involved with achieving some very positive developments. The perinatal services across Norfolk and Suffolk, with the proposed inpatient provision are timely initiatives as are the focus on a physical healthcare strategy and the introduction of a no smoking initiative. The Recovery College continues to expand and the concept of recovery is more firmly embedded within the Trust philosophy. The programme of re-building to ensure safety, dignity and appropriate facilities will improve the patient experience and the crisis service for young people will offer more support and prevent admission.

The greater emphasis on understanding the service user and carer experience will provide further evidence to improve existing provision.

Finally the Governors recognise the time and expertise which is inherent in the processes and documentation which inform the Quality Account. They commend the positive change of attitude and culture within the Trust since receiving the CQC special measures rating. They also recognise the major impact this has had on the existing workforce which has to incorporate significant improvement whilst delivering an increasingly complex service. The need to establish and evidence safe, high quality practice is essential for the Trust, and the Quality Account demonstrates a cautious but steady approach towards achieving this.

South Norfolk Clinical Commissioning Group

NHS South Norfolk Clinical Commissioning Group (SNCCG), as the coordinating commissioner for Norfolk and Suffolk Foundation Trust (NSFT) for the Norfolk and Waveney CCG's (Norwich, North Norfolk, South Norfolk, West Norfolk and Great Yarmouth & Waveney), supports the Trust in its publication of the 2017/18 Quality Account.

Having reviewed the mandatory detail of the report, the CCG's are satisfied that the Quality Account incorporates the mandated elements that are required. The CCG recognises that NSFT have undertaken to develop and deliver a significant number of quality improvement initiatives. Going forward the CCG's would like to see NSFT making better use of measurable outcomes using Quality based metrics from quantitative and qualitative data sources to inform where improvement is required and to demonstrate their ongoing improvement and success. The development of a new more robust Quality Dashboard is welcomed.

The CCG's recognise the challenges experienced by the Trust having been placed back into special measures in 2017/18 and the impact that this has had on the organisation as a whole not least its frontline staff. NSFT is currently awaiting feedback from the Section 29a letter submitted to the CQC in March.

The Trust continues to work collaboratively with a range of stakeholders and has received external support from both NHS I and NHS E during the year. The CCG has and will continue to support the Trust through Clinical Quality Review Meetings (CQRM).

Quality Priorities 2017/18

1. To ensure that 80% of inpatient service users with 'challenging behaviour' will have an individualised behaviour support plan informed by a recent holistic assessment.

2. The CCG's confirms that NSFT has achieved the required >80%.

3. To ensure that at least 50% of detained patients will report that they were offered information about Independent Mental Health Advocates (IMHAs).

4. GYW confirms that NSFT has achieved the required >50%, however, improvement is needed during 2018/19.

5. Data reported monthly will demonstrate 95% compliance with core assessments, risk assessments and care plans.

6. The CCG's recognise that some progress has been made however this has been limited (1% overall to date) and further improvement is required. A Contract Performance Notice remains in place. The overarching quality of care plans is also an area that would benefit further improvement. The CCG's recommend that this remains a Quality Priority for 2018/9.

7. To ensure that 95% of service users have their capacity to consent to treatment on admission, recorded in the electronic record.

8. SNCCG are unable to comment on this as the data has not been submitted as part of the monthly reports. SNCCG are working with NSFT to ensure this is included in the Quality Schedule going forward.

9. To ensure that Section 17 leave is managed in accordance with the Code of Practice, monitored by Mental Health Act (MHA) administration team.

10. NSFT have made good progress towards delivery of this Quality Priority. From the data below it can be seen that further work is required to ensure that all patients sign the Section 17 leave form and that a copy of this is provided to the patient and the carer.

Data for January / February 2018

	Section 17 Leave Granted	Section 17 form complete	Section 17 form signed by patient	% Section 17 form signed by patient	Target Section 17 signed by patient	Copy Section 17 form provided to patient	% Copy Section 17 form provided to patient	Target Section 17 provided to patient	Copy Section 17 form to NR/carer	% Copy Section 17 form provided to NR/carer	Target Section 17 provided to NR/carer
Dragonfly	2	2	2	100%	100%	2	100%	100%	0	0%	100%
Foxglove	3	3	0	0%	100%	0	0%	100%	0	0%	100%
Laurel	5	5	4	80%	100%	0	0%	100%	0	0%	100%
Glaven	0				100%			100%			100%
Rollesby	6	6	6	100%	100%	6	100%	100%	6	100%	100%
Thurne	4	4	3	75%	100%	2	50%	100%	2	50%	100%
Waveney	15	15	6	40%	100%	6	40%	100%	1	7%	100%
Whitlingham	11	11	9	82%	100%	9	82%	100%	10	91%	100%
Yare	10	10	6	60%	100%	1	10%	100%	2	20%	100%
Chrchill	5	5	5	100%	100%	4	80%	100%	0	0%	100%
Beach	0				100%			100%			100%
Reed	1	1	1	100%	100%	0	0%	100%	0	0%	100%
Rose	0				100%			100%			100%
Sandringham	4	4	3	75%	100%	4	100%	100%	4	100%	100%
GYAS	10	10	9	90%	100%	9	90%	100%	8	80%	100%

Quality Priorities 2018/19

The CCG's are in support of the key quality priorities for 2018/19. The CCG's do however recommend that the Trust continues to ensure that all Quality Priorities for 2018/19 are designed in such a way that they ensure ongoing delivery of the CQC 'must-do's' and most importantly to ensure sustainable change thereafter. NSFT should ensure that there are SMART Action plans put in place so that all improvements are both measureable and demonstrable.

The CCG's will continue to work with the Trust to monitor and review progress on the areas identified and have made the following recommendations:

Patient Safety

- Audit will demonstrate that at least 95% of a sample of patients will have had their physiological observations taken post rapid tranquillisation complying with National Institute for Health and Care Excellence (NICE) guidance.
- The CCG's agree that this is an important aspect of physical healthcare within mental health, it is however, not the only aspect. Recognising the excellent work undertaken to develop a new Physical Health care Strategy, the CCG's would recommend that this Quality Priority is extended to include the key deliverables identified within that Strategy.

  The CCG also asks that the Trust addresses new key and emerging recommendations to review incident reports and to consider what action you need to take on an individual basis, as well as how you are ensuring the sexual safety of patients on wards in general. This will extend beyond having regard for the national guidance on eliminating mixed sex hospital accommodation because the some of the incidents reported to the NRLS appear to have taken place on same sex wards.

Patient Experience

- To monitor service user and carer involvement in interview panels and to report the percentage of interviews involving a service user or carer in 2018. The aim is to increase the percentage by at least 20% per year towards achieving a 90% target of service users or carers involved with recruitment to all posts that involve contact with service users.
- The CCG's fully support this Quality Priority and recognise the value of service user involvement in recruitment.

Clinical Effectiveness

- To achieve a 10% reduction in service users requiring readmission for clinical reasons within 28 days.
- The CCG recognises the important of reducing the number of readmissions however, as noted above, progress against the 2017/18 priority to ensure that 95% of service users have a core assessments, risk assessment and care plan put in place has been limited. Therefore the CCG's suggest that this should remain as a second Quality Priority for 2018/19.

NSFT continues to take a pro-active approach to the review and reduction of service user mortality.

The Mortality Review Group continues to examine and understand all deaths within the Trust, and the Suicide Prevention Strategy focuses on one of the main causes.

As noted above the Trust continues to demonstrate high levels of reporting for serious incidents and are open and transparent on all matters of patient safety. NSFT are reviewing internal serious incident reporting processes and the CCG looks forward to seeing the revised policy. The CCG has established new quarterly Serious Incident review meetings in partnership with NSFT to undertake regular reviews of SI's and to ensure that the learning is fully implemented.

NSFT have continued to make progress against the delivery of the CQC Action Plan however it is acknowledged by all stakeholders that there are areas that require further improvement. The CQC action plan is comprised of 25 'must do' points of which 14 are rated red including: alarms; staffing; personalised care; access to clinical records; physical health needs; supervision & appraisal and waiting times.

CPA also remains an area of concern. The Trust have been asked to provide urgent narrative and recovery action plan around this including assurance that the quality of care plans is robust.

The fifth meeting of the Oversight and Assurance Group took place in March 2018. This was the final meeting prior to submission of the response to the Section 29A warning letter on the 11th March 2018. NSFT are waiting feedback from CQC following this submission.

We commend the Trust for using a wide range of national and local audits, national and local key performance indicators (KPIs), surveys and other forms of feedback such as the Friends and Family Test (FFT) to gain feedback from service users and their families and to improve services. Whilst outcomes from some of these measures (for example, FFT response rates) are showing signs of improvement there is further work to be done. The Trust continues to explore different ways of improving feedback and engagement.

The CCG notes that the Trust remains focused on reducing the number of Out of Area Placements however the number of admissions to non-NSFT beds continues to cause concern. NSFT are a significant outlier in their use of out of area bed days. NHSI, NSFT and the CCG have met to discuss this ongoing high reliance of Out of Area placements and to agree a plan of action to address this.

NSFT are implementing Quality Assurance processes to ensure that these providers are safe. The CCG will continue to monitor and work with NSFT to ensure that patient safety, effectiveness and experience is not compromised. The CCG's will continue to seek assurance that all waiting lists are being triaged effectively and that no patient is experiencing harm whilst waiting for assessment or treatment.

Finally the CCG's recognise, that while the recent staff survey was undertaken at the time when the Trust returned to Special Measures, there are areas that are of concern. NSFT previously worked hard to improve staff satisfaction through a robust Workforce and Organisational Development Strategy however it is clear there is more to do.

The CCG looks forward to continuing to working in a positive and collaborative manner with the Trust to continue improvements in patient care during the coming year.

Ipswich and East Suffolk Clinical Commissioning Group

Ipswich and East Suffolk Clinical Commissioning Group, as the commissioning organisation for Norfolk and Suffolk Foundation Trust, confirm that the Trust has consulted and invited comment regarding the Quality Account for 2017/2018.

This has occurred within the agreed timeframe and the CCG is satisfied that the Quality Account incorporates all the mandated elements required.

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

Ipswich and East Suffolk Clinical Commissioning Group is currently working with clinicians and manager from the Trust and with local service users to continue to improve services to ensure quality, safety, clinical effectiveness and good patient/care experience is delivered across the organisation. This Quality Account demonstrates the commitment of the Trust to improve services. The Clinical Commissioning Group endorses the publication of this account.

Norfolk Health Overview and Scrutiny Committee

The Norfolk Health Overview and Scrutiny Committee has decided not to comment on any of the Norfolk provider Trusts' Quality Accounts and would like to stress that this should in no way be taken as a negative comment. The Committee has taken the view that it is appropriate for Healthwatch Norfolk to consider the Quality Accounts and comment accordingly.

Suffolk Health Overview and Scrutiny Committee

As has been the case in previous years, the Suffolk Health Scrutiny Committee does not intend to comment individually on NHS Quality Accounts for 2018. This should in no way be taken as a negative response. The Committee has, in the main, been content with the engagement of local healthcare providers in its work over the past year. The Committee has taken the view that it would be appropriate for Healthwatch Suffolk to consider the content of the Quality Accounts for this year, and comment accordingly.

Healthwatch Suffolk

Patient Experience / Improve Service User Experience

To ensure that at least 50% of detained patients will report they were offered information about IMHAs.

This is a very important part of ensuring detained patients understand the full range of their legal rights. We welcome the improvement to 53.57% but still question whether a 50% target for this is ambitious enough?

NHS Staff Survey

A disappointing set of results this year as acknowledged by the Trust. It's good to see Management listed as a priority as the survey would indicate a sharp deterioration in staff reporting good communication between staff and senior managers. We welcome the Executive listening sessions, but the Trust should be aware that there is a weariness amongst staff, service users and Carers who experience being listened to but report not see any resulting action.

Clinical effectiveness

Early intervention.

We welcome the expansion Norfolk's EI service but can see no equivalent development for Suffolk.

Recovery College

Now in year 5, the college continues to achieve 'exceptionally positive feedback' for service users, Carers and staff, and is highly valued with CQC and many, if not all partners. In light of this has the college been supported and funded to an extent that the maximum number of people across the Trust can benefit?

Quality priorities in 2018/19:

Physical health monitoring following rapid tranquillisation.

This is an agreed essential, life preserving safety requirement and we are not clear why the aim is for less for than 100% of affected service users to receive physiological observations in line with NICE guidelines.

This is related to the 2017/18 quality priority of reducing restrictive interventions. It is good to see that the work carried out in 2017 and the new Promoting Positive Practice Strategy has contributed to the Trust recently beginning to meet compliance of 80% of identified inpatient service users having an individualised behaviour support plan. We would encourage the Trust to continue to concentrate efforts on consistently reducing restrictive interventions.

Patient experience / Service user and carer involvement: Values Based Recruitment.

Last year the quality account indicated that a system would be established to capture the percentage of interview panels held where there was a service user or carer on the panel.

It would indeed be helpful to reference the starting base and to identify whether there are service lines or geographical areas where there is a pressing need to recruit, train and sustain an active list of service users and carers available.

Given the constant recruitment drive and staff turnover, together with the past shortage of VBR training courses, there is a real opportunity to invest in a "new start" for this aspect of co-production and engagement.

We would wish to encourage the Trust that a drastic overhaul and improvement in service user, carer and staff engagement generally would be one of the single most important drivers of quality improvement overall.

The Trust should note that as this happens a growing number of posts will involve service user and carer contact that haven't up to now. They should consider working towards 100% of interviews involving service users.

Clinical effectiveness / improve service user experience, 2017/18

The trust has made good progress in having 92.75% care plans in place although we would like to see an improvement in the 73.55% of core assessments being in place.

Over and above this compliance we welcome the trusts focus on the quality of all aspects of care plans.

Clinical effectiveness / inpatient discharges:

We note the plans to establish a purposeful inpatient admissions model and, to be successful, service users experience of care must be integrated as a core driver of change.

Healthwatch Norfolk

Healthwatch Norfolk appreciates the opportunity to make comments on the NSFT Quality Account for 2017/18.

In terms of the format of the document we could not find any details about how to obtain the document in large print, Braille or another

language. There is a list of abbreviations and acronyms, which is helpful to the lay reader.

There is no currently Executive Summary or CEO Statement. The document presents some quality information however it is not easy for members of the public to understand. This could perhaps be addressed through adding an Executive Summary in plain English. The layout and formatting of the draft document did not assist navigation or interpretation. There is no index and it is not easy to follow where different sections begin and end.

2017/18 priorities for improvement are stated as having been:

1. Patient safety / reduce restrictive interventions
2. Patient Experience / Improve Service User experience
3. Clinical effectiveness / Improve Service User experience

As per last year the format used in this section is "where we were" and "where we are now". As we commented last year, it is not always clear where the starting point is and whilst there is detail of the processes that have been put in place, the actual outcomes achieved are not always clear.

It appears that work on the first of these priorities has only really begun from January 2018. It is not possible from the data given to determine if the target has really been achieved or not. Different terminology about what is actually being measured compared to what the target was defined as make any conclusions impossible.

The second priority states that there was no base line data until January 2018 so it is impossible to determine whether this target has been met although one set of figures for just March 2018 would indicate the 50% target had just been met. This section talks about liaison with the Suffolk User Forum to increase the profile of advocacy services but there is no mention of similar work in Norfolk.

Last year 87.8% of inpatients said they would recommend the Trust to their family and friends (an increase of 4.4% on the previous year) but we were unable to draw any conclusion as to the actual score of the Friends and Family Test this year as the test is not clear on this matter.

We could not find any reference to the 'Duty of Candour' policy this year.

We could not find data on numbers or themes of complaints.

The figures reported for staff feeling able to recommend the Trust as a provider of care to their family and friends are disappointing at 3.26 /5 compared to a National Average of 3.67 which places the Trust as one of the lowest ranking in this area and a decline of 0.11 since last year.

We could not find any mention of the actual numbers of unexplained deaths during 2017-18 although there is comment about the themes of learning from the mortality review. We would have expected more detail on this.

There are large amounts of data missing or yet to be provided which makes the document almost impossible to comment upon. We cannot say that this account provides a clear picture of the effectiveness and management of the trust.

It would appear that following the latest CQC inspection there has been a great deal of work begun in many areas of Quality Governance but no evidence as of yet as to its effectiveness.

We remain totally committed to work with the Trust to ensure that the views of patients, their families and carers are taken into account and to make recommendation for change, where appropriate.

Key

BNF	British National Formulary
BoD	Board of Directors
CAMHS	Child and Adolescent Mental Health Service
CCGs	Clinical Commissioning Groups
CPA	Care Programme Approach
CQC	Care Quality Commission: www.cqc.org.uk
CQUIN	Commissioning for Quality and Innovation
DCLL	Dementia and Complexity in Later Life
DH	Department of Health
DPA	Data Protection Act
EBCD	Experience Based Co-Design
ECT	Electroconvulsive Therapy
ECTAS	Electroconvulsive Therapy Accreditation Service
EE	Enabling Environment
EIP	Early Intervention in Psychosis
EWS	Early Warning Score
FFT	Friends and Family Test
GP	General Practitioner
HQIP	Healthcare Quality Improvement Partnership
IAPT	Improving Access to Psychological Therapies
IDT	Integrated Delivery Team
ILP	Individual Learning Plan
IMHA	Independent Mental Health Advocate
IPAC	Infection Prevention and Control
LD	Learning Disability
LeDeR	Learning Disability Mortality Review Programme
LIPACS	Local Infection Control Prevention and Control Supporter
MCA	Mental Capacity Act
MHA	Mental Health Act
MHLF	Mental Health Law Forum
MIHSOG	Making it Happen Strategy Oversight Group
NCAP	National Clinical Audit of Psychosis
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCISH	National Confidential Inquiry Into Suicide and Homicide by People with Mental Illness
NHS	National Health Service
NHSI	NHS Improvement
NICE	National Institute of Health and Care Excellence: www.nice.org.uk
NPSA	National Patient Safety Agency: www.nrls.npsa.nhs.uk
NRLS	National Reporting and Learning Service
NSAID	Nonsteroidal anti-inflammatory drug
NSFT	Norfolk and Suffolk NHS Foundation Trust
OFSTED	Office for Standards in Education, Children's Services and Skills
PALS	Patient Advice and Liaison Service
PBSP	Positive Behaviour Support Plan
PICU	Psychiatric Intensive Care Unit
PIPE	Psychologically Informed Planned Environment
PLACE	Patient Led Assessment of the Care Environment: www.england.nhs.uk
PMO	Project Management Office
POMH-UK	Prescribing Observatory for Mental Health
PROM	Patient Reported Outcome Measure
QIP	Quality Improvement Plan
RCA	Root Cause Analysis
SAR	Safeguarding Adult Review
SCR	Serious Case Review
SEND	Special Educational Needs and Disabilities
SI	Serious Incident
SIRG	Serious Incident Review Group
SMI	Severe Mental Illness
SPoA	Single Point of Access
STP	Sustainability and Transformation Plan
SU&CTPM	Service Users and Carers Partnership Meeting
TPM	Trust Partnership Meeting
WAT	Wound Assessment Treatment

Norfolk and Suffolk
NHS Foundation Trust

Annual accounts

for the year ended
31 March 2018

Statement of the Chief Executive's responsibilities

as the accounting officer of Norfolk and Suffolk NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on NHS Improvement by the NHS Act 2006, has given Accounts Directions which require Norfolk and Suffolk NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Norfolk and Suffolk NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance, and
- Prepare the financial statements on a going concern basis

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

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

Signed: 

Antek Lejk
Chief Executive

Date: 22 May 2018

KPMG

Independent auditor's report

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

. REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Norfolk and Suffolk NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which 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, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of the Trust's income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview		
Materiality: Trust financial statements as a whole	£3.3m (2016-17:£3.3m) 1.5% (2016-17: 1.5%) of total operating income	
Coverage	100% (2016-17: 100%) of trust total operating income	
Risks of material misstatement		**vs 2016-17**
Recurring risks	Valuation of land and buildings	◀▶
	Recognition of NHS and non-NHS income	◀▶

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows (unchanged from 2016-17):

	The risk	Our response
Land and buildings £113.0 million; (2016-17: £114.0 million) *Refer to page A25 (accounting policy) and pages A50 to A51 (financial disclosures).*	**Subjective valuation** Land and buildings are required to be held at current value in existing use. The Trust's main land and buildings relate to sites across Norfolk and Suffolk; As hospital buildings are specialised assets and there is not an active market for them they are valued on the basis of the cost to replace them with an equivalent asset (Depreciated Replacement Cost); The appropriate valuation of land and buildings relies on: the expertise of the valuer and the accuracy of the records provided to the valuer to prepare the valuation; The Trust commissioned external valuers, to carry out a desktop review of land and buildings as at 31 March 2018, which resulted in an immaterial movement. The previous full valuation was carried out as at 31 March 2017 There is a risk that land and buildings values are materially misstated, therefore our work focused on whether the basis of valuation as at 31 March 2018 was appropriate.	Our procedures included: — **Assessing valuer's credentials:** We assessed the scope, qualifications and experience of the valuer and the overall methodology of the valuation performed to identify whether the approach was in line with industry practice and the valuer was appropriately experienced and qualified to undertake the valuation; — **Benchmarking assumptions:** We compared the valuer's assumptions to externally derived data by comparing to other available indices to determine whether they are indicative of local market conditions; — **Test of detail:** We reviewed the valuation of any additions to land and buildings made during the year to ensure they have been appropriately revalued to fair value and that an appropriate valuation basis has been applied; – **Our sector experience:** We reviewed the use of assets across the estate to ensure that the valuation methodology remains appropriate. In particular, with regards to the Hellesdon site, we have made inquiries to determine whether there have been any changes to the FTs capital plan. As part of this, we assessed whether the useful economic life remains appropriate; and – **Indicators of impairment:** We reviewed board meeting minutes to identify any changes in use or indicators of impairment of the Trust's land and/or buildings, which could lead to a change in the valuation.

	The risk	Our response
NHS and non- NHS income Income: £227 million (£215 million; 2016-17) Refer to page A24 (accounting policy) and pages A33 to A34 (financial disclosures).	**Recognition of NHS and non-NHS income** Of the Trust's reported total income, £213 million (2016/17, £203m) came from commissioners (Clinical Commissioning Groups (CCGs) and NHS England). Seven CCGs and NHS England make up 94% of the Trust's income. The majority of this income is contracted on an annual basis, however actual achievement is based on completing the planned level of activity and achieving key performance indicators (KPIs). If the Trust does not meet its contracted KPIs then commissioners are able to impose penalties, reducing the level of income achievement.	Our procedures included: **Tests of detail:** — obtaining the outcome of the agreement of balances exercise with other NHS bodies. Where there were significant mismatches we sought explanations and supporting evidence to verify the Trust's entitlement to the receivable;

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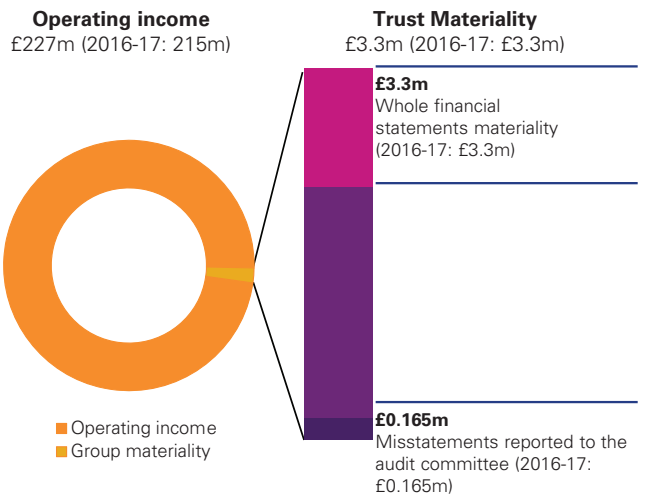
	The risk (Continued)	Our response (Continued)
NHS and non- NHS income Income: £227 million (£215 million; 2016-17) Refer to page A24 (accounting policy) and pages A33 to A34 (financial disclosures).	In 2017-18, the Trust received transformation funding from NHS Improvement. This is received subject to achieving defined financial and operational targets on a quarterly basis. The Trust received a total of £3.1m transformation funding. Additional funding is available at year end if targets are achieved. An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances from each party in transactions and variances over £300,000 are required to be reported to the National Audit Office to inform the audit of the Department of Health consolidated accounts. The Trust reported income of £13.9 million (2016/17: £12.8 million) from other activities, primarily education and training, research and development, and other activities. There is a greater risk that the income has not been recognised under the accruals basis, and instead on a cash basis.	We obtained copies of the signed contracts in place for the largest CCG commissioners and NHS England. For a sample of contracts, we reconciled the income per the contract to the actual income recognised in the year and agreed variances to source documentation; We re-performed the Trust's calculation of performance against the financial and operational targets used in determining receipt of transformation funding to determine the amount the Trust qualified to receive. We agreed the amounts recorded in the accounts to our calculation; We tested a sample of non-NHS income items to third party notifications confirming that income has been recorded in the correct accounting period; and We reviewed invoices and credit notes raised around the year end date to ensure the income had been recognised in the correct accounting period

3. Our application of materiality and an overview of the scope of our audit

Materiality for the Trust's financial statements as a whole was set at £3.3 million (2016/17: £3.3 million), determined with reference to a benchmark of operating income (of which it represents approximately 1.5% (2016/17: 1.5%)).

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £165,000 (2016/17: £165,000), in addition to other identified misstatements that warranted reporting on qualitative grounds.



4. We have nothing to report on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work, we have not identified material misstatements in the other information.

In our opinion, the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trusts's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page A2, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

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Our conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is qualified

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Qualified conclusion

As a result of the matters outlined in the basis for adverse conclusion paragraph below, we are unable to satisfy ourselves that, in all significant respects Norfolk and Suffolk NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for adverse conclusion

The Trust was put back into special measures after an inspection by the Care Quality Commission (CQC), rated the trust as 'overall inadequate' in October 2017. The Trust is in the process of implementing a quality improvement plan but remains in special measures.

The findings and overall rating of this report is evidence of weaknesses in arrangements for planning, organising and developing the Trust's resources effectively to deliver strategic priorities.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out below together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Regulators – external review	Foundation Trusts are subject to external review including the CQC. The results of these reviews give an indication of whether the Trust is effectively deploying it's resources to provide a good quality of service.	Our work included: • Review of the CQC reports issued; and • Review of the special measures quality improvement plan and understanding of the processes in place to monitor delivery of the plan. **Our findings on this risk area:** • In October 2017 the Trust was placed back into special measures after being rated as inadequate by the CQC. The Trust is in the process of implementing the quality improvement plan but remains in special measures; • The CQC report and findings from this is evidence of weaknesses in arrangements for planning and deploying resources to deliver the Foundation Trusts priorities effectively.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Norfolk and Suffolk NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Stephanie Beavis
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
Dragonfly House
2 Gilders Way,
Norwich,
NR3 1UB

25 May 2018

Annual Governance Statement

1. Scope of responsibility

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Norfolk and Suffolk NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Norfolk and Suffolk NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Trust has a Risk Management Strategy and operational policies approved by the Trust Board. Leadership is given to the risk management process through a number of measures, including designation of Executive and Non-executive Directors to key committees within the Trust's governance structure.

The Audit and Risk Committee has delegated responsibility for ensuring the Board Assurance Framework is well-maintained and other board committees review risks relevant to their terms of reference. Locality management team meetings review their locality risk registers.

The Company Secretary has delegated authority for ensuring the implementation of the Assurance Framework. All directors have responsibility to identify and manage risk within their specific areas of control in line with the management and accountability arrangements within the Trust.

The Risk Management Department provides support to localities and departments on all aspects of effective risk assessment and management. The department maintains the Trust's incident and risk reporting system and risk registers. Training is provided by the Department and is also included in the Trust's mandatory training requirement for all staff.

The Service Governance team is responsible for the dissemination of good practice and lessons learned from incidents or near misses. Good practice is disseminated within the Trust through information sharing, cascading of information via newsletters and via the groups and committees within the governance structure. The Trust has implemented reflective learning groups, provides a regular patient safety update that promotes learning and has identified dedicated time in community teams to discuss incidents.

The Board of Directors regularly reviews its governance structures and systems against latest guidance and reports. This supports assurance that the Trust's performance management systems are working effectively.

4. The risk and control framework

Management of risk

Attitude and management of risk is embedded within the Trust's Risk Management Strategy, which provides the framework for the management of both clinical (patient-related) and non-clinical risk to provide a safe environment for service users, their families and carers, visitors and staff. The strategy also provides a framework for managing organisational risks at local and Trust-wide levels. It sets out the organisational structure for reporting and review of risks at all levels.

The main focus of the Risk Management Strategy is the risk management culture that engages all staff. The Board of Directors is committed to ensuring risk management forms an integral part of its philosophy, practices and business plans. It also demonstrates that the Trust is open with stakeholders, receptive to challenges and keen to learn.

The Risk Management Strategy describes the risk management process and provides clear lines of accountability to ensure that all risks are appropriately managed with action plans to mitigate against occurrence or reduce impact to an acceptable level. The strategy empowers staff to make judgments and decisions concerning the management of risk and risk taking.

All services assess their own risk profiles, which are reported and recorded on the Trust's risk register with an action plan to eliminate or reduce the risk. The Risk Management Department monitors active risks with oversight of the process by the Audit and Risk Committee. Risks are assessed using a 5x5 risk assessment matrix where the total score is an indicator as to the seriousness of the risk.

Each Locality or corporate team assesses their services and records risks that threaten their services. Risks are monitored and reviewed on a monthly basis at the Locality Governance or corporate team meeting. The results of the review are recorded on the register. Risks are managed at the level at which they are owned.

Risks are escalated according to the level of the risk rating.

- Risks rated 1-11 are held at local level
- Risks rated 12 and above are escalated to and monitored by the committees of the Board. The Trust Executive meeting receives a monthly update and each Board Committee monitors its risks at least quarterly

For each risk rated 15 or above a detailed narrative update is prepared quarterly by the risk manager, in consultation with the relevant Executive Director, for the relevant Board Committee.

During 2017/18 the Board continued to develop the format and structure of the Board Assurance Framework (BAF). The Trust's Risk Manager liaises with the Company Secretary four times a year to cross-reference the Trust's Risk Register with the BAF. The Board Assurance Framework is reported to the Board four times per year and is reviewed by the Audit and Risk Committee at each meeting (also quarterly).

Risk management is embedded in the activity of the organisation. For example, The Trust policy Promoting Equality, Diversity and Inclusion emphasises the Trust's public sector equality duty and other legal obligations. The Equality Assessments policy Q04 requires that "Equality assessments will be conducted/reviewed for all new/revised policies/strategies/projects and services. Any report recommending a new policy or function, or reviewing an existing one, will also include a completed Equality Assessment"

The Trust has business continuity plans in place to address the key risks identified.

The Trust was not affected by 'Wannacry' (the cyber-security attack on the NHS in 2017) and has had additional investment in cyber-security during the year to reinforce our systems from attack. NHS Improvement has mandated that all health and care provider organisations report on their compliance with the 2017/18 Data Security Protection Requirements. Of the ten requirements, NSFT is fully compliant on nine and partially compliant for the remaining one for which an action plan is being finalised with NHS digital and will be agreed by the end of May 2018.

Control framework

The Trust has established an Assurance Framework to support the Corporate Governance Statement. The framework ensures the collection and review of evidence that an effective system of control operates within the Trust. The framework includes:

- The consideration of risks to strategic objectives through the Board Assurance Framework
- Regular review of longer-term corporate and strategic risks by the Executive Team and Board of Directors
- Results of the Care Quality Commission specific reviews and outcomes from site visits, including Mental Health Act inspections

- Comprehensive live risk register that includes strategic, corporate, financial, clinical and other non-clinical risks
- Regular reviews of risk register by the Board of Directors, Audit and Risk Committee, with relevant risks being reviewed by the appropriate board committee and the Executive Team meeting
- Regular visits (including unannounced) to clinical areas by both Executive and Non-executive Board Members
- Feedback from external bodies, including NHS Improvement (referred to as NHSI, previously Monitor), Care Quality Commission, and NHS Litigation Authority (NHSLA)
- Root Cause Analysis reports, which include learning from patient safety issues, with any significant themes included in reports to the Board of Directors where appropriate
- A wide range of communication and consultation mechanisms also exists with relevant stakeholders, both internal and external, which includes the use of external advisors, where appropriate, to assist in determining the extent of a particular risk

Trust Risks

The Trust's 2017/18 major risks and mitigations are noted below.

Staffing

Risk: The inability to recruit sufficient staff with appropriate qualifications could affect patient care and staff morale.

Mitigations: Vacancy levels are comparable with other MH Trusts but it is important to recognise risks in some areas where there are particularly high staff vacancy pressures. This required the temporary closure of some beds in 2017/18 to ensure patient safety. Additional administrative capacity to support clinical team leaders was introduced in 2017/18.

Leadership

Risk: Inconsistent leadership results in poor management of people and performance and accountability.

Mitigations: Following the departure of three executive directors mid-year, senior leadership was supported by acting and interim directors with substantive recruitment to these vacancies due to be completed in 2018. The interim arrangements ensured that the quality improvement requirements were acted upon and the response to the CQC section 29a letter was submitted on 9 March 2018.

Data quality

Risk: poor data quality results in inaccurate information about performance.

Mitigations: Arrangements to improve data quality also strengthened during 2017/18 through the work of the Digital Information Improvement Group (DIIG) leading to a revised performance dashboard from April 2018. The DIIG work streams continue into 2018/19 and consist of:

- Skills, capability and capacity
- Systems performance
- Data cleanse
- Performance reporting

Demand and capacity

Risk: Managing demand is a risk for the Trust with demand continuing to rise above the indicative activity plan levels.

Mitigations: 2017/18 has seen mitigation through strengthening of risk management for waiting lists, improved caseload monitoring, and preparation for new models for supporting people in crisis, but these have not yet led to a reduction in this risk.

The Trust Board

The Health and Social Care Act (2012) places a duty on the Board as a whole, and directors individually, to act with a view to promote the success of the Trust and maximise the benefits for members and the public. In relation to risk and control, the Board fulfils this duty through the governance structures of the Board and its committees. This structure is complemented by a policy and procedure framework that covers risk assessment and management, the scheme of delegation, standing financial instructions and the allocation of responsibility to specified post holders across the organisation.

In 2017/18 Board of Director Committees consisted of:

- Audit and Risk Committee
- Quality Governance Committee
- Performance and Finance Committee
- Charitable Funds Committee
- Mental Health Act Hospital Managers Committee
- Remuneration and Terms of Service Committee (which acts as a nominations committee for executive director posts)
- Organisational Development and Workforce Committee

Through the information received from these committees and presented at the Board, the Board has a high level of oversight of the Trust's performance.

The Trust's Audit and Risk Committee oversees the effectiveness of the organisation's governance structures including the information used to assess risks to compliance with the Trust's licence. The Quality Governance Committee plays a specific role in assessing quality risks and has a reporting link to the Audit and Risk Committee as well as a Non-executive Director (the Senior Independent Director) who sits on both committees.

The Quality Governance Committee is chaired by the Senior Independent Director. A report is made to the next Board of Directors meeting following each committee meeting. There are close links between the Audit and Risk and Quality Governance Committees and all committees cross-refer issues where appropriate.

The Performance and Finance Committee is chaired by a Non-executive Director. It is responsible for ensuring the effective management of all of the Trust's affairs, including management of the Trust's cost and finance base, significant investment decisions, and overall performance. This committee has the capacity to scrutinise Trust performance and escalates areas of concern to the Board of Directors. The committee monitors the Trust's cost improvement programmes and provides oversight of the organisation's integrated performance management systems. A report is made to the next Board of Directors meeting following each committee meeting.

The purpose of the Charitable Funds committee is to ensure that charitable funds are properly collected, invested and allocated in line with overarching statutory and policy requirements and in accordance with any specific requirements attached to individual funds or bequests. The Committee acts to ensure the Trust meets its obligations as a corporate trustee as set out by the Charities Act and other related legislation and regulations. It acts as a host for other NHS Trust charitable funds. A report is made to the next Board of Directors' meeting following each committee meeting.

The Organisational Development and Workforce Committee is chaired by a Non-executive Director. It recommends and oversees the approval and review of the Trusts Organisational Development and Workforce strategy and associated implementation plans. It has oversight of all employee related matters including, but not limited to, recruitment and retention plans, workforce remuneration and terms and conditions, employee / staff side consultation issues and concerns and staff engagement activity. The committee monitors workforce performance data and employee development and training and oversees the staff survey action plan. It monitors the elements of the Quality Improvement Plan (overseen by the Transformational Project Board) that relate to the committee's areas of responsibilities. The committee reports to the Board of Directors following each meeting highlighting areas of assurance, concerns and risks.

As a mental health NHS Foundation Trust, the Trust sometimes needs to detain and treat patients against their will under the Mental Health Act (MHA) (1983). Within this statutory framework there is a requirement for hospital managers (who are not employed by the Trust, and who are independent of the Trust's management) to review detentions and decide whether they continue to be required. The MHA Hospital Managers' Committee serves this function and is chaired by a Non-executive Director. An annual report from this committee is reviewed by the Board of Directors.

The Remuneration and Terms of Service Committee oversees the appointment and remuneration of executive directors, as well as providing assurance on the process for setting objectives and performance appraisal. The committee also oversees succession planning and Board skill mix. A report is made to the next Council of Governor's meeting following each Remuneration and Terms of Service Committee meeting.

The Nominations Committee is primarily a Council of Governors committee that oversees recruitment and appraisal of the Chair and Non-executive Directors.

Following the Trust's return to 'Special Measures' a Quality Programme Board was established to focus on the improvement plan and specifically the requirements of the Section 29A letter from the Care Quality Commission. The Quality Programme Board is chaired by the Chief Executive and membership includes a Non-executive Director and all other Executive Directors. The Programme Board reports to the Trust Board.

Equality and Diversity

The Head of Equalities and Engagement supports staff in equality assessment arrangements in line with the Equality Act (2010). In April 2016 the Board of Directors approved a three-stepped approach to meeting its Equality Delivery System (2) objectives. This consists of the appointment of local equality leads, a local assessment and an action plan based on this. The three-stepped approach is monitored through the Trust's Performance Accountability Reviews. Guidance is available for staff carrying out service based equality assessments and policy equality assessments and where service plans change assessments are updated. In order to support the implementation of equality assessment plans the Trust has developed several key documents based on the Equality Act's protected characteristics. These include practice guidelines on supporting lesbian, gay and bisexual service users, spiritual and pastoral care guidelines, guidelines for supporting transgender service users and staff and guidance on challenging racist and discriminatory behaviours. Compliance with human rights legislation is supported through the work of the Head of Equalities and Engagement and the Safeguarding Team, as well as the Mental Health Law Forum which oversees policy and practice in relation to the mental capacity and mental health legislation.

Data security

The Trust manages its information risks by undertaking an annual information governance audit using the NHS toolkit provided for this purpose and seeking to improve year on year. The Trust has undertaken the 2018 assessment and is 93% compliant (an improvement from 91% last year).

Public stakeholders

The Trust engages with its public partners in a number of ways relating to risk, including:

- Sustainability and transformation partnerships (STPs) and integrated care systems (ICSs), to develop and implement shared proposals to improve health and care in the local economy
- A&E delivery boards, where risks to services are managed jointly by the participating organisations
- Commissioning Quality Review Group – a commissioner / provider forum to discuss and address issues of quality and risk

Foundation Trust License

The Foundation Trust is not fully compliant with the registration requirements of the Care Quality Commission. Following a CQC inspection in July 2017, the Trust was rated as "inadequate" overall in October 2017 and as a result it was then placed in special measures by NHS Improvement (Monitor). The rating across the five domains was as follows:

Safe – Inadequate

Well-led – Inadequate

Effective – Requires Improvement

Responsive – Requires Improvement

Caring – Good

The Trust has published the full report via a link from its public website home page www.nsft.nhs.uk

In its letter to the Trust, NHS Improvement noted,

> "NHS Improvement has reasonable grounds to suspect that the Licensee has provided and is providing healthcare services for the purposes of the NHS in breach of the following conditions of its licence: FT4(2), FT4(4)(a)-(c), FT4(5)(b), FT4(5)(c), FT4(5)(e), FT4(5)(f) and FT4(6)(a)-(f).
>
> 1.1. In particular:
>
> 1.1.1. Following inspections of the Licensee by the Care Quality Commission ("CQC") in July 2017, the CQC found the Licensee to

be "inadequate" overall. CQC highlighted the following specific areas in which the service provided by the Licensee was 'Inadequate': are the services safe; are the services well led.

These findings are set out in the CQC's report dated 13 October 2017 (the "CQC Report").

1.1.2. The Licensee has been issued with a Section 29A warning notice where the CQC found failing with systems and processes that did not operate effectively to ensure that the risks to patients were assessed, monitored, mitigated and the quality of healthcare improved in relation to: systems to monitor and learn for quality and performance information; ligature point management and environmental risks; seclusion environments and seclusion practice; accommodation for men and women; staffing levels; management oversight and governance to ensure staff had regular supervision, appraisal and training; access to services; risk assessment and care planning; access to alarms and emergency equipment.

The breaches by the Licensee detailed in 1.1.1. and 1.1.2. above demonstrate a failure of governance arrangements in particular but not limited to a failure by the Licensee to ensure appropriate systems and standards of governance, adequate oversight by the Board and establishment and implementation of associated governance systems and processes including those relating to quality and to ensure appropriate and sufficient capacity."

The CQC issued a S.29a letter which set out the areas where substantial improvement was required by 11.03.18. The Trust submitted its response to the S.29a letter on 09.03.18.

Following the S.29a letter, the Trust developed an improvement plan against which progress has been regularly monitored. Progress reported immediately following the year end confirmed the majority of elements on the plan were rated Green or Amber; with only 5% rated Red. The Trust continues to make progress on the plan and there is a clear plan for addressing the Red and Amber elements.

Other controls

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

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

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

Further information is given in the Annual Report.

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

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

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

In response to the CQC report, and as part of its commitment to quality improvement, the Trust introduced a Quality Programme Board (QPB) (which reports to the Board) supported

by a Quality Mobilisation Group (QMG). The QPB supports board assurance that the quality improvement plan including actions from the CQC inspection report. The QMB focuses on the detail of the planning and actions to deliver quality outcomes. It provides support and challenge to service line leads and reports to the QPB.

The Executive team report any concerns to the Board on a monthly basis and it is the Board who is ultimately responsible for ensuring the economic, efficient and effective deployment of resources.

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

The Trust is an active member of the NHS Benchmarking Network, a member community involving over 330 health and social care organisation throughout the UK which combines benchmarked information with evidence based good practice to identify key areas of service improvement and resource provision.

The Trust has recently become a member of the NHS Improvement Mental Health and Community Procurement Savings Collaborative, along with 26 other cohort trusts which aims to help improve procurement capabilities in trusts and identify and realise savings in non-pay expenditure.

6. Information Governance (IG)

During 2017/18, there was one Information Governance (IG) incident that required upward reporting to Department for Health and the Information Commissioner (ICO). In this incident a member of staff sent a fax containing sensitive personal data to the CQC instead of a GP surgery. We reported this to the ICO who determined that our policy, process and training met their requirements and accepted that this was a failing of the individual involved; they advised that no further action was required.

The IG Sub Committee and its operational sub-group have continued to work towards preparation for the EU General Data Protection Regulation (GDPR); for which we are well placed. In addition to the Annual Report, routine quarterly reports to the Audit and Risk Committee are now being issued after the IG Group's full meetings.

The Information Governance Manager has remained the Chair of the Suffolk Clinical Information Assurance Group (CIAG) and the Norfolk IG Peer Group to ensure that the Trust is well placed to influence, support and develop the IG agenda across both counties.

7. Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports, which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Trust has produced an Annual Quality Account for 2017/18. The information contained in this report draws on information from the same systems that underpin the Trust's normal reporting processes, including activity management, performance management and risk and governance systems. The Report is developed by the Governance Team.

The lead executive director for the Quality Report is the Director of Nursing, Quality and Patient Safety. This provides separation of accountability from operational services. The Trust has a dedicated Informatics Team that oversees operational data collection and analysis. The team's function includes reviewing data quality and reporting on key performance indicators. Workforce and education and training KPI data analysis is provided by separate staff within those teams.

Throughout the year the Quality Governance Committee which is chaired by the Trust Chair scrutinises reports which will form part of the Quality Report. The Quality Governance Committee includes the Senior Independent Director / Deputy Chair and another Non-executive Director. The Senior Independent Director is also a member of the Trust's Audit and Risk Committee which oversees the systems of control that support assurance on information quality including data collection and reporting.

The 2017/18 work plan for the Trust's Internal Audit service included several audits which tested assurance on elements supporting the Quality Report. These included risk management arrangements, data quality, clinical audit and

incident reporting. The Quality Report itself is the focus of an independent auditor's report to the Council of Governors (carried out by the Trust's external auditors).

The Board were asked to give feedback on the Trust's draft Quality Account as part of the March 2018 Board meeting prior to the Draft being disseminated to stakeholders for comment as required in the guidance.

The account sets three priorities for improvement for 2018/19, which are:

- Physical health monitoring following rapid tranquillisation
- Values Based Recruitment
- In Patient Discharges

8. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee, Operational Risk Management Group, and Quality Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In order to assess the effectiveness of the internal control the following have been considered:

- Reports from external audit
- Significant Assurance provided through the Head of Internal Audit's Opinion on the effectiveness of internal control
- Inspection reports on the Trust's services by the CQC
- Results from clinical audit reviews
- Reports from external assessors as regards to the financial and clinical governance systems and procedures within the Trust

The Head of Internal Audit Opinion for the period 1 April 2017 to 31 March 2018 states:

"Our overall opinion for the period 1 April 2017 to 31 March 2018 is that based on the scope of reviews undertaken and the sample tests completed during the period, that:

- *Partial assurance can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The level of non-compliance in certain areas puts some system objectives at risk. The weaknesses identified which put system objectives at risk relate to network perimeter access, partnership working, core financial systems, and electronic staff rostering."*

The internal control risks identified by internal audit are as follows:

- Partnership working. The lack of formal risk assessments being completed for all partners prior to the establishment of the partnerships and the absence of signed contracts with the Partners to the Norfolk Wellbeing Service, two years into the delivery of services, reduces the level of assurance that can be provided to the Board
- Network perimeter access review. There is a need to centralise the responsibility for notifying ICT when someone leaves the Trust to the HR Department
- Financial systems. There was a high volume of reconciling items awaiting investigation by the Trust in the payroll control accounts. There was not a clear process for investigating and clearing these items in a timely way. There was also a relatively high level of expenditure authorised retrospectively as opposed to via proactive purchase orders – this can lead to a lack of control and visibility over expenditure levels
- Electronic staff rostering. As at 31 March 2018, 2 out of 26 rosters (8%) were not

approved before the six-week deadline in accordance with Trust policy. Although the quality of some of the roster that have been approved do not meet the requirements of the Trust's policy. The Trust did not have signed and approved user forms for a number of the staff who have access to HealthRoster

The original audit plans were revised to reflect areas which were being reviewed under the CQC action plans.

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

The ongoing development of the Board Assurance Framework (BAF) ensures that the Board of Directors is fully aware of the risks associated with the Trust meeting its strategic objectives. The BAF is cross-referenced to the Trust Risk Register and updated quarterly. See details in the Risk and Control section above.

The Trust's key policies and procedures are subject to regular review and the relevant committee and the Executive Team undertake this process, before taking the revised policy to the Board of Directors for final approval, if required.

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

The new executive quality group will receive reports from service lines and localities to support improvement as well as monitoring the delivery of performance targets and compliance with quality standards. The group will provide assurance to the Quality Governance Committee which reports to Trust Board.

Monthly performance review meetings have been held with NHSI and other key stakeholders during 2017/18 as part of the quality improvement plan to address CQC recommendations.

9. Conclusion

To the best of my knowledge and belief, based on the above processes, there have been no significant control issues identified.

The control issues identified by the internal audit function (listed above) were not sufficiently significant to the overall running of the Trust.

During the 2017/18 financial year there was a CQC inspection which rated the quality of care provided and the governance systems, structures and processes as inadequate.

The Trust continues to implement its quality improvement plan so as to improve services for local people and works to improve the CQC rating with a view to leaving special measures.

Signed:

Antek Lejk
Chief Executive

Date: 22 May 2018

Foreword to the accounts

as the accounting officer of Norfolk and Suffolk NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Norfolk and Suffolk NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed: 

Antek Lejk
Chief Executive

Date: 22 May 2018

Statement of Comprehensive Income for the year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	213,273	202,879
Other operating income	4	13,938	12,780
Operating expenses	5, 7	(222,558)	(238,273)
Operating surplus/(deficit) from continuing operations		**4,653**	**(22,614)**
Finance income	10	35	27
Finance expenses	11	(909)	(927)
PDC dividends payable		(2,637)	(3,160)
Net finance costs		**(3,511)**	**(4,060)**
Other gains / (losses)	12	(76)	-
Surplus / (deficit) for the year from continuing operations		1,066	(26,674)
Surplus / (deficit) for the year		1,066	(26,674)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	-	(21,288)
Revaluations		-	16,728
Other reserve movements		-	135
Total comprehensive income / (expense) for the period		**1,066**	**(31,099)**
of which			
Sustainability and Transformation Fund Income (STF)	4	(3,197)	(2,630)
Underlying financial performance excluding STF		**(2,131)**	**(33,729)**

Statement of Financial Position

for the year ended 31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	13	219	313
Property, plant and equipment	14	124,726	120,612
Total non-current assets		**124,945**	**120,925**
Current assets			
Inventories	16	91	70
Trade and other receivables	17	20,082	18,400
Non-current assets held for sale	18	224	975
Cash and cash equivalents	19	14,640	9,782
Total current assets		**35,037**	**29,227**
Current liabilities			
Trade and other payables	20	(28,201)	(21,942)
Borrowings	22	(1,222)	(1,211)
Provisions	23	(10,038)	(8,144)
Other liabilities	21	(10,567)	(11,512)
Total current liabilities		**(50,028)**	**(42,809)**
Total assets less current liabilities		**109,954**	**107,343**
Non-current liabilities			
Borrowings	22	(12,372)	(13,592)
Provisions	23	(2,931)	(3,191)
Other liabilities	21	(293)	(475)
Total non-current liabilities		**(15,596)**	**(17,258)**
Total assets employed		**94,358**	**90,085**
Financed by			
Public dividend capital		85,043	81,836
Revaluation reserve		37,623	38,286
Income and expenditure reserve		(28,308)	(30,037)
Total taxpayers' equity		**94,358**	**90,085**

The notes on pages A24 to A54 form part of these accounts.

Signed: 

Antek Lejk
Chief Executive

Date: 22 May 2018

Statement of Changes in Equity

for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**81,836**	**38,286**	**(30,037)**	**90,085**
Surplus/(deficit) for the year	-	-	1,066	**1,066**
Transfer to retained earnings on disposal of assets	-	(663)	663	**-**
Public dividend capital received	3,207	-	-	**3,207**
Taxpayers' equity at 31 March 2018	**85,043**	**37,623**	**(28,308)**	**94,358**

for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**81,591**	**42,711**	**(3,363)**	**120,939**
(Deficit) for the year	-	-	(26,674)	**(26,674)**
Impairments	-	(21,288)	-	**(21,288)**
Revaluations	-	16,728	-	**16,728**
Public dividend capital received	245	-	-	**245**
Other reserve movements	-	135	-	**135**
Taxpayers' equity at 31 March 2017	**81,836**	**38,286**	**(30,037)**	**90,085**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to NHS Foundation Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable to the Department of Health as the public dividend capital dividend at a rate of 3.5%.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS Foundation Trust.

Statement of Cash Flows

for the year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,653	(22,614)
Non-cash income and expense:			
Depreciation and amortisation	5	7,448	6,636
Net impairments	6	-	23,335
(Increase) / decrease in receivables and other assets		(2,222)	(9,206)
(Increase) / decrease in inventories		(21)	306
Increase / (decrease) in payables and other liabilties		4,598	9,276
Increase / (decrease) in provisions		1,507	3,092
Other movements in operating cash flows		9	-
Net cash generated from / (used in) operating activities		**15,972**	**10,825**
Cash flows from investing activities			
Interest received		35	27
Purchase of property, plant, equipment and investment property		(11,132)	(4,099)
Sales of property, plant, equipment and investment property		887	-
Net cash generated from / (used in) investing activities		**(10,210)**	**(4,072)**
Cash flows from financing activities			
Public dividend capital received		3,207	245
Movement on loans from the Department of Health and Social Care		(1,057)	(1,056)
Capital element of PFI, LIFT and other service concession payments		(153)	(142)
Interest paid on PFI, LIFT and other service concession obligations		(568)	(553)
Other interest paid		(300)	(329)
PDC dividend (paid) / refunded		(2,089)	(3,700)
Cash flows from (used in) other financing activities		57	89
Net cash generated from / (used in) financing activities		**(904)**	**(5,446)**
Increase / (decrease) in cash and cash equivalents		**4,858**	**1,307**
Cash and cash equivalents at 1 April 2017 - brought forward		**9,782**	**8,475**
Cash and cash equivalents at 31 March 2018	19	**14,640**	**9,782**

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health. The accounting policies contained in the GAM 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 GAM permits a choice of accounting policy, the accounting policy that 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 are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

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.

Going concern

These accounts have been prepared on a going concern basis.Whilst there are issues for the Trust relating to the quality of care provided and the governance system structures and processes at Board, management and operational levels (please refer to the Annual Governance Statement), the Trust Board considers that there is sufficient assurance that there will be a continuation of service provision in the future. This decision has been made with reference to future financial plans.

Critical judgements in applying accounting policies

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

Note 1.1 Income

Income 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 income for the Trust is contracts with commissioners in respect of health care services.

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

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

The value of the benefit received when accessing funds from the Government's national apprenticeship scheme is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.2 Expenditure on employee benefits

Short-term employee benefits

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

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension 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 in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore the scheme is accounted for as a defined contribution scheme.

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

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

Note 1.3 Expenditure on other goods and services

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

Note 1.4 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes
- It is probable that future economic benefits will flow to, or service potential be provided to the Trust
- It is expected to be used for more than one financial year
- The cost of the item can be measured reliably
- The item has cost of at least £5,000, or
- Collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control

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

Measurement

Valuation

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

All assets are subsequently measured at fair valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

- Land and no-specialised buildings – market value for existing use,
- Specialised buildings – depreciated replacement cost.

Non-property assets are carried at depreciated historic costs as a proxy for fair value.

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.

Assets in the course of construction are valued at cost and are valued by professional valuers at the same time as other land and building assets after they are brought into use.

Subsequent expenditure

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

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

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 residutal values are reviewed each year-end, with the effect of any changes recognised on a prospective basis.

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

Revaluation gains and losses

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

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

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

Impairments

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

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

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

De-recognition

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

- The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- The sale must be highly probable i.e:
  - Management are committed to a plan to sell the asset
  - An active programme has begun to find a buyer and complete the sale
  - The asset is being actively marketed at a reasonable price
  - The sale is expected to be completed within 12 months of the date of classification as 'Held for Sale' and
  - The actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated and grant funded assets

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

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

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual unitary payments are apportioned between the repayment of the liability, a finance cost and the charges for services. Appropriate estimation techniques will be applied where necessary.

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

PFI Asset

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

PFI liability

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

An annual finance cost is calculated by applying the implicit interest rate in the lease on the operating lease liability for the period, and is charged to "Finance Costs" within the Statement of Comprehensive Income. The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance costs and to repay the lease liability over the contract term. An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as a contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

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

Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is shown in the table below:

	Min Life Years	Max Life Years
Buildings, excluding dwellings	15	80
Dwellings	30	45
Plant and machinery	5	15
Transport equipment	5	7
Information technology	3	5
Furniture and fittings	5	15

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.5 Intangible assets

Recognition

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

Internally generated intangible assets

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

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

- The project is technically and commercially feasible to the point of completion and will result in an intangible asset for sale or use, (the Trust must be able to demonstrate how the asset will generate future economic benefits)
- The Trust intends to complete the asset and sell or use it for future economic benefits
- The asset will generate probable future economic benefits, e.g., revenues or reduced future costs
- Adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset
- The Trust can measure reliably the expenses attributable to the asset during development
- The Trust has control of the intangible asset (power to obtain benefits from the asset)
- The Trust can distinguish the development phase of the project and costs are separately identifiable from research costs (if this is not possible then the whole cost is expensed as research costs)

Software

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

Measurement

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

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

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

Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is shown in the table below:

	Min Life Years	Max Life Years
Intangible assets - internally generated	3	5
Intangible assets - purchased	3	5

Note 1.6 Revenue government and other grants

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

Note 1.7 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) methodology.

Note 1.8 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 three 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. Cash, bank and overdraft balances are recorded at current values.

Note 1.9 Financial instruments and financial liabilities

Recognition

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

De-recognition

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

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", loans and receivables.

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

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term.

Derivatives are also categorised as held for trading unless they are designated as hedges.
These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

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

The Trust's loans and receivables comprise current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured

subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health and Social Care are not held for trading and are measured at historic costs with any unpaid interest accrued separately.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred and recognised in "Finance Costs" in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

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

Impairment of financial assets

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

Note 1.10 Leases

The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are recognised as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the term of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as lessor

Operating 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 as an expense on a straight-line basis over the lease term.

Note 1.11 Provisions

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Trust is disclosed at note 23.1 but is not recognised in the Trust's accounts.

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 NHS Resolution 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 when the liability arises.

Note 1.12 Public dividend capital

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

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.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

(i) Donated assets (including lottery funded assets),

(ii) Average daily cash balances held with the Government Banking Services (GBS), and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and

(iii) Any PDC dividend balance receivable or payable

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.13 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.

Note 1.14 Corporation tax

The Trust has determined that there is no corporation tax liability.

Note 1.15 Foreign exchange

The functional and presentational currency of the trust is sterling.

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

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

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

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

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

Note 1.16 Third party assets

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

Note 1.17 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 the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.18 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.19 Early adoption of standards, amendments and interpretations

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2017/18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018

Note 2 Operating segments

Financial information reported to the Board is at a Trust-wide level, and not reported segmentally. Individual locality issues are reported on an exceptions basis.

Income from healthcare activities is included at note 3.1 Income from Patient Care Activities Income balances with a single external customer that amount to a material proportion of income are disclosed in note 29 to the accounts, Related Party Transactions.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2017/18	2016/17
	£000	£000
Mental health services		
Block contract income	199,575	184,991
Clinical partnerships providing mandatory services (including S75 agreements)	9,412	9,439
Clinical income for the secondary commissioning of mandatory services	2,228	2,552
Other clinical income from mandatory services	1,884	5,777
All services		
Other clinical income	174	120
Total income from activities	**213,273**	**202,879**

Note 3.2 Income from patient care activities (by source)

	2017/18	2016/17
	£000	£000
Income from patient care activities received from:		
NHS England	17,485	17,649
Clinical commissioning groups	185,305	171,117
Other NHS providers	97	257
NHS other	114	116
Local authorities	12,276	12,338
Non NHS: other	(2,004)	1,402
Total income from activities	**213,273**	**202,879**
Of which:		
Related to continuing operations	213,273	202,879

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	1,381	1,338
Education and training	5,082	3,449
Non-patient care services to other bodies	858	1,822
Sustainability and transformation fund income	3,197	2,630
Rental revenue from operating leases	385	312
Other income	3,035	3,229
Total other operating income	**13,938**	**12,780**
Of which:		
Related to continuing operations	13,938	12,780

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017/18	2016/17
	£000	£000
Income from services designated as commissioner requested services	211,215	196,982
Income from services not designated as commissioner requested services	2,058	5,897
Total	**213,273**	**202,879**

Note 4.2 Profits and losses on disposal of property, plant and equipment

The following assets held for sale were disposed during the year:

	2017/18
296 Drayton High Road	**£000**
Sale Proceeds received	290
Net Book Value	(250)
Profit on disposal	**40**

Northgate Surplus Land	**£000**
Sale Proceeds received	597
Net Book Value	(725)
(Loss) on disposal	**(128)**
Net losses on disposal of property	(88)

Both assets were deemed surplus to requirement for the provision of commisioner requested services in 2016/17 and subsequently disposed in 2017/18.

Note 5 Operating expenses

Note 5.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,753	2,218
Purchase of healthcare from non-NHS and non-DHSC bodies	18,377	16,933
Staff and executive directors costs	161,830	157,952
Remuneration of non-executive directors	147	139
Supplies and services - clinical (excluding drugs costs)	838	751
Supplies and services - general	6,444	5,917
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	2,714	2,848
Consultancy costs	314	130
Establishment	647	814
Premises	9,401	8,788
Transport (including patient travel)	2,670	2,693
Depreciation on property, plant and equipment	7,354	6,540
Amortisation on intangible assets	94	96
Net impairments	-	23,335
Increase/(decrease) in provision for impairment of receivables	15	(276)
Increase/(decrease) in other provisions	487	449
Change in provisions discount rate(s)	-	462
Audit fees payable to the external auditor - statutory audit	83	77
Internal audit costs	120	149
Clinical negligence	475	483
Legal fees	571	687
Insurance	200	73
Education and training	1,813	1,008
Rentals under operating leases	3,295	3,237
Redundancy	162	85
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	1,199	1,159
Car parking and security	232	225
Hospitality	12	10
Losses, ex gratia and special payments	-	41
Other services, e.g. external payroll	435	389
Other	876	861
Total	222,558	238,273
Of which:		
Related to continuing operations	222,558	238,273

Note 5.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2016/17: £1m).

Note 6 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	-	23,335
Other	-	-
Total net impairments charged to operating surplus / deficit	-	23,335
Impairments charged to the revaluation reserve	-	**21,288**
Total net impairments	-	**44,623**

Note 7 Employee benefits

	2017/18	2016/17
	£000	£000
Salaries and wages	116,409	113,620
Social security costs	11,627	11,309
Apprenticeship levy	568	-
Employer's contributions to NHS pensions	15,062	14,641
Termination benefits	162	18
Temporary staff (including agency)	18,164	18,382
Total staff costs	**161,992**	**157,970**

Note 7.1 Retirements due to ill-health

During 2017/18 there were eight early retirements from the Trust agreed on the grounds of ill-health (seven in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £426k (£403k in 2016/17). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as of 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

The next actuarial valuation is to be carried out as at 31 March 2018 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

c) National Employment Savings Scheme (NEST)

The Trust also offers an additional defined contribution workplace pension scheme (the National Employment Savings Scheme (NEST)). This scheme is accounted for as a defined contribution scheme. The cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

Note 9 Operating leases

Note 9.1 Norfolk and Suffolk NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Norfolk and Suffolk NHS Foundation Trust is the lessor.

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	385	312
Total	**385**	**312**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	360	312
Total	**360**	**312**

These lease rental agreements will be subject to IFRS16 for accounting periods from January 2019. However, the application of this standard will be subject to pending HR Treasury FReM guidance. Therefore early adoption is not permitted.

Note 9.2 Norfolk and Suffolk NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Norfolk and Suffolk NHS Foundation Trust is the lessee.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	3,295	3,237
Total	**3,295**	**3,237**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,987	2,953
- later than one year and not later than five years;	6,272	6,567
- later than five years.	4,982	6,491
Total	**14,241**	**16,011**

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	35	27
Total	**35**	**27**

Note 11 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	341	374
Main finance costs on PFI and LIFT schemes obligations	281	294
Contingent finance costs on PFI and LIFT scheme obligations	287	259
Total	**909**	**927**

Note 12 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	12	-
(Losses) on disposal of assets	**(88)**	**-**
Total gains / (losses) on disposal of assets	**(76)**	**-**
Total other gains / (losses)	**(76)**	**-**

Note 13 Intangible assets

Note 13.1 Intangible assets - 2017/18

	Software licences	Total
	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**1,044**	**1,044**
Reclassifications	(3)	**(3)**
Gross cost at 31 March 2018	**1,041**	**1,041**
Amortisation at 1 April 2016 - brought forward	**731**	**731**
Provided during the year	94	**94**
Reclassifications	(3)	**(3)**
Amortisation at 31 March 2018	**822**	**822**
Net book value at 31 March 2018	**219**	**219**
Net book value at 1 April 2017	**313**	**313**

Note 13.2 Intangible assets - 2016/17

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**1,044**	**1,044**
Valuation / gross cost at 31 March 2017	**1,044**	**1,044**
Amortisation at 1 April 2016 - as previously stated	**635**	**635**
Provided during the year	96	96
Amortisation at 31 March 2017	**731**	**731**
Net book value at 31 March 2017	**313**	**313**
Net book value at 1 April 2016	**409**	**409**

Note 14 Property, plant and equipment

Note 14.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**11,477**	**90,814**	**4,280**	**7,619**	**4,961**	**325**	**11,318**	**2,621**	**133,415**
Additions	-	-	-	11,788	-	-	-	-	**11,788**
Reclassifications	-	3,720	(199)	(11,067)	147	-	3,469	3,933	**3**
Transfers (to) / from assets held for sale	(33)	(225)	-	-	(11)	-	-	-	**(269)**
Disposals / derecognition	-	-	(96)	-	-	-	-	-	**(96)**
Valuation / gross cost at 31 March 2018	**11,444**	**94,309**	**3,985**	**8,340**	**5,097**	**325**	**14,787**	**6,554**	**144,841**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**236**	**-**	**-**	**3,169**	**325**	**7,031**	**2,042**	**12,803**
Provided during the year	**-**	**4,340**	**492**	**-**	**364**	**-**	**1,883**	**275**	**7,354**
Reclassifications	-	-	-	-	(152)	-	3	152	**3**
Transfers (to) / from assets held for sale	-	(38)	-	-	(7)	-	-	-	**(45)**
Accumulated depreciation at 31 March 2018	**-**	**4,538**	**492**	**-**	**3,374**	**325**	**8,917**	**2,469**	**20,115**
Net book value at 31 March 2018	**11,444**	**89,771**	**3,493**	**8,340**	**1,723**	**-**	**5,870**	**4,085**	**124,726**
Net book value at 1 April 2017	**11,477**	**90,578**	**4,280**	**7,619**	**1,792**	**-**	**4,287**	**579**	**120,612**

Note 14.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016	**19,917**	**117,893**	**4,523**	**3,525**	**4,961**	**325**	**10,547**	**2,618**	**164,309**
Additions	-	-	-	5,428	-	-	-	-	**5,428**
Impairments	(9,073)	(35,550)	-	-	-	-	-	-	**(44,623)**
Revaluations	698	8,110	(243)	-	-	-	-	-	**8,565**
Reclassifications	-	560	-	(1,334)	-	-	771	3	**-**
Transfers (to) / from assets held for sale	(65)	(199)	-	-	-	-	-	-	**(264)**
Valuation / gross cost at 31 March 2017	**11,477**	**90,814**	**4,280**	**7,619**	**4,961**	**325**	**11,318**	**2,621**	**133,415**
Accumulated depreciation at 1 April 2016	**-**	**4,248**	**123**	**-**	**2,744**	**325**	**5,266**	**1,734**	**14,440**
Provided during the year	-	**3,922**	**120**	**-**	**425**	**-**	**1,765**	**308**	**6,540**
Revaluations	-	(7,920)	(243)	-	-	-	-	-	**(8,163)**
Transfers (to) / from assets held for sale	-	(14)	-	-	-	-	-	-	**(14)**
Accumulated depreciation at 31 March 2017	**-**	**236**	**-**	**-**	**3,169**	**325**	**7,031**	**2,042**	**12,803**
Net book value at 31 March 2017	**11,477**	**90,578**	**4,280**	**7,619**	**1,792**	**-**	**4,287**	**579**	**120,612**
Net book value at 1 April 2016	**19,917**	**113,645**	**4,400**	**3,525**	**2,217**	**-**	**5,281**	**884**	**149,869**

Note 14.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	11,444	88,793	3,493	8,340	1,723	-	5,870	4,085	**123,748**
On-SoFP PFI contracts and other service concession arrangements	-	978	-	-	-	-	-	-	**978**
NBV total at 31 March 2018	**11,444**	**89,771**	**3,493**	**8,340**	**1,723**	**-**	**5,870**	**4,085**	**124,726**

Note 14.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	11,477	89,082	4,280	7,619	1,792	-	4,287	579	**119,116**
On-SoFP PFI contracts and other service concession arrangements	-	1,496	-	-	-	-	-	-	**1,496**
NBV total at 31 March 2017	**11,477**	**90,578**	**4,280**	**7,619**	**1,792**	**-**	**4,287**	**579**	**120,612**

Note 15 Revaluations of property, plant and equipment

Land and buildings were valued independently by Montagu Evans LLP as at 31 March 2017 in line with the accounting policies. The valuation included positive and negative valuation movements. Revaluation losses were taken to the Revaluation Reserve to the extent there was a revaluation surplus. Any losses over and above the revaluation surplus were charged to the Statement of Comprehensive Income (SOCI).

Where the revaluation resulted in an increase in an asset's value, this increase was credited to the Revaluation Reserve unless it reversed a revaluation loss previously recognised in operating expenses, in which case it was credited initially to retained earnings and thereafter to the Revaluation Reserve.

Impairment reviews are undertaken annually to ensure that the carrying values reflect fair values. The latest review carried out by Montagu Evans LLP as at 31 March 2018 showed no significant change in valuation of the current Land and Buildings in use. No impairments have been recognised in the 2017/18 financial year (£28,290k - 2016/17).

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

Reclassifications included above also include assets under construction reclassified as intangible assets.

Note 16 Inventories

	31 March 2018	31 March 2017
	£000	£000
Drugs	91	70
Total inventories	**91**	**70**

Inventories recognised in expenses for the year were £2,474k (2016/17: £2,848k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

Note 17 Receivables

Note 17.1 Trade receivables and other receivables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade receivables	13,003	12,362
Accrued income	4,589	3,421
Provision for impaired receivables	(440)	(429)
Prepayments (non-PFI)	1,382	1,309
PDC dividend receivable	-	540
VAT receivable	746	262
Other receivables	802	935
Total current trade and other receivables	**20,082**	**18,400**
Total non-current trade and other receivables	**-**	**-**
Of which receivables from NHS and DHSC group bodies:		
Current	14,301	15,126

Note 17.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**429**	**864**
Increase in provision	111	(20)
Amounts utilised	(4)	(159)
Unused amounts reversed	(96)	(256)
At 31 March	**440**	**429**

Note 17.3 Credit quality of financial assets

	31 March 2018	31 March 2017
	Trade and other receivables	Trade and other receivables
	£000	£000
Ageing of impaired financial assets		
0 - 30 days	-	-
30 - 60 Days	-	-
60 - 90 days	12	-
90 - 180 days	-	-
Over 180 days	428	429
Total	**440**	**429**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	10,769	10,092
30 - 60 Days	1,282	739
60 - 90 days	90	343
90 - 180 days	79	300
Over 180 days	334	242
Total	**12,554**	**11,716**

The Trust's net operating costs are incurred largely under contracts with local Clincal Commissioning Groups (CCGs) which are financed from resources voted annually by Parliament. As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Note 18 Non-current assets for sale and assets in disposal groups

	2017/18	2016/17
	Total £000	Total £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**975**	**725**
Assets classified as available for sale in the year	224	250
Assets sold in year	(975)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**224**	**975**

During the 2017/18 financial year Blomfield House was transferred out of assets in use into assets classified for sale in February 2018 at a net book value of £224k. The property has been placed on the market and is expected to be sold during the next financial year.

Note 19 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

Note 19.1 Cash and cash equivalents movements

	2017/18	2016/17
	£000	£000
At 1 April	**9,782**	**8,475**
Net change in year	4,858	1,307
At 31 March	**14,640**	**9,782**
Broken down into:		
Cash at commercial banks and in hand	104	87
Cash with the Government Banking Service	14,536	9,695
Total cash and cash equivalents as in SoFP	**14,640**	**9,782**

Note 19.2 Third party assets held by the NHS foundation trust

The Trust held cash and cash equivalents which relate to monies held by the Foundation 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 2018	31 March 2017
	£000	£000
Bank balances	209	229
Total third party assets	**209**	**229**

Note 20 Trade and other payables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	7,656	4,180
Capital payables	2,523	1,867
Accruals	12,986	10,758
Social security costs	886	528
Other taxes payable	2,203	2,134
PDC dividend payable	8	-
Accrued interest on loans	42	45
Other payables	2,024	2,430
Total current trade and other payables	**28,328**	**21,942**
Total non-current trade and other payables	-	-
Of which payables to NHS and DHSC group bodies:		
Current	601	1,453

Note 21.1 Other liabilities

	31 March 2018	31 March 2017
	£000	£000
Current		
Deferred income	10,447	11,360
Deferred grants	74	106
Lease incentives	46	46
Total other current liabilities	**10,567**	**11,512**
Non-current		
Deferred income	10	139
Lease incentives	283	336
Total other non-current liabilities	**293**	**475**

Note 22 Borrowings

	31 March 2018	31 March 2017
	£000	£000
Current		
Loans from the Department of Health and Social Care	1,056	1,056
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	166	155
Total current borrowings	**1,222**	**1,211**
Non-current		
Loans from the Department of Health and Social Care	8,999	10,055
Obligations under PFI, LIFT or other service concession contracts	3,373	3,537
Total non-current borrowings	**12,372**	**13,592**

Note 23 Provisions for liabilities

Note 23.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2017	**1,670**	**458**	**566**	**8,641**	**11,335**
Arising during the year	-	167	-	7,154	**7,321**
Utilised during the year	(191)	(165)	(86)	(3,643)	**(4,085)**
Reversed unused	(216)	-	(480)	(1,033)	**(1,729)**
At 31 March 2018	**1,263**	**460**	**-**	**11,119**	**12,842**
Expected timing of cash flows:					
- not later than one year;	174	460	-	9,277	**9,911**
- later than one year and not later than five years;	618	-	-	488	**1,106**
- later than five years.	471	-	-	1,354	**1,825**
Total	**1,263**	**460**	**-**	**11,119**	**12,842**

The pensions' provision relates to the NHS Pensions Agency in respect of early retirement award, payable to formef employees of the Trust and is calculated using actuarial information on named individuals and is reviewed on a quarterly basis.

The provision for legal claims relates to unresolved claims arising from tribunal hearings, equal pay claims, clinical negligence claims, and other legal matters.

Other provisions include £1,809k in respect of Injury Benefits Awards. Other provisions have been made for service redesign and other potential liabilities.

The value and expected timings of the injury benefit provisions are calculated by reference to information available at the balance sheet date, provided by the Trust's advisors. As new evidence comes to light, the value of the provision can change either up or down. Similarly, new evidence can affect the expected timings of cashflows.

Note 23.2 Clinical negligence liabilites

At 31 March 2018, £4,910k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Norfolk and Suffolk NHS Foundation Trust (31 March 2017: £3,846k).

Note 24 Contractual capital commitments

	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	3,659	731
Total	**3,659**	**731**

Note 25 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2018	31 March 2017
	£000	£000
not later than 1 year	2,440	-
after 1 year and not later than 5 years	-	-
paid thereafter	-	-
Total	**2,440**	**-**

Note 26 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has a 30 year contract that commenced on the 27 May 2002, under the Private Finance Initiative with GH Bury for the provision of a fully serviced Mental Health inpatient facility in Bury St.Edmunds. At the end of the contract the asset reverts to the Trust.

Under IFRIC 12 the asset is treated as an asset of the Trust. The substance of the contract is that the Trust has a finance lease and payments comprise two elements - imputed finance lease charges and service charges.

The PFI contract as been calculated using the Department of Health approved template incorporating a 2.5% annual inflation uplift for future years. Past years' inflation is calculated to bring the annual unitary charge in line with the amount actually paid.

Note 26.1 Imputed finance lease obligations

Norfolk and Suffolk NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018	31 March 2017
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**12,478**	**11,412**
Of which liabilities are due		
- not later than one year;	744	705
- later than one year and not later than five years;	3,205	2,917
- later than five years.	8,529	7,790
Finance charges allocated to future periods	(8,939)	(7,720)
Net PFI, LIFT or other service concession arrangement obligation	**3,539**	**3,692**
- not later than one year;	166	155
- later than one year and not later than five years;	807	748
- later than five years.	2,566	2,789

Note 26.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The Trust's total future obligations under these on-SoFP schemes are as follows:

	31 March 2018	31 March 2017
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	33,878	31,039
Of which liabilities are due:		
- not later than one year;	1,985	1,882
- later than one year and not later than five years;	8,551	7,783
- later than five years.	23,342	21,374

Note 26.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the Trust's payments in 2017/18

	2017/18	2016/17
	£000	£000
Unitary payment payable to service concession operator	**1,920**	**1,854**
Consisting of:		
- Interest charge	281	294
- Repayment of finance lease liability	153	142
- Service element and other charges to operating expenditure	1,199	1,159
- Contingent rent	287	259
Total amount paid to service concession operator	**1,920**	**1,854**

Note 27 Financial instruments

Note 27.1 Financial risk management

IAS 32, 39 and IFRS 7, Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

The Trust is not exposed to significant financial risk factors arising from financial instruments. Because of the continuing service provider relationship that the Trust has with local Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. The Trust's transactions are almost all undertaken in sterling and so it is not exposed to foreign exchange risk. It holds no significant investments other than short-term bank deposits. Other than cash balance, the Trust's financial assets and liabilities carry nil or fixed rates of interest and the Trust's income and operating cash-flows are substantially independent of changes in market interest rates.

Credit risk is the possibility that other parties might fail to pay amounts due to the Trust. Credit risk arises from deposits with banks as well as credit exposures to the Trust's commissioners and other debtors. The Trust's net operating costs are incurred largely under contracts with local CCGs, which are financed from resources voted annually by Parliament. As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary. An analysis of the ageing of debtors and provision for impairment can be found at Note 17 "Trade and other receivables".

Liquidity risk is the possibility that the Trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding from an adequate amount of committed credit facilities.

Note 27.2 Carrying values of financial assets

	Loans and receivables	Total
	£000	£000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	17,954	17,954
Cash and cash equivalents at bank and in hand	14,640	14,640
Total at 31 March 2018	**32,594**	**32,594**
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	15,990	15,990
Cash and cash equivalents at bank and in hand	9,782	9,782
Total at 31 March 2017	**25,772**	**25,772**

Note 27.3 Carrying value of financial liabilities

	Other financial liabilities	Total
	£000	£000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	10,055	10,055
Obligations under PFI, LIFT and other service concession contracts	3,539	3,539
Trade and other payables excluding non financial liabilities	25,189	25,189
Total at 31 March 2018	38,783	**38,783**

	Other financial liabilities	Total
	£000	£000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	11,111	11,111
Obligations under PFI, LIFT and other service concession contracts	3,692	3,692
Trade and other payables excluding non financial liabilities	18,981	18,981
Total at 31 March 2017	**33,784**	**33,784**

Note 27.4 Fair values of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	26,412	20,192
In more than one year but not more than two years	1,236	1,056
In more than two years but not more than five years	3,796	3,918
In more than five years	7,339	8,618
Total	**38,783**	**33,784**

Note 28 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses:				
Cash losses	2	-	5	1
Stores losses and damage to property	2	-	9	1
Total losses	**4**	**-**	**14**	**2**
Special payments:				
Compensation under court order or legally binding arbitration award	9	107	7	28
Ex-gratia payments	23	4	20	10
Total special payments	**32**	**111**	**27**	**38**
Total losses and special payments	**36**	**111**	**41**	**40**

The four losses payments above totalled to less than £1k in 2017/18

Note 29 Related parties

Norfolk and Suffolk NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health. During the year none of the board members or members of the key management staff or parties related to them has undertaken any material transactions with the Trust (2016/17 - £nil).

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

The Trust also had £13,341k of expenditure with NHS Professionals for temporary staff costs (2016/17 - £10,044k). In addition, the Trust had a significant number of material transactions with other Government bodies, namely Norfolk County Council and Suffolk County Council.

The Trust is the corporate trustee of the Norfolk and Suffolk NHS Foundation Trust Charitable Funds. The members of the Trust Board of Directors act on behalf of the Trust in its capacity as corporate trustee. During the year none of the Trustees or members of the key management staff or parties related to them has undertaken any material transactions with the Charitable Trust. On the grounds of materiality the Charitable Fund has not been consolidated.

Board members (and other senior staff) take decisions both on Charity and Exchequer matters but endeavour to keep the interests of each discrete and do not seek to benefit personally from such decisions. Declarations of personal interest have been made in both capacities and are available to be inspected by the public.

	Receivables		Payables	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Department of Health and Social Care	-	858	65	68
NHS England	2,500	1,724	49	142
NHS Foundation Trusts	324	248	188	530
NHS Trusts	45	20	99	493
Clinical Commissioning Groups (CCGs)	11,232	10,840	10,494	338
Health Education England	118	100	-	2
Other NHS bodies	82	107	24	141
Local Government and other WGA bodies	1,850	640	4,812	7,480
Total	**16,151**	**14,537**	**15,731**	**9,194**

	Income		Expenditure	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Department of Health and Social Care	-	58	6	4
NHS England	2,500	20,558	2,500	-
NHS Foundation Trusts	1,159	735	2,120	2,006
NHS Trusts	220	263	664	630
Clinical Commissioning Groups (CCGs)	205,453	177,736	(1,611)	39
Health Education England	5,071	2,512	13	5
Other NHS bodies	395	215	1,312	665
Local Government and other WGA bodies	13,053	13,189	41,175	36,526
Total	**227,851**	**215,266**	**46,179**	**39,875**

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NSFTrust

Norfolk and Suffolk NHS Foundation Trust values and celebrates the diversity of all the communities we serve. We are fully committed to ensuring that all people have equality of opportunity to access our service, irrespective of their age, gender, ethnicity, race, disability, religion or belief, sexual orientation, marital or civil partnership or social and economic status.