NHS
Norfolk and Suffolk
NHS Foundation Trust

Annual report and accounts

April 2018 to March 2019

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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

When I arrived at the Trust in February 2019, I was met with a genuine determination across the organisation to rapidly improve the quality and outcomes of the services we provide, and to do so in partnership with those who use our services and their loved ones. I could truly see why our regulators, the Care Quality Commission, had told us that our staff are good at caring.

My subsequent conversations and visits to services have confirmed that NSFT has not only the determination but the ability and plans to do much better for our service users and carers. What has made the strongest impact on me is the willingness of those we have failed, to work with us to make sure we not only learn from our mistakes but further improve.

The Care Quality Commission told us that we have 'outstanding' areas of service within our child and adolescent mental health unit and rated us 'good' for forensic inpatient services and community mental health services for people with autism or learning disabilities. In the coming year we are fully committed to ensuring a minimum of 'good' is the NSFT standard.

During the year 2018/19 we have done much to make this a reality. We have built a new leadership team, refocused on localities and began to create the conditions where our staff are empowered to make positive changes, spread best practice and have their voice heard, without blame. Importantly, we have also begun to strengthen our patient and carer involvement in all aspects of the Trust and to ensure that clinicians take the lead role, because patients, carers and clinicians are the ones who understand what works best. Those who understand services best are being put in the driving seat.

The Trust has also become more focused on and knowledgeable about our key areas of underperformance, the areas which have the greatest impact and risk on people's lives. This has helped us to work with our system to draw up plans and consider further investment where it is needed most. I am looking forward to an even more productive partnership with our health, social care, council, voluntary and independent sector colleagues as we work together to ensure we can provide truly integrated and locally accessible services that are responsive and relevant. Creating systems that are built around the individuals who need us rather than focus on organisational boundaries.

NSFT will continue to improve at pace next year and we are steadfast in our commitment to bring more people home, so that they are cared for closer to those they love and in surroundings they know, to ensure that people do not have to wait as long to be treated and that they have the support they need when they are in crisis. This also includes improving the experience of people who are on our wards.

As well as empowering staff and learning from service users, we will embed and grow our quality improvement work so that our progress is continuous and evidence-based. We will also be introducing new and innovative ways to recruit, retain and ensure staff are fulfilled at work.

I would like to take this opportunity to thank everyone who has been so welcoming and not only willing to support but are actively urging me on to ensure we become known as a 'good' Trust as a first step. This includes our patients, carers, staff, clinicians, Governors, partners, campaign groups and local political leadership. We will get Better Together.

Marie Gabriel CBE
NSFT Chair

Performance report

Overview

It has again been a challenging 12 months for our Trust, which remains in special measures after receiving an 'inadequate' overall rating following the Care Quality Commission's (CQC) inspection of our services in September 2018. Everyone at NSFT has been working hard to make improvements, so we were obviously disappointed with these findings. However, we also appreciate that the progress we had made by the time the inspectors visited had not been as rapid as both our Trust and the CQC had hoped for.

We remain committed to making the necessary changes to ensure our services provide safe, effective care for everyone in Norfolk and Suffolk, and have been focusing unrelentingly on driving improvements since the CQC's visit. We have acted on the immediate concerns found by the inspectors and have been continuing to listen to our staff and service users since to make sure we fully understand the deeper challenges the Trust faces.

Although there is still some way to go, I'm pleased to report that we have made some notable progress so far. This includes:

- **Developing a Quality Improvement Plan** - which includes short and longer-term actions to address safety and quality issues while also ensuring they are embedded across the Trust
- **Recruiting a new leadership team** - in April, I took up my role as the Trust's new Chief Executive for a two-year period. We have also appointed a new Chief Nurse, Chief Operating Officer and Director of Human Resources and Organisational Development, as well as a Chair, two Non-executive Directors and a Company Secretary. All these staff have extensive experience of driving organisational change and a track record of improvement
- **Developing a new organisational structure** - which places a renewed focus on clinical leadership and making sure that service users are involved in shaping the care we provide. The new structure will see a Service Director, Clinical Director, Nursing Lead and People Participation Lead appointed to every locality to ensure that quality priorities can be addressed locally

  We are also restructuring our staffing models to make sure our Trust has the right people with the right strengths in the right posts to make sure our services are safe, responsive and of a high quality. We are consulting with our staff at every stage of this restructure, which is taken in phases to minimise its impact on our day-to-day operations
- **Finalising a two-year package** - which will see staff from East London NHS Foundation Trust, which has been rated as 'outstanding' by the CQC, provide support to improve quality and safety for our service users
- **Completing three rapid action plans** - to improve our performance around crisis response, access to services, restrictive interventions and rapid tranquilisation. These targeted projects have helped reduce waiting times, patient breaches and the number of referrals which are downgraded, while rapid tranquilisation on key wards has also decreased

In addition, more than 100 staff have attended dedicated quality improvement training and are now leading 29 separate quality improvement projects across the Trust. We have also begun a major culture change programme designed to improve staff engagement and involve colleagues, service users and carers as we develop our strategic ambition and values.

Achievements during 2018/19

Over the past 12 months, our Trust has achieved some key successes on behalf of our service users and patients. The CQC once again rated us as 'good' in the caring domain and highlighted the kindness and compassion of our staff several times throughout their inspection report. Several of our individual services also received 'good' ratings, while the Dragonfly Unit, which provides dedicated inpatient care for children and young people, was 'outstanding'. Our thanks go to our hard-working and dedicated staff for helping us to achieve these results, which provided us a positive foundation on which to build during the remainder of the year.

During 2018/19, we also invested in both improving the environment from which care is delivered and introducing new services. These projects included:

- **The Kingfisher Mother and Baby Unit**, which opened in January 2019 to ensure mums and their babies can stay together while the mother receives inpatient care for conditions such as severe postnatal depression, serious anxiety disorders and postpartum psychosis
- **The expansion of our Suffolk Perinatal Service**, which can now provide targeted help to even more women with complex mental health conditions after six new staff were recruited
- A £4m project to bring adult acute mental health services onto one central site at **Chatterton House in King's Lynn**. Work is progressing well, with the Samphire Ward due to open this summer. The ward will be made up of 16 single en-suite rooms and will replace the Churchill Ward at the Fermoy Unit
- Completion of a £3.85 million redesign of **NSFT's secure services**. This has seen low and medium secure female services amalgamated, five low secure male beds opened in Ipswich and parts of Norvic Clinic refurbished and reopened under the new name of Northside House
- Increasing the number of children and young people's **inpatient beds at the Dragonfly Unit** from seven to 12 following investment from NHS England
- The start of a new five-year contract to provide **mental health services at Norwich Prison**, which began on 1 April 2019

Looking ahead

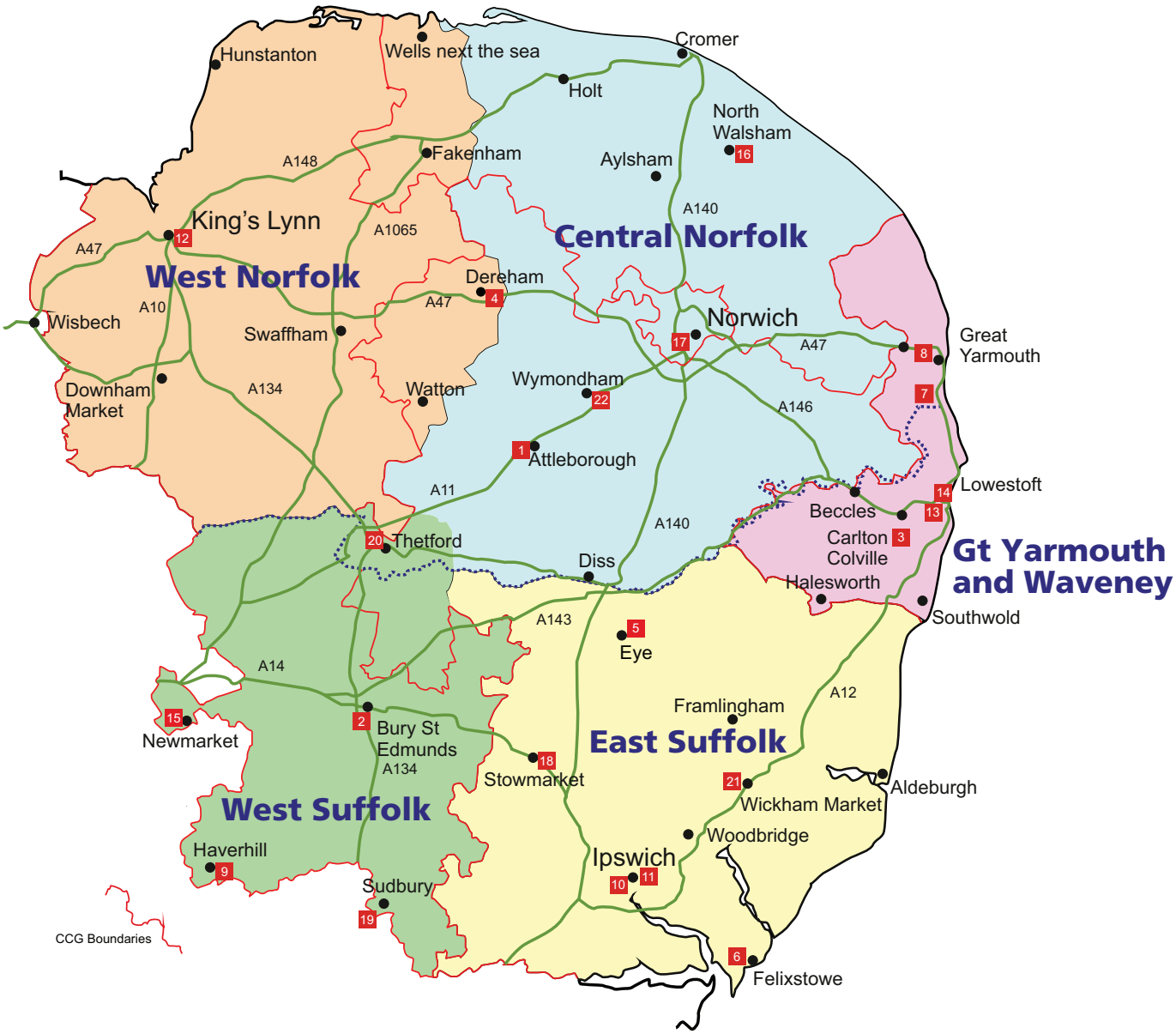
During the coming 12 months, our focus will remain on embedding quality and safety in everything we do. Our drive to create a culture which truly embraces staff and service user engagement will continue, as will our work to fill our vacancies and make sure we have the right staff in the right roles to provide the best possible care.

We will also continue to roll out our new organisational structure across NSFT, which will strengthen clinical leadership in each directorate. This change will give our clinical workforce the chance to contribute more fully to our quality improvement programme while also ensuring the needs of our service users and carers remain at the centre of everything we do.

Such wide-scale transformation will take time and will not always be smooth, but we remain committed to making the necessary changes in the right way to ensure we are providing safe, effective and responsive care.

Professor Jonathan Warren
Chief Executive

Date: 23 May 2019



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
The Atrium NR28 9HZ

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

18 Stowmarket
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

Issue date 03/05/19

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

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 2018/19, we have continued to be a key partner of both Sustainability and Transformation Partnerships in Suffolk and North East Essex and Norfolk and Waveney, helping to shape the future of mental health services through the development of adult and children, families and young people's mental health strategies.

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

During 2018/19 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 subcommittees throughout the year. The key risks are identified as follows:

1. The Care Quality Commission (CQC) re-inspected the Trust in September 2018 with its final report made public in November 2018. The outcome of the review was an overall rating of 'inadequate'. As a result, the Trust was unable to come out of Special Measures which it had originally been placed under by NHS Improvement in October 2017. In response to this latest inspection, the Trust implemented a locality-driven improvement plan to address the concerns identified. This plan continues to place quality and safety as our number one priority and is owned and delivered at a locality / service level, with support from Trust-wide enablers where required.

2. Recruitment and retention of our staff continues to be a challenge. We exceeded our agency cap set by NHS Improvement during the year by £0.5m and spent just under £1m more on agency staff than in the previous year. The reliance on agency clinical and medical staff continues to be a major concern in terms of the impact this has on the quality of service provision. A Safer Staffing group was established in the year in to look at initiatives and incentives to encourage both recruitment and retention of difficult-to-hire staffing groups as well as retain existing staff. It is well recognised across the NHS that there remains a national shortage of registered psychiatric medical and clinical staff.

3. Expenditure on Out of Area Placements during the year was significantly higher than in previous years which impacted on the ability of CCGs to fund further investments which ultimately impact on service user experience.

4. The Trust managed once again to deliver its financial plans and improved its financial position with an outturn £2.2m surplus (underlying deficit £1.7m) in 2018/19, an improvement of £1.1m on the position in 2017/18. The Board of Directors is aware of the continuing need to operate financial control while continuing to address the service improvements identified by the CQC. The financial plan is monitored at the Performance and Finance Committee and the Board of Directors monthly.

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 2018/19 the Digital Information Improvement Group (DIIG) continued its work and has been pivotal in ensuring the quality of the data that is reported to the Board and external agencies. The new dashboards developed in 2017/18 continue to be used to inform decision making although a review is planned. Further developments around waiting times and the accuracy of the data that is captured and recorded on Lorenzo was progressed, and this work will continue in 2019/20 as the quality of patient care continues to be reviewed and data is used to support actions taken.

The focus remains on ensuring all performance is consistently managed and measured despite differences in the ways services are commissioned.

As new Executive Directors have been appointed, the use of Performance Accountability Review Meetings (PARMs) has been under review and these have not continued in their original format. Instead, local accountability discussions occur, and weekly or daily telephone calls are instigated around any specific areas of poor performance.

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 2019 and also the corresponding target. At each monthly Performance and Finance Committee, the Chief Operating Officer, with the support of corporate teams, presents an analysis of the month's achievement and outlines any action taken to resolve any failure to meet the target with a trajectory for resolution. Areas of specific interest in 2018/19 were Out of Area placements and waiting times and access to services and improvements to the quality of Care Plans for CPA and nCPA.

Single Oversight Framework

The Single Oversight Framework (SOF) 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 (1)	80.5%	53.0%
Data Quality Majority Index (DQMI) – Mental Health Services Data Set dataset score (2)	98.4%	95.0%
People referred to the IAPT programme will be treated within 6 weeks of referral	87.1%	75.0%
People referred to the IAPT programme will be treated within 18 weeks of referral	100%	95.0%
IAPT patients who complete treatment and 'move to recovery'	51.7%	50.0%
Total number of bed days patients have spent in inappropriate Out of Area placements	12,324	11,989
IAPT patients who have depression and / or anxiety disorders who receive psychological therapy (3)	32,624	31,212
Care Programme Approach (CPA) patients receiving follow up within seven days of discharge	96.5%	95.0%
CPA patients having formal review within 12 months	93.8%	95.0%
Admissions to inpatient services had access to Crisis Resolution and Home Treatment (CRHT) teams	95.8%	95.0%

Notes:

1. Report figures on referrals to existing (a) 14-35-year-old early intervention services in Suffolk, and (b) 14-65-year-old early intervention services in Norfolk and Waveney. No NSFT early intervention services currently commissioned to triage, assess and treat people with an at-risk mental state.
2. Reporting on the original 6 MHSDS Data Items used in the DQMI: MHS-DQM01 (NHS Number), MHS-DQM02 (Postcode), MHS-DQM04 (Gender), MHS-DQM05 (Ethnicity), MHS-DQM06 (GP Code), MHS-DQM12 (Code of Commissioner).
3. Commissioned percentages are different in Norfolk and Suffolk, figures presented as a total number of individual IAPT patients to aid understanding of the data.

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 2018/19 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 and perinatal services

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, a young people's inpatient unit and a Mother and Baby Unit (Perinatal). 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.

Financial review

The Trust reported a surplus of £2.2m in the year to 31 March 2019. This was an improvement on the planned deficit of £0.2m as a result of an underlying improvement in performance of £0.2m and the subsequent additional non-recurrent Provider Sustainability Funding (PSF) announced by NHS Improvement. The total PSF received in year was £3.9m which, when removed, gives an underlying deficit of £1.7m.

A full set of 2018/19 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 has 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 2019, the Trust had delivered the following performance:

- A year-end surplus of £2.2m
- A finance and use of resources rating of 2
- Capital expenditure of £16.1m
- A cash balance of £13.6m

Income

The Trust's total income (turnover) for the year was £235m, of which £222.2m was for the provision of patient care activities.

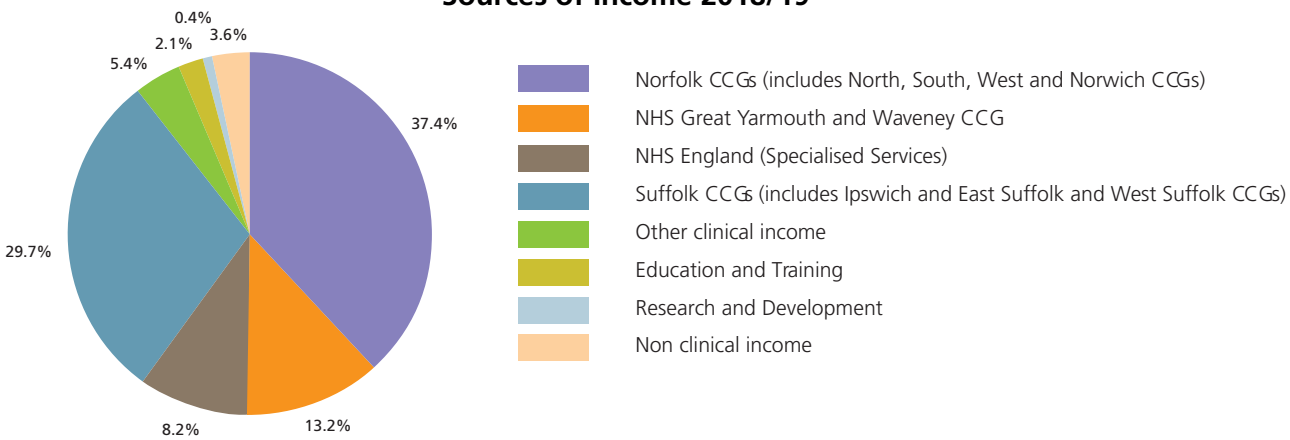
The NHS financial settlement for 2018/19 resulted in a net 0.1% increase to funding received by the Trust from Clinical Commissioning Groups (CCGs). This was made up of a 2.1% inflationary uplift offset by a 2.0% efficiency target on health care services contracts. There was also a 3.2% uplift from Suffolk CCGs for parity of esteem with prioritised investment to enable continued progress towards meeting the requirements of the national Five Year Forward View for Mental Health Services. The CCGs across Norfolk and Waveney invested a further 3.0% in service developments.

Research and development funding of £1.0m was secured in addition to education and training income of £5.1m. This included £0.5m income from the National Apprenticeship Fund, which was used specifically for approved apprenticeship posts (both clinical and non-clinical) 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 also received £3.9m of Provider Sustainability Funding (PSF) from NHS England. Of this, £1.8m was core PSF for delivery of the Trust's 2018/19 control total, with an additional £2.1m received for achieving and improving on the planned Trust control total.

(FR1)

Norfolk and Suffolk NHS Foundation Trust
Sources of Income 2018/19

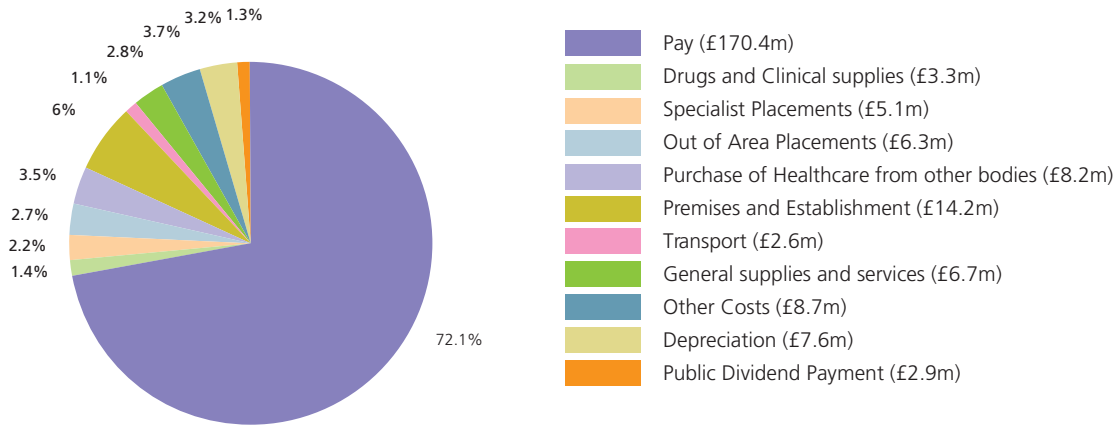


Expenditure

Total expenditure during 2018/19 amounted to £236m which is summarised by type of spend in the chart below.

(FR2)

Norfolk and Suffolk NHS Foundation Trust
Analysis of Expenditure 2018/19



The Trust delivered its target of £8.3m 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. This was 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 2 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. A detailed summary of this performance can be found within the Single Oversight Framework on pages 51-52.

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 £2.9m in 2018/19.

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 surpluses and depreciation charges) or to agree an interest-bearing loan with either the Foundation Trust Financing Facility (FTFF) or a commercial lender. In 2018/19 the Trust secured additional PDC funding of £0.6m during the year for additional improvements to the Adult Acute Services reconfiguration in west Norfolk. A loan for £5.2m was approved by the FTFF to support the Trust in delivering required safety and quality works following visits from the Care Quality Commission (CQC).

The outstanding balance on loans from the FTFF was £14.2m as at 31 March 2019.

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 once again prioritised over and above other originally planned expenditure.

Blomfield House in Bury St Edmunds was sold during the year as part of the Estates Strategy to dispose of properties deemed surplus to requirements for the provision of services.

Private Finance Initiative (PFI)

The Trust provides services from one location developed as a PFI – 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 2018/19 financial year.

Charitable funds

The Trust administers the Norfolk and Suffolk NHS Foundation Trust Charitable Fund (Charity Number 1050441). These funds are used for the benefit of both service users 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 2018/19.

Financial outlook for 2018/19

The next year will be another challenging year for the Trust. The Trust is planning to invest a significant amount of money to reflect urgent responses to the quality performance of the Trust. NSFT is also working closely with East London NHS Foundation Trust (ELFT) to improve quality, waiting times and service user outcomes.

All NHS provider organisations have been allocated non-recurrent funding from the £1.25 billion Provider Sustainability Fund (PSF) in 2019/20. In addition, NHS Improvement has created a £1.05 billion Financial Recovery Fund (FRF) to support the sustainability of essential services. The financial plans of the Trust for next year include both PSF and FRF monies.

In line with NHS Operational Planning guidance the Norfolk and Suffolk CCGs have made significant investment in our services as part of their requirement to invest in mental health services in line with the national Mental Health Investment Standard (MHIS). Significant investments will be made in Early Intervention in Psychosis (EIP), Children's Eating Disorders, Personality Disorders, Crisis, and Children's and Young People's services.

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 regions.

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 Chief Executive taking overall responsibility, supported by the Deputy Director of Commercial Resources. They lead on the vision for the Trust to over-achieve on the national carbon reduction targets and overall sustainability programme.

Actions to address our environmental impact include:

- A sustainability section on the intranet, enabling staff to access key information and links to events and issues of interest
- A national funding bid for LED lighting which has been successful, enabling a future carbon saving of 523 tonnes per annum
- Reduction of the energy carbon footprint by 3000 tonnes in three years
- An active programme of staff engagement through Champions and ward meetings
- Frequent contributions to the weekly Trust news, sharing good practice and information on initiatives
- The internal promotion of NHS Sustainability Day via computer pop ups and a staff event
- Regular staff updates about health and wellbeing, which aids sustainability by reducing sickness and associated agency fees
- Information about cycling and bus discounts to promote fitness and low-carbon travel
- Links to cycle purchase schemes and lift share sites for all areas available via the intranet
- Greater use of home working and local hub access to enable reduction in travel
- Reduce, reuse and recycle and Blue Planet Strategy on waste and equipment
- Work with procurement on the purchase of more sustainable options such as eliminating single use plastics

There are sustainable energy options in using sun pipes, ground source underfloor heating and PV panels on six properties (all owned by the Trust) at Grange Lodge, Kingfisher Mother and Baby Unit, Justin Gardiner House, Northgate Hospital, Hammerton Court and Carlton Court. Surplus energy has been sold back to the national grid from the Mother and Baby Unit and Grange Lodge.

The Trust has introduced alternative taps which reduce water wastage across the estate and energy consumption has been reduced by 20.0% on last year's figures.

The Trust has continued to maximise recycling of stock and equipment. Items no longer fit for purpose by the Trust have been forwarded to charities both nationally and abroad. This has enabled the Trust to reduce our costs and achieve a far more environmentally-friendly option for disposal, while also providing support for a variety of organisations. Electronics (not sensitive computer ware) are sent to a company that recycles electrical waste, so that it can be purchased by service users at a competitive cost and avoids high disposal costs. We also work with local charities providing furniture for refugee families and our own service users. Implementation of the furniture recycling scheme across the whole Trust has resulted in cost avoidance of £80,000 per year.

Waste management is closely managed with an increase in direct recycling to approximately 56% through extended recycling schemes across the Trust. The waste contractor has also contributed through a system of filtering the general waste for other recyclates, with the remaining residue being converted into refuse derived fuel. Overall, this means our recycling rate can confidently be reported to be over 95.0%. The clinical waste is sent to an 'Energy from Waste' site which provides heat via steam for Ipswich Hospital and our own Woodlands site.

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

The Trust submitted their Sustainable Development Assessment Tool in 2018, which shows an improvement in sustainability and led us to receive a certificate of excellence in sustainability reporting.

We have played a major part in the development of the East of England Sustainability Managers forum alongside the Health Estates and Facilities Management Association (HEFMA) where we have been proactive in sharing good practice with other Trusts and CCGs. This forum meets four times per year.

Social, community and human rights issues

With around 4,000 employees and a turnover of over £235m, 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 2018/19 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, Black History Month conference, 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 on the topic of 'Health and Recovery Through Social Prescribing', one in Norwich and one in Ipswich, and a 'Signposts to Wellbeing' event at Gorleston Library which was again a multi-agency event and attracted new Members.

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 inter-agency 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 2018/19 we have continued to strengthen 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 (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 in 2017/18 to incorporate new guidance from NHS England on declarations of interest. The Policy includes a section on the Trust's commitment to the Anti-bribery Act 2010 which explains the definition of bribery and gives examples of how the risk might manifest in our Trust. It is clearly explained that any staff who believe or suspect any fraudulent activities or a breach of this policy must notify the Local Counter Fraud Specialist immediately.

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 on pages 32-35.

We publish all Directors' interests annually on the Trust's website as part of our Board papers. 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

In March 2018 NHS Improvement (NHSI) commissioned PricewaterhouseCoopers (PwC) to undertake a review of governance to provide the Trust with an external insight into its current governance framework and to identify areas for improvement to address concerns raised by the CQC in 2017.

The resulting action plan, approved by the Board in May 2018, and complementing the Quality Improvement Plan, identified priorities for organisational development in relation to Board development, clinical leadership, strategy and culture, and the management of risk.

During 2018/19, substantive appointments were made to the Executive team, with the Chief Operating Officer and the Director of Human Resources and Organisational Development commencing in August, and the Chief Nurse commencing in November. A substantive CEO took up post in May 2018. New Non-executive Directors were appointed in October.

Since the 2017 inspection, NHSI have placed an Improvement Director with the Trust and East London NHS Foundation Trust (ELFT), is providing intensive support. Multi-stakeholder overview and assurance group (OAG) meetings, led by NHSI, take place monthly to monitor the Trust's performance.

The CQC inspection in July 2018, reported in November 2018, again gave a rating of 'inadequate' for the metric 'well-led'. Work has intensified to strengthen the governance of the Trust. A new Chair was appointed in January 2019, who is also Chair of ELFT, and following the resignation of the CEO in March 2019, a new CEO has been appointed. A contract is now in place between ELFT and the Trust for formal support. A further review of the Board and committee governance is underway, with an improved performance reporting dashboard now in place. New leadership teams are being recruited in localities and care groups to improve clinical accountability, and intensive work is underway to improve the quality and safety culture and the approach to continuous learning. Risk training has been delivered across the Trust, a new Board Assurance Framework is in place and the risk framework is under review to sit alongside the new care group governance structures.

Further information about the 2018 CQC report and the subsequent regulatory action can be found in the Annual Governance Statement on pages A9 to A17 and the Quality Report on pages 86 to 88.

Summary of action plans to improve the governance of quality

Over the course of 2018/19, the Trust reviewed its approach to the governance of quality and assurance to the Board on quality and safety. Urgent action was taken to address safety in response to CQC findings. The high-level 100-day plan runs from 14 January 2019 until 31 May 2019 and is supported by a detailed Quality Improvement Plan, both monitored by the Executive and the Board, with oversight by NHSI and stakeholders at OAG meetings. A locality-based clinical leadership model is being established across the Trust.

Our staff, service users' and carers' voices and needs are central to all we do and have been consulted at each stage of our quality improvement agenda. They are a key part of the governance of quality. People Participation Leads are being recruited as part of the leadership of each care group, and a People Participation Board Committee is being established. A review of the quality groups supporting the Board is underway.

Patient care

The Trust uses its foundation trust status to develop its services and improve patient care through the work of the Council of Governors. Governors represent the wider community in challenging the Trust's approach to quality and safety, in triangulating the quality performance with service user and carer experience and by holding the Non-Executive Directors to account for the performance of the Board, particularly in relation to CQC reports, Out of Area placements, workforce plans and the development of Sustainability and Transformation partnerships.

The Trust has implemented a robust Quality Improvement approach, with cohorts of staff trained and over 20 Quality Improvement projects in place, including national projects for reducing restrictive interventions.

The Green Light Tool is being embedded and the People Participation Team have organised service user and carer development days.

Quality and Safety reviews are carried out across services with service user and carer input.

Consultation and involvement

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.

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).

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 2018/19 the Trust Executives held over 60 sessions to consult on a draft of the strategy and improvement plan. These sessions were attended by over 2,000 members of staff, Governors, service users, carers and those with lived experience of our services who use their experience to help others (e.g. peer tutors, peer support workers, expert by experience advisors). These sessions resulted in the current Quality Improvement Plan. A series of sessions is now being planned to formulate the final version of the Trust strategy and this plan will be presented to the Board in May 2019.

Involvement of service users and carers

Our Improving Services Together Strategy, which was launched in 2015, is still an aspiration for the Trust.

In line with the CQC response and partnership working with East London NHS Foundation Trust (ELFT), and in order to improve quality of care and recovery, the Trust's operations care groups are being restructured, including the department which oversees the participation role and recovery role.

In this context, various actions are being undertaken to review and improve participation and involvement:

- NSFT webpage regarding service user and carers involvement is currently being redesigned by a partnership of service users, carers and staff, and will be co-edited going forwards. This will detail ongoing opportunities for involvement, groups, volunteering and updates on projects already being co-produced

- Formal hubs across the Trust have had inconsistent attendance and membership, so these are currently under review
- People Participation Leads are being recruited across the Trust. Once in post, they will be developing the Working Together Groups which will feed into Board
- ELFT are providing joint training for service users, carers and staff on quality improvement, incorporating:

  - Model for improvement
  - Quality improvement tools
  - Measurement and analysing data
  - Plan, Do, Study, Act cycle
  - Sharing and learning from projects

Recovery College: The recovery strategy has been moved to Operations to ensure teams can implement strategies on a locality-basis. The Recovery College has produced an introductory film to share information with those teams. Values-Based Recruitment training has continued to be available in all local Recovery Colleges as well as bespoke sessions on offer via the participation team.

Family and Friends Test (FFT): There has been a slight increase in the both the number of returns and the positive responses from the FFT; however, learning from the Test is negligible. A quality improvement project is due to be launched in June 2019 to review and improve the impact of the FFT.

Partnerships: The Trust continues to work within the Triangle of Care standards across the community teams, in partnership with third sector carer support charities and public interest companies, such as Norfolk Carers Matter, Suffolk Parent Carers Network and others. Across both counties there are Carers' Leads who are supporting and voicing carers' needs across the Trust.

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 stand for election as a Governor (if aged 16 or over).

Member involvement (and involvement with the wider public) by Governors is managed by the Membership Officer and is overseen by the Governor-led Governor and Member Development Subgroup which reports to the Council of Governors.

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 2018, the Council of Governors hosted two successful conferences for Members and the wider public on the topic of 'Health and Recovery Through Social Prescribing', one in Norwich and one in Ipswich.

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 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 95.0% 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 next table:

(DR1)

Performance by number	Non-NHS suppliers	NHS suppliers	Total
Paid within 30 days	19,790	775	20,565
Paid over 30 days	5,076	184	5,260
% paid within target	**79.6%**	**80.8%**	**79.6%**
Performance by value (£000)			
Paid within 30 days	£96,101	£19,000	£115,101
Paid over 30 days	£14,492	£3,546	£18,038
% paid within target	**86.9%**	**84.3%**	**86.5%**

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 the steps that they ought to have taken as a Director 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 core standard questions, the Trust was fully compliant on 44 standards and partially compliant on four standards. In 2018 this rating improved to a compliance of 47 of the 48 Core Standards, again creating a rating of Partially Compliant.

The Core Standard requiring improvement is *40 Cooperation - LHRP attendance: The Accountable Emergency Officer, or an appropriate Director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum*. This has been acknowledged by the Accountable Emergency Officer with a commitment to increase attendance.

This self-assessment is expected to be reviewed and ratified by NHSE during the coming months, subject to the availability of the regional NHSE team.

Professor Jonathan Warren
Chief Executive

Date: 23 May 2019

Remuneration report

Annual 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 2018/19 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)

CEO	Antek Lejk from 1 May 2018 to 31 March 2019
CEO	Jonathan Warren from 1 April 2019
Chief Nurse	Diane Hull from 21 November 2018
Chief Operating Officer / Deputy CEO	Stuart Richardson from 1 August 2018
Director of Human Resources and Organisational Development	Duncan Forbes from 20 August 2018

The Executive team and Board have had professional advice and support from Rebecca Driver in relation to Corporate Affairs and Communications.

During the reporting period the Committee oversaw the appointment of two substantive Chief Executives. The appointments were made through an open competitive process and included stakeholder panels that provided feedback for the interview panel to consider.

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 took up his position in May 2018 but resigned in March 2019 to take a secondment with East London NHS Foundation Trust.

The Council of Governors approved the appointment of Jonathan Warren as the new CEO on 25 March 2019. Jonathan Warren took up his position as CEO on 1 April 2019.

Remuneration

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

Marie Gabriel CBE
Chair

Date: 23 May 2019

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.

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 regard to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 takes account of the pay levels for senior managers (Band 8c and above) when considering the remuneration for Executive Directors to ensure an appropriate differential given the different 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 2018/19 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 2018/19 are listed on page 22.

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

	26 April 2018 Additional	4 June 2018	4 Sept 2018 Stood down	4 Dec 2018 Stood down	5 Mar 2019 Stood down	28 Mar 2019 Additional
Gary Page (Chair to Nov 2018)	✓	✓				
Marie Gabriel (Chair from Jan 2019)						✓
Tim Newcomb (NED; Interim Chair Nov 2018 to Jan 2019)	✓	✓				✓
Marion Saunders (Deputy Chair / SID to Aug 2018)	✓	✓				
Ian Brookman (NED to Dec 2018)	✓	A				
Tim Stevens (NED)	✓	A				✓
Jill Robinson (NED to Dec 2018)	A	✓				
Adrian Matthews (NED)	✓	✓				A
Pip Coker (NED from Oct 2018)						✓
Ken Applegate (NED from Oct 2019)						✓
Julie Cave (CEO to May 2018)	✓					
Antek Lejk (CEO from May 2018)		✓				*

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	3	Sheila Preston Ron French
Co-Lead Governor (automatic seat)		Nigel Boldero
Suffolk Public	3	Paddy Fielder Andrew Good Ian Hartley
Staff and Co-Lead Governor (automatic seat)	1	Howard Tidman
Service User	1	Vacant
Carer	1	Christine Hawkes
Lead Governor (automatic seat)	1	Catherine Wells to January 2019

Non-Voting Governor: Stephen Fletcher (Public Governor Norfolk).

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 four appointments: Ken Applegate and Pip Coker who replaced Ian Brookman and Jill Robinson as Non-executive Directors, Alex Ferguson as Non-executive Director and Marie Gabriel as Chair. The Committee oversaw an open competitive process with a strong field and recommended that Ken Applegate and Pip Coker be appointed for three years from 1 October 2018. Alex Ferguson was also appointed as a Non-executive Director in January 2019 but subsequently resigned from her position.

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 is shown in the table on page 27.

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

	29 May 2018	18 July 2018	8 Oct 2018	15 Jan 2019 Stood down
Marion Saunders (Deputy Chair / SID to 31 Aug 2018)	✓	A		
Tim Newcomb (NED / SID)			✓	
Catherine Wells (Lead Governor)	✓	✓	✓	
Sheila Preston – Norfolk Public	✓	✓	✓	
Andrew Good – Suffolk Public	✓	✓	✓	
Ron French – Norfolk Public	✓	✓	A	
Ian Hartley – Suffolk Public	A	✓	A	
Christine Hawkes – Carer	✓	✓	✓	
Paddy Fielder – Suffolk Public	✓	✓	A	
Howard Tidman – Staff	✓	A	✓	
Gary Page (Chair to Nov 2018)	✓	✓	✓	

A – Apologies received.

(RR5) Directors' remuneration (subject to audit)

Name and job title	Salary and Fees (in bands of £5,000) 2018/19	All taxable benefits (total to the nearest £100) 2018/19	All pension related benefits (in bands of £2,500) 2018/19	Total (in bands of £5,000) 2018/19	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
Antek Lejk Chief Executive from 1 May 2018	160 to 165	-	-	160 to 165	-	-	-	-
Julie Cave (a) Interim Chief Executive To 30 April 2018; Managing Director From 1 May to 30 Nov 2018	95 to 100	-	-	95 to 100	150 to 155	-	202.5 to 205	355 to 360
Bohdan Solomka (b) Medical Director	140 to 145	-	5 to 7.5	145 to 150	135 to 140	-	20 to 22.5	155 to 160
Daryl Chapman Interim Director of Finance	120 to 125	-	30 to 32.5	150 to 155	55 to 60	-	30 to 32.5	90 to 95
Dawn Collins Interim Director of Nursing, Quality and Patient Safety to 21 Nov 2018	65 to 70	-	80 to 82.5	145 to 150	45 to 50	-	132.5 to 135	180 to 185
Josie Spencer (c) Interim Chief Operating Officer and Deputy Chief Executive to 15 June 2018	25 to 30	-	-	25 to 30	30 to 35	-	5 to 7.5	35 to 40
Stuart Richardson Chief Operating Officer From 1 Aug 2018	80 to 85	-	105 to 107.5	185 to 190	-	-	-	-
Duncan Forbes Director of HR and Organisational Development from 20 Aug 2018	70 to 75	-	10 to 12.5	80 to 85	-	-	-	-
Diane Hull Chief Nurse From 21 Nov 2018	45 to 50	-	75 to 77.5	120 to 125	-	-	-	-
Gary Page Chair to 27 Nov 2018	30 to 35	-	-	30 to 35	45 to 50	-	-	45 to 50
Marie Gabriel CBE Chair from 29 Jan 2019	5 to 10	-	-	5 to 10	-	-	-	-
Tim Newcomb Non-executive Director; Acting Chair from 28 Nov 2018 to 28 Jan 2019	20 to 25	-	-	20 to 25	10 to 15	-	-	10 to 15
Marion Saunders Non-executive Director To 31 Aug 2018	5 to 10	-	-	5 to 10	15 to 20	-	-	15 to 20
Ian Brookman Non-executive Director To 31 Dec 2018	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 To 31 Dec 2018	5 to 10	-	-	5 to 10	10 to 15	-	-	10 to 15
Adrian Matthews Non-executive Director	10 to 15	-	-	10 to 15	5 to 10	-	-	5 to 10
Ken Applegate Non-executive Director From 15 Oct 2018	5 to 10	-	-	5 to 10	-	-	-	-
Phillipa Coker Non-executive Director From 15 Oct 2018	5 to 10	-	-	5 to 10	-	-	-	-
Alex Ferguson Non-executive Director 1 Jan 2019 to 18 Jan 2019	0 to 5	-	-	0 to 5	-	-	-	-

(a) On the 1 December 2018 Julie Cave was seconded to the role of Interim Chief Operating Officer for the Norfolk and Waveney Sustainability and Transformation Partnership.
(b) Total remuneration for the Medical Director includes £16.7k in respect of his clinical role.
(c) Josie Spencer was seconded to the Trust from Coventry and Warwickshire Partnership NHS Trust and NSFT made a contribution to her pension scheme in the year whilst on secondment.

NSFT currently has 28 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 £18.9k (2017/18 £14.8k).

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.

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.

(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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018 (rounded to nearest £000)	Real increase in Cash Equivalent Transfer Value at 1 April 2018 (rounded to nearest £000)	Cash Equivalent Transfer Value at 31 March 2019 (rounded to nearest £000)
Julie Cave Interim Chief Executive To 30 April 2018; Managing Director From 1 May to 30 Nov 2018	0 to 2.5	-	60 to 65	160 to 165	1,165	56	1,305
Bohdan Solomka Medical Director	0 to 2.5	-	40 to 45	115 to 120	794	83	916
Daryl Chapman Interim Director of Finance	0 to 2.5	-	5 to 10	-	28	16	61
Dawn Collins Interim Director of Nursing, Quality and Patient Safety To 21 Nov 2018	2.5 to 5	2.5 to 5	30 to 35	75 to 80	477	74	628
Stuart Richardson Chief Operating Officer From 1 Aug 2018	2.5 to 5	5 to 7.5	20 to 25	50 to 55	274	72	408
Duncan Forbes Director of HR and Organisational DevelopmentFrom 20 Aug 2018	0 to 2.5	-	0 to 5	-	-	-	10
Diane Hull Chief Nurse From 21 Nov 2018	0 to 2.5	0 to 2.5	20 to 25	5 to 10	261	22	348

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.

They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

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 25.0% 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 2018/19 was £175k-£180k on a full-year effect (2017/18, £150k-£155k). This was 5.9 times (2017/18, 5.5 times) the median remuneration of the workforce, which was £29,898 (2017/18, £27,124). The median has increased due to the national Agenda for Change pay deal impacting substantive, band and agency staff rates of pay in addition to incremental increases within the financial year. The ratio has increased due to an increase in the highest paid Director in year.

In 2018/19 two (2017/18, three) employees received remuneration in excess of the highest-paid Director. Remuneration ranged from £17,652 to £240,840, (2017/18, £15,558 to £220,643)

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)

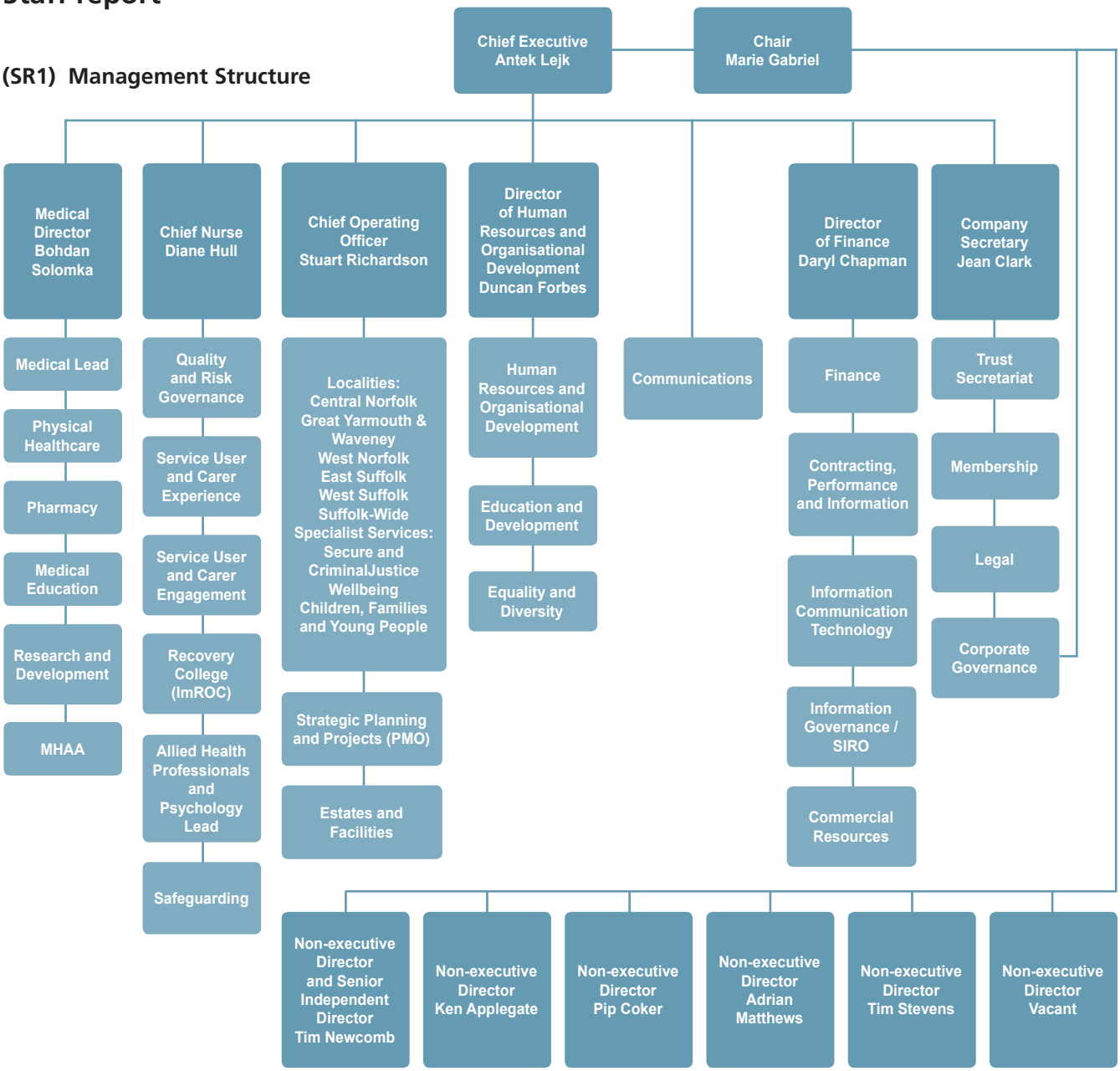
	2018/19 £	**2017/18 £**
Band of highest paid Director (full year effect)	175,000-180,000	150,000-155,000
Median total remuneration	29,898	27,124
Ratio	5.9 times	5.5 times

Professor Jonathan Warren
Accounting officer

Date: 23 May 2019

Staff report

(SR1) Management Structure

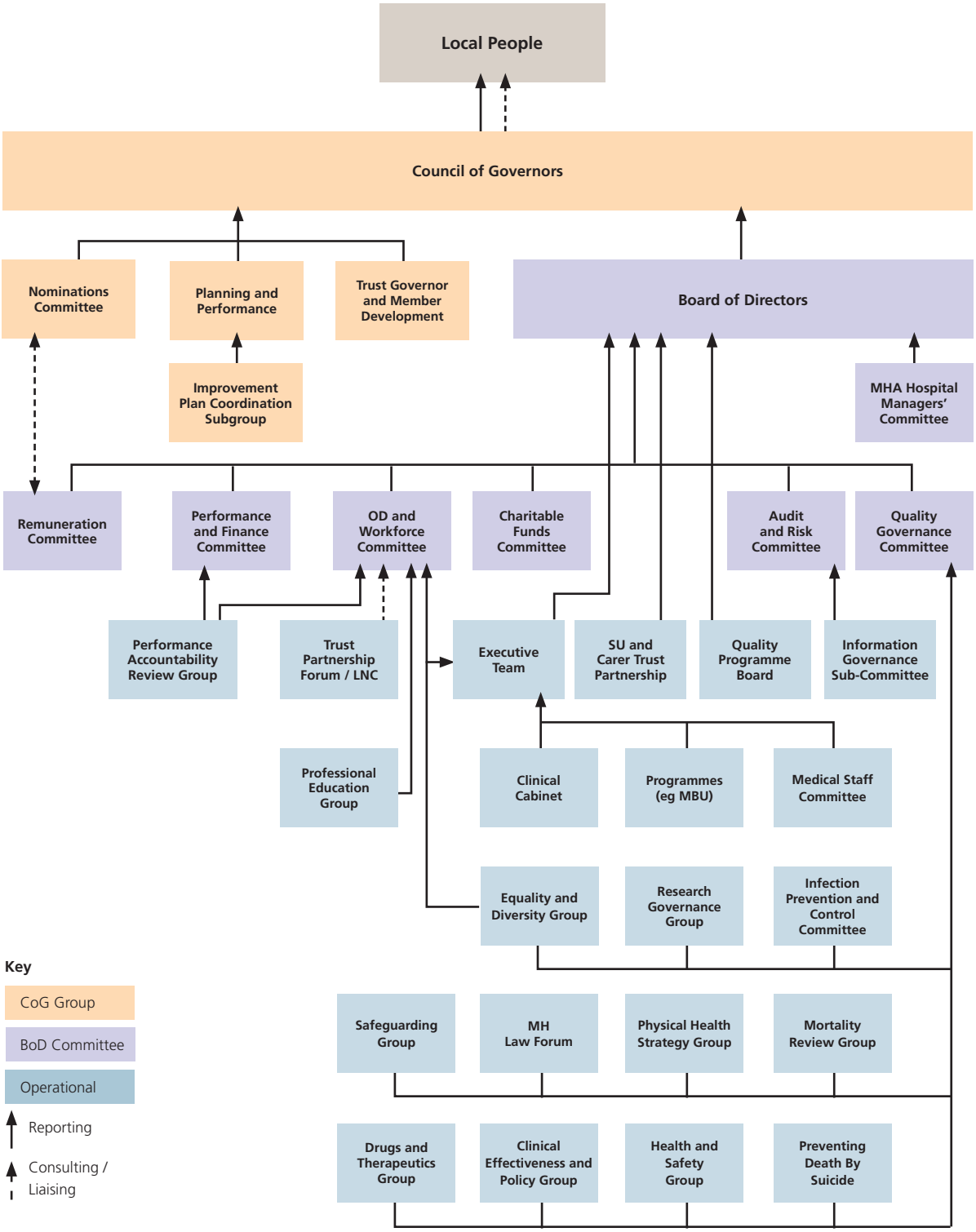


During 2018/19, there were several changes to the Board and the diagram above shows the position as at 31 March 2019. The key changes were as follows:

- Following Julie Cave (Director of Finance / Deputy CEO), who was acting as Interim CEO, Antek Lejk was appointed as CEO in May 2018
- Julie Cave has been seconded as Chief Operating Officer to Norfolk and Waveney STP. Daryl Chapman has continued as Interim Director of Finance
- Duncan Forbes was appointed as Director of Human Resources and Organisational Development as from August 2018
- Diane Hull was appointed as Chief Nurse with Interim Director of Nursing, Dawn Collins, returning to her Deputy Chief Nurse position
- Stuart Richardson was appointed to the new position of Chief Operating Officer
- Robert Nesbitt, Company Secretary, retired and has been replaced by Jean Clark
- Gary Page, Chair of the Trust, resigned. Tim Newcomb, Non-executive Director undertook this role on an interim basis prior to the appointment of Marie Gabriel CBE
- Jill Robinson, Non-executive Director; and Marion Saunders, Non-executive Director and Senior Independent Director, left at the end of their terms
- Tim Newcomb, Non-executive Director, took on the role of Senior Independent Director
- Alex Ferguson, was engaged as a Non-executive Director and left to take up full time employment
- Ken Applegate and Pip Coker joined as Non-executive Directors

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

(SR2) Committee and Subgroup structure



Chair, Non-executive Director and Executive Director expertise and qualifications 2018/19

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

	Experience and Skills	Qualifications
Gary Page (Chair from 3 April 13 to 27 Nov 18)	• 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)
Marie Gabriel (Chair from 29 Jan 18)	• Chair of East London NHS Foundation Trust (ELFT) since October 2012. ELFT is rated as 'outstanding' by the CQC and was the Health Service Journal's (HSJ) 'Trust of the Year' in 2016 • Recognised on the HSJ's inaugural 'Inspirational Women' list and made a CBE for services to the NHS in the Queen's birthday honours in 2017 • Chair of a variety of health organisations, including NHS East London and the City, North East London and the City, NHS Newham and Newham Community Health Council • Prior to these positions, held various senior roles in local government and the charity sector	• BA (Hons) DMS
Tim Newcomb (NED; Senior Independent Director and Vice Chair) (Interim Chair 28 Nov 18 to 28 Jan 19)	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

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)
Ken Applegate (NED from 15 Oct 2018; Chair of Audit and Risk Committee)	• Extensive NHS experience, having served as Chair of Norfolk Community Health and Care NHS Trust and as a NED with Norfolk and Waveney Mental Health Foundation Trust • Previously worked at a Board level with Norwich Union Insurance, and was also Managing Director of Hill House Hammond	
Pip Coker (NED from 15 Oct 2018)	• 10 years as Chief Executive of Julian Support; also worked in the Probation Service, latterly in Norfolk as Assistant Chief Probation Officer • Former Chair of the Mental Health Provider Forum, • A member of the Norfolk Health and Wellbeing Board and a Partner Governor at NSFT	• Certificate of Qualification in Social Work • Diploma in Management Studies
Marion Saunders (Senior Independent Director and Deputy Chair to 31 Aug 2018)	• 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 to 31 Dec 2018; 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 and Wales (ICAEW)
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
Alex Ferguson (NED from 1 Jan 19 to 18 Jan 19)	• A qualified accountant working in various roles with Aviva, including Head of Customer Experience • Director of Customer Oversight and Customer Retention Programme Director. Sponsor and business ally for Aviva Pride, which involved promoting diversity and inclusion	• Membership to the Institute of Chartered Accountants

(SR4) CEO and Executive Directors

	Experience and Skills	Qualifications
Jonathan Warren (CEO from 1 April 2019)	• A senior manager and clinical leader with over 35 years' experience in a variety of healthcare settings, predominantly within mental health • Deputy Chief Executive and Chief Nurse for Surrey and Borders Partnership NHS Foundation Trust and East London NHS Foundation Trust • Specialist advisor to the Care Quality Commission and the National Mental Health Patient Safety Collaborative • Visiting Professor City University and Surrey University	• RMN • BA (Hons)
Antek Lejk (CEO from 1 May 2018 to 31 Mar 2019)	• Extensive NHS and public sector background, with 12 years as Chief Executive of NHS commissioning and provider organisations as well as a charitable company • Previously STP lead for Norfolk and Waveney • Director of a number of public / private companies and Chair of two	• BSoc.Sci (Hons) • IOD Certificate in Company Direction
Julie Cave (Interim Chief Executive to 30 April 2018. Managing Director from 1 May 2018 to 30 November 2018)	• 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 healthcare 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
Stuart Richardson (Chief Operating Officer from 1 Aug 2018)	• Managing Director of Mental Health and Specialist Services with Pennine Care NHS Foundation Trust • Registered learning disability nurse; previously held senior roles in mental health, learning disability and community services	
Duncan Forbes (Director of HR and Organisational Development from 20 Aug 2018)	• Worked as HR Director with Her Majesty's Courts and Tribunals Service • Held a variety of roles across the UK and Europe, including HR Director at Jaguar Land Rover, Organisational Development and Change Consultant at E-On and HR Director at WorldPay • Has run own successful consultancy business	

Dr. Bohdan Solomka (Medical Director from 1 Jan 2015)	• 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 from January 2013 to December 2014	• B Med. Sci. • BM BS • Member of the Royal College of Psychiatrists • M.Phil. Criminology
Diane Hull (Chief Nurse from 21 Nov 2018)	• Chief Nurse with Sussex Partnership NHS Foundation Trust • Held several senior roles at East London Foundation Trust, including Interim Director of Services, Deputy Director of Nursing and Associate Director for Forensic Nursing • Qualified as a Registered Mental Health Nurse in 1990 and worked at St Clements in East London before moving to Hackney, fulfilled roles such as Nurse Specialist, Matron and Lead Nurse	• RMN
Josie Spencer (Interim Chief Operating Officer / Deputy CEO from 2 Jan 2018 to 15 June 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)
Dawn Collins (Interim Director of Governance and Nursing from 18 Oct 2017 to 21 Nov 2018)	• 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

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 2018/19 attendance

	26 Apr 2018	22 May 2018 (ARA)	31 May 2018	28 Jun 2018	26 Jul 2018	27 Sep 2018	10 Oct 2018 (AGM)	25 Oct 2018	29 Nov 2018	19 Dec 2018 (Private)	31 Jan 2019	28 Feb 2019	28 Mar 2019
Ken Applegate								✓	✓	✓	✓	✓	✓
Ian Brookman	✓	✓	✓	✓	✓	✓	✓	✓	✓	A			
Julie Cave	✓	✓	✓	✓	✓	✓	✓	✓					
Daryl Chapman	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓
Pip Coker								✓	✓	✓	✓	✓	✓
Dawn Collins	A	✓	✓	✓	✓	✓	✓	✓	✓				
Alex Ferguson										✓			
Duncan Forbes						✓	✓	A	✓	✓	✓	A	✓
Marie Gabriel (Chair from Jan 2019)												✓	✓
Diane Hull										✓	✓	✓	✓
Antek Lejk		A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Adrian Matthews	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	A
Tim Newcomb (Interim Chair Nov 2018 – Jan 2019)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gary Page (Chair to Nov 2018)	✓	✓	✓	✓	✓	✓	✓	✓					
Stuart Richardson						✓	✓	✓	✓	✓	✓	✓	✓
Jill Robinson	A	✓	✓	✓	✓	✓	A	A	A	A			
Marion Saunders	✓	✓	✓	✓	✓								
Bohdan Solomka	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓
Josie Spencer	✓	A	A										
Tim Stevens	✓	A	✓	✓	✓	✓	A	✓	✓	✓	✓	A	✓

A – Apologies received

The Board of Directors met ten times in public during the year in Norfolk and Suffolk. 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 (NEDs) 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

Governors have an important role in making an NHS foundation trust publicly accountable for the services it provides. They bring valuable perspectives and contributions to its activities. The Health and Social Care Act (2012) clarified the general duties of the Council of Governors:

- "To hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors, and
- To represent the interests of the Members of the corporation as a whole and the interests of the public"

In addition, the Council of Governors:

- Appoint or remove the Chair and other Non-executive Directors
- Approve the appointment of the Chief Executive
- Decide the remuneration and allowances, and other terms and conditions of office, of the Non-executive Directors (delegated to the nominations committee)
- Appoint or remove the Trust's external auditor

Governor 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.

The Trust's Governors represent the interests of Trust Members and the public and canvass their opinions in a number of ways: using informal and formal networks, organising and attending community events and learning from service user and carer experience. They feed these insights back to the Board of Directors through the Council of Governors, by raising questions with Directors and by attending the Board of Directors' meeting. The Council of Governors and Board of Directors work as a constructive partnership to inform the development of the Trust's strategic priorities, objectives and Annual Plan.

The Council of Governors met in public on the following dates in 2018/19. A summary of the business is shown in the table below and 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
12 April 2018	Update on Overview Assurance Group Annual Review of Declarations of Interest Update on Lorenzo, the Trust's clinical information system Recruitment, retention and e-rostering update Membership Strategy Review
12 July 2018	Update on Overview Assurance Group Reappointment of two NEDs for second terms: Ian Brookman and Tim Stevens Revised Code of Conduct Annual Report and Accounts External Audit KPMG LLP Report Governor Election Plan 2018/19 CoG Subgroup Membership and attendance
11 October 2018	Update on Overview Assurance Group Appointment of three new NEDs: Ken Applegate, Pip Coker, Alex Ferguson Lead Governor Elections Approval of appointment of Suffolk Youth Governor Crisis Service update Governance Review Report
12 December 2018 (additional)	Approval of the Chair's appointment
10 January 2019	Annual Report from the Audit and Risk Committee Review of External Audit CoG Development Programme update Nominations Committee Terms of Reference Report from the Physical Health Team Update on Overview Assurance Group
28 January 2019 (additional)	Amendments to the constitution The appointment of Marie Gabriel CBE to the role of Trust Chair
25 March 2019 (additional)	Approve the appointment of the CEO

In addition to the meetings in public, the Council of Governors hosted two successful conferences for Members and the wider public on the topic of 'Health and Recovery Through Social Prescribing', one in Norwich and one in Ipswich, and a 'Signposts to Wellbeing' event at Gorleston Library which was again a multi-agency event and attracted new Members.

Summary of changes to the constitution approved by the Council of Governors in 2018/19

With the appointment of the Chair, the constitution was amended to reflect the revised constituency area. These changes were approved by an extraordinary meeting of the Council of Governors on 28 January 2019. 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 2018/19 attendance

	Constituency	12 Apr 2018	12 Jul 2018	11 Oct 2018	12 Dec 2018	10 Jan 2019	28 Jan 2019	25 Mar 2019	
Christine Hawkes	Carer – N	A	A	✓	✓	A	✓	✓	Elected 1 Feb 2018 (opposed)
Anne Humphrys	Carer – S	✓	✓	✓	✓	✓	✓		Elected 1 Feb 2016, stood down Jan 2019
Peter Coleman	Carer – S							✓	Elected 1 Feb 2019 (opposed)
Stephen Benns	Public – N							✓	Elected 1 Feb 2019 (opposed)
Nigel Boldero	Public – N	✓	A	✓	A	A	*	✓	Re-elected Feb 2019 (sub)
Stephen Fletcher	Public – N	A	✓	✓	A	✓	✓		Re-elected 1 Feb 2016 (opposed), term ended Jan 2019
Ronald French	Public – N	✓	✓	✓	✓	✓	✓	✓	Re-elected 1 Feb 2017 (opposed)
Hilary Hanbury	Public – N	A	✓	A	✓	✓	✓	A	Re-elected 1 Feb 2018 (opposed)
Sheila Preston	Public – N	A	✓	✓	✓	✓	✓	✓	Re-elected 1 Feb 2017 (opposed)
Clare Smith	Public – N	✓	A	✓	✓	A	*	✓	Appointed 8 Mar 2018
Rebecca Toye	Public – N							✓	Elected 1 Feb 2019 (opposed)
Catherine Wells	Public – N	✓	✓	✓	✓	✓	✓		Re-elected 1 Feb 2016 (opposed), stood down Jan 2019
Katharine Axford	Public – S							✓	Elected 1 Feb 2019 (opposed)
Kathleen Ben Rabha	Public – S	✓	*	A	✓	✓	*	A	Re-elected 1 Feb 2017 (opposed)
Paddy Fielder	Public – S	✓	✓	✓	✓	✓	✓	✓	Formerly Partner Governor from Apr 2012
Ian Hartley	Public – S	✓	✓	✓	✓	✓	✓	✓	Re-elected 1 Feb 2017 (opposed)
Andrew Good	Public – S	✓	✓	✓	✓	A	*	✓	Elected 1 Feb 2018 (unopposed)
Sara Muzira	Public – S							✓	Re-elected 1 Feb 2017 (opposed)
Steve Roche	Public – S	✓	*						Elected 1 Feb 2019 (opposed)
Martin Wright	Public – S	✓	✓	A					Elected 1 Feb 2018 (unopposed), stood down 13 Aug 2018
Ginnie Benedettini	Service User – N	A							Elected 1 Feb 2016 (opposed), stood down 30 Oct 2018
Richard Gorrod	Service User – N	*	✓	✓	✓				Elected 1 Feb 2016, stood down 14 Apr 2018
Kevin James	Service User – N							✓	Elected 1 Feb 2019 (opposed)
Malcolm Blowers	Service User – S	✓	A	✓	✓	✓	✓		Elected 1 Feb 2016 (opposed), term ended Jan 2019. Formerly Partner Governor from Feb 2015
Georgia Butler	Service User – S	*							Elected 1 Feb 2018 (opposed), stood down 2 May 2018
Maximillian Clark	Service User – S							✓	Elected 1 Feb 2019 (opposed)
Derek Sanders	Service User – S							A	Elected 1 Feb 2019 (opposed)
Jill Curtis	Staff	✓	✓	✓	*	*	*	✓	Elected 1 Feb 2018 (opposed)
Marcus Hayward	Staff	✓	✓	✓	✓	✓	✓		Elected 1 Feb 2016, term ended Jan 2019
Howard Tidman	Staff	✓	✓	✓	✓	✓	✓	✓	Re-elected 1 Feb 2018
Zeyar Win	Staff	A	A	*	✓	✓	*		Elected 1 Feb 2016, term ended Jan 2019
Lisa Breame	Staff							*	Elected 1 Feb 2019 (opposed)
Jemima Jackson	Staff							**A**	Elected 1 Feb 2019 (opposed)
Richard Rout	Partner – Suffolk County Council	*							Appointed 18 Aug 2017, stood down 14 June 2018
Sian Coker / Dr Peter Beazley from Feb 19	Partner – UEA	A	*	*	A	*	*	✓	Appointed 22 Feb 2016
James Reeder	Partner – Suffolk County Council		*	✓	✓	✓	✓	**A**	Appointed 14 June 2018
Heather Rugg	Partner – UCS	A	A	*	A	✓	*	*	Appointed 11 Aug 2017
Thomas Smith	Partner – Norfolk County Council			✓	A	✓	*	*	Appointed 1 Aug 2018
Meghan Teviotdale	Partner – Youth Council (Norfolk)	✓	A	✓	✓	✓	A	✓	Appointed 11 Jan 2018
Vikki Versey	Partner – Youth Council (Suffolk)				*	*	✓	✓	Appointed 11 Oct 2018
Gary Page (Chair to Nov 2018)	Trust Chair	✓	✓	✓					Stood down Nov 2018
Marie Gabriel (Chair from Jan 2019)	Trust Chair							✓	Appointed 28 Jan 2019
Tim Newcomb (Interim Chair from Nov 18 to Jan 19)	NED / Interim Chair				✓	✓	✓		Interim Chair from Nov 2018 to Jan 2019

A – Apologies received * – Not attended, apologies not noted

The work of the Audit and Risk Committee

The Audit and Risk Committee is a non-executive committee of the Trust Board with delegated authority to review the establishment and maintenance of an effective system of integrated governance, risk management and financial and non-financial, non-clinical internal controls, which supports the achievement of the Trust's objectives. The Committee works in partnership with the other Board committees to fulfil these aims.

The principal purpose of the Committee is to assist the Board in discharging its responsibilities for monitoring the integrity of the Trust's accounts. In addition, it reviews the adequacy and effectiveness of the Trust's systems of risk management and internal controls, and monitors the effectiveness, performance and objectivity of the Trust's external auditors, internal auditors and local counter fraud specialists.

Composition of the Audit and Risk Committee

The membership of the Committee comprises three independent Non-executive Directors; the Chair of which is a qualified accountant.

During the year the Committee met on five occasions. A Governor representative attended one of those meetings.

Two members must be present for the meeting to be quorate. All meetings achieved this status during 2018/19.

(SR8) Audit and Risk Committee 2018/19 attendance

	18 May 2018 ARA	8 Jun 2018	6 Aug 2018	7 Dec 2018	15 Mar 2019
Ian Brookman	✓	✓	✓	✓	
Jill Robinson	✓	✓	✓	✓	
Marion Saunders	✓	✓			
Ken Applegate					✓
Tim Newcomb					✓

ARA = Annual Report and Accounts meeting.

The Director of Finance, the Risk Manager, the Company Secretary and representatives from Internal Audit, External Audit and Local Counter Fraud Specialists attended all meetings. The Committee directs and receives reports from these representatives and seeks assurance from Trust officers.

Effectiveness of the Committee

The Committee reviews and self-assesses its effectiveness annually, using criteria from the NHS Audit Committee Handbook and other best practice guidance, and ensures that any matters arising from this review are addressed.

The Committee also reviews the performance of its internal and external auditors' services against best practice criteria identified from the NHS Audit Committee Handbook and the Public Sector Internal Audit Standards (PSIAS).

The Committee is supported by the Company Secretary. Meetings were scheduled to allow enough time to enable a full and informed debate. Each meeting is minuted and reported to the Trust Board.

Internal Audit

The Trust's internal auditors for 2018/19 were Grant Thornton UK LLP. Internal Audit provides an independent appraisal service to provide the Trust Board with assurance about the Trust's systems of internal control. Internal Audit prepare and deliver a three-year, risk-based audit strategy which is translated into an internal audit plan each year. The plan considers 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 of Directors.

Their work is undertaken in accordance with the 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 2018/19.

External Audit

The Trust's external auditors for the year were KPMG LLP. The main responsibility of External Audit is to plan and carry out an audit that meets the requirements of NHS Improvement's Audit Code for NHS Foundation Trust. Under the Code, External Audit is required to view and report on:

- The Trust's Accounts
- Whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources

The External Auditors also review the content of the Trust's Quality Account.

The Audit and Risk Committee reviews the External Audit Plan at the start of the financial year and receives regular updates on progress. The Committee also receives an Annual Audit Letter. The Committee annually assesses their performance and reports on this to the Board of Directors and Council of Governors.

KPMG's remuneration for 2018/19 was £64,400 excluding VAT. During the year no non-audit services were provided by KPMG LLP.

Counter fraud and bribery

Local Counter Fraud Specialist (LCFS) services are provided by Grant Thornton UK LLP and their role is to:

- Assist in creating an anti-fraud and anti-bribery culture within the Trust
- Deter, prevent and detect fraud and bribery
- Investigate any suspicions that arise; to seek to apply appropriate sanctions
- Seek redress in respect of monies obtained through fraud and bribery

The Audit and Risk Committee receives regular progress reports from the LCFS during the year. The Committee reviews the levels of fraud reported and detected and the arrangements to prevent, minimise and detect fraud and bribery.

External Auditor's reporting responsibilities

KPMG reports to the Trust's Council of Governors through the Audit and Risk Committee. Their report on the Trust's financial statements is based on its examination conducted in accordance with International Financial Reporting Standards (IFRS) and NHS Improvement's Financial Reporting Manual. Their work includes a review of the Trust's internal control structure for the purpose of designing their audit procedures.

Relationship with the Council of Governors

In an NHS Foundation Trust, the Council of Governors is vested with the responsibility for the appointment of the Trust's External Auditors and will consider recommendations from the Audit and Risk Committee when doing so.

How the Audit and Risk Committee discharges its responsibilities

The purpose of the Committee is to provide one of the key means by which the Trust Board ensures that effective internal financial control arrangements are in place. In addition, the Committee is tasked with providing a form of independent check upon the executive arm of the Trust Board. The Committee operates in accordance with its Terms of Reference set by the Trust Board which are consistent with the NHS Audit Committee Handbook and the Foundation Trust Code of Governance. All issues and minutes of these meetings are reported to the Trust Board.

In discharging its responsibilities in respect of the Annual Report and Accounts, including the Annual Governance Statement, the Committee considered reports from management and from the Internal and External Auditors to assist in their consideration of:

- The Trust's accounting policies, with particular reference to any changes and compliance
- The clarity of disclosures and their compliance with relevant reporting requirements
- Key judgements made in preparation of the financial statements
- Compliance with legal and regulatory requirements
- The accounting of Trust property, plant and equipment, and ensuring that independent, professional advice has been obtained in valuing the Trust's property portfolio
- Whether the Annual Report is fair, balanced and understandable, and provides the information necessary to assess the Trust's performance and strategy

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 misstatements in the Trust's accounts these are considered for their significance and understanding of the accounts. These are reported to the Board of Directors and are listed by the external auditors in their report.

In addition to the above areas of work the Audit and Risk Committee receives regular reports on losses and special payments incurred by the Trust.

Membership strategy summary 2018/19

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 member of staff 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 a new membership officer in post who is working closely with the Council of Governors to build our membership and refreshing our approach to meaningful engagement. This is our focus for 2019/20.

This year, the Council of Governors has hosted successful Member events on the topic of Health and Recovery Through Social Prescribing, one in Norwich and one in Ipswich. These were multi-agency events with stalls, speakers and activities which promoted good mental health through social prescribing. In addition, Governors organised a 'Signposts to Wellbeing' event at Gorleston Library which was again a multi-agency event and attracted new membership.

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 90.0% of new Members do so.

(SR9) Membership report 2018/19

Membership	2018/19
Public constituency	
At year start (April 1)	11,227
New Members	86
Members leaving	213
At year end (March 31)	11,100
Staff constituency	
At year start (April 1)	3,996
New Members	714
Members leaving	507
At year end (March 31)	4,208
Patient constituency*	
At year start (April 1)	1,586
New Members	46
Members leaving	35
At year end (March 31)	1,597

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 2018/19:

(SR10)

Staff Group	2018/19			2017/18		
	Permanent	Other*	Total	Permanent	Other*	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Medical and dental	19,569	5,319	**24,888**	13,228	10,864	**24,092**
Administration and estates	35,668	1,880	**37,548**	31,562	3,481	**35,043**
Healthcare assistants and other support staff	26,083	6,418	**32,501**	20,856	7,456	**28,312**
Nursing, midwifery and health visiting staff	45,682	5,100	**50,782**	45,917	6,241	**52,158**
Scientific, therapeutic and technical staff	22,218	-	**22,218**	19,251	3,136	**22,387**
Social care staff	2,401	-	**2,401**	**	**	**
Total	**151,621**	**18,717**	**170,338**	**130,814**	**31,178**	**161,992**

* 'other' includes short-term contract staff, inward secondments, agency and other temporary staff.
** In 2017/18 Social care staff were included in Nursing, Midwifery and health visiting staff.

Analysis of average staff numbers

The table below shows the average number of employees in the 2018/19 financial year, split by permanently employed and other staff:

(SR11)

Average number of employees (WTE basis)	2018/19			2017/18		
	Permanent	Other*	Total	Permanent	Other*	Total
Medical and dental	152	54	206	139	71	210
Administration and estates	934	107	1,041	885	98	983
Healthcare assistants and other support staff	889	269	1,158	861	265	1,126
Nursing, midwifery and health visiting staff	1,051	121	1,172	1,134	149	1,283
Scientific, therapeutic and technical staff	439	19	458	344	58	402
Social care staff	54	1	55	**	**	**
Total average numbers	**3,519**	**571**	**4,090**	**3,363**	**641**	**4,004**

* 'other' includes short-term contract staff, inward secondments, agency and other temporary staff.
** In 2017/18 Social care staff were included in Nursing, Midwifery and health visiting staff.

Breakdown of male / female at year end

The male / female split for the Trust's workforce for the financial year 2018/19 is 71.9% female and 28.1% male. The proportion of women decreases to 54.2% at senior management level and decreases further at director level (to 37.5%). The number of male / female staff in each group is set out in table SR12.

(SR12)

Annual report category	Female	Male	Total
Director	3	5	8
Senior Manager	38	32	70
Other employee	2,986	1,146	4,132
Total	**3,027**	**1,183**	**4,210**

Sickness absence data

In accordance with the Department of Health and Social Care Group Accounting Manual, the sickness absence rate is reported on a calendar year basis. The Trust's annualised sickness absence rate for the calendar year 2018 was 4.9% (2017: 4.8%).

The average days sick per FTE employee was 10.9 days (10.8 FTE days in 2017).

The largest known reason for sickness absence is due to 'anxiety / stress / depression / other psychiatric illnesses', accounting for 32.9% of all absence (equivalent to 1.7% of days lost), (2017/18: 31.9%). The top five reasons for absence are:

- Anxiety / stress / depression / other psychiatric illnesses
- Other musculoskeletal problems
- Cold, cough, flu - influenza
- Unknown causes / not specified
- Gastrointestinal problems

Episodes of long-term absence (defined as being absence episodes of 28 days or more) account for 62.4% of time lost and short-term absences (absences below 28 days in length) account for 37.6%.

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 previously received national recognition of the work we are doing to improve staff wellbeing. Initiatives delivered as part of this strategy include:

- 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
- Continuing to deliver the Healthy Worker Programme aimed at increasing staff resilience as well as Supportive Leadership workshops for managers
- Staff access to physiotherapy / occupational therapy and counselling support

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
- Development of a reasonable adjustment toolkit of resources to support recruitment by making job roles accessible, providing job ads in accessible formats, supporting interview panels and expediting any reasonable adjustment requests for new hires
- Learning Disability Employment Pledge to recruit more people with a learning disability

Theme 2:
Keeping and developing your people:

- Providing mentoring, coaching, buddying 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
- Reviewing the procurement process for reasonable adjustment requests to ensure equipment is provided in a timely manner and is working as intended for the recipient
- A Disability Employee Network Group provides peer support, and a safe space for employees to raise issues affecting themselves and other staff with disabilities

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

Members of the Executive Team provide regular updates to staff on key issues affecting the Trust, our services and staff. This includes a weekly Trust Update communication, Dialogue magazine, email updates and Skype broadcasts. Vlogs and blogs have also been used. A review of our corporate approaches to communication is currently being undertaken with recommendations to be implemented from the first quarter of the year.

Board members regularly visit teams. A series of Executive-led staff listening events are also being held. These are used to inform our quality improvement plans and to test effectiveness.

Other sources of information include a Staff Handbook, induction and information held on the intranet.

Action on consulting with staff or representatives

We hold regular forums to consult with staff representatives. Trust Partnership Meetings (TPM) are held monthly with Staff Side colleagues for all recognised unions and professional bodies, and the Local Negotiating Committee (LNC) meets every other month which involves doctors and the BMA. Executive Directors and other senior managers attend both these meetings. These meetings provide an opportunity to discuss, consult and work collaboratively on matters affecting our workforce, including organisational change and performance. In addition to this, regular listening events are held directly with staff, so we can understand how things feel for them, what makes a great day and what creates challenges, to inform improvements.

Performance

Performance is reported to localities monthly 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, enable locality leadership teams to be held accountable 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 Wellbeing Operational Management Group and also with 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 (NHS CFA) 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.

The Trust completes an annual self-assessment covering twenty-three fraud and corruption management Standards that are prescribed by the independent NHS fraud and corruption regulator, the NHS CFA.

NHS Staff survey

The NHS Staff Survey is conducted annually (between October and December). Questions are grouped into themes and results calculated on a score out of 10, with the indicator score being the average of those.

The response rate to the 2018 survey among Trust staff was 53.5% (2017: 55.5%). The national average was 54.0%.

Scores for each indicator together, with that of the survey benchmarking group (Mental Health / Learning Disabilities), are presented below:

(SR13)

	2018		2017		2016	
	Trust	MH/LD	Trust	MH/LD	Trust	MH/LD
Equality, diversity and inclusion	8.8	8.8	8.7	9.0	8.9	9.0
Health and wellbeing	5.8	6.1	5.7	6.2	5.9	6.2
Immediate managers	6.9	7.2	6.7	7.2	6.8	7.1
Morale	5.9	6.2	n/a	n/a	n/a	n/a
Quality of appraisals	5.3	5.7	5.2	5.5	5.4	5.5
Quality of care	6.7	7.3	6.7	7.3	6.9	7.4
Safe environment – bullying and harassment	7.6	7.9	7.7	8.0	7.8	8.0
Safe environment – violence	9.2	9.3	9.3	9.2	9.2	9.2
Safety culture	6.2	6.7	6.1	6.7	6.3	6.6
Staff engagement	6.5	7.0	6.4	7.0	6.6	6.9

There have been statistically significant improvements for the themes of immediate managers, safety culture and staff engagement, however, these are still significantly below our benchmark group average and require continued concerted focus. These areas of focus are in line with our Quality Improvement Plans. There is no statistically significant change across the other themes.

Further discussion of staff engagement, staff survey results and future priorities can be found in the Quality Report on pages 83 to 84.

Trade union facility time

The following data is for the reporting period 1 April 2017 to 31 March 2018 (data for 2018/19 is due to be published by July 2019).

(SR14) Relevant Union Officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
Unknown (information held by unions, not employer)	3,637

The table below shows the number of employees who were relevant union officials employed during the relevant period and the percentage of their working hours spent on facility time.

(SR15) Percentage of time spent on facility time

Percentage of time	Number of employees
0%	1
1-50%	4
51-99%	0
100%	1

(SR16) Percentage of pay bill spent on facility time

Total cost of facility time:	£40,000
Total pay bill:	£143,666,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.03%

The table below shows the hours spent on paid trade union activities by employees who were relevant union officials during the relevant period, as a percentage of total paid facility time hours.

(SR17) Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	8.2%

Exit packages

(SR18) Exit packages

No redundancy or other departure payments were made during the year. There were no other departure payments.

Reporting of compensation schemes - exit packages

Exit package cost band (including any special payment element):	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages	
	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18
<£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**

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 pages A9 to A17 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 carries out a full review of the Trust's compliance against the Code each year.

(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. The Board work with the Council of Governors (CoG) to promote the success of the organisation and maximise the benefits for the Members of the Trust and for the public. There is a clear statement of how the Board and Council operate and how any disagreements would be resolved. They hold joint sessions throughout the year.
	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 23-26 and 40.
A.5.3	Details of the Council of Governors are set out on page 39. Records of the number of meetings of the CoG and the attendance of individual Governors are maintained and published in 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. NEDs links with other organisations are set out 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. 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 based on 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	The process set out in the Code of Governance was followed for the appointment of the Chair in January 2019 and there is a declaration of interests at both the Board and CoG. The Chairperson is also the Chair of East London 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 areas that they are aligned to. Directors have access to training and development opportunities funded by the Trust, where appropriate.
B.5.6	Governors canvass the opinion of the Trust's Members and the public in a variety of meetings and Member activities. This is overseen by the CoG subgroups and these insights inform the Trust's Annual Plan and Quality Account. This is stated further within the Annual Report on pages 37-38.
B.6.1	The performance of the Board, its subcommittees, Directors and the Chair is included within the Annual Report.
B.6.2	PwC carried out an external governance review in Q4: 2017/18 – Q1: 2018/19. PwC have no other connection with the Trust.
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 Board delegates responsibility for overseeing risk management and internal control systems to the Audit and Risk Committee, informed by the work of internal and external audit. A review of the effectiveness of the Trust's system of internal controls is outlined in the Annual Governance Statement on pages A9 to A17. The report from the Audit and Risk Committee is scrutinised by the Governors.
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 how the members of the Board, and in particular the NEDs, develop an understanding of the views of Governors and Members. NEDs attend CoG meetings, are paired with link-Governors whom they meet informally, carry out joint service visits with Governors, and attend Member events.
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 page 43. 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 helping NHS providers attain, and maintain, Care Quality Commission ratings of 'good' or 'outstanding' and 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 for 2018/19.

Segmentation

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' for the first three quarters and achieved a rating of '2' by the end of the year which was due to improvements in its liquidity and income and expenditure (I&E) margin. See table for details of the calculation.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

(SOF1)

		2018/19 Scores				2017/18 Scores			
Area	**Metric**	**Qtr 1 Score**	**Qtr 2 Score**	**Qtr 3 Score**	**Qtr 4 Score**	**Qtr 1 Score**	**Qtr 2 Score**	**Qtr 3 Score**	**Qtr 4 Score**
Financial stability	Capital service capacity	3	3	3	2	3	3	3	1
	Liquidity	4	4	4	2	4	4	4	4
Financial efficiency	I and E margin	2	3	3	2	4	4	4	2
Financial controls	Distance from financial plan	1	1	1	1	1	1	1	1
	Agency spend	2	2	2	2	1	1	1	1
Overall score		**3**	**3**	**3**	**2**	**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 2018/19 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
- Implementation of an improved governance structure to put front-line equality leads in contact with their locality managers via a locality equality coordinator
- Localities taking ownership of consultation with our service users to obtain the most relevant and accurate data to evidence Equality Delivery System (EDS 2) reporting

- Workforce Race Equality Standard (WRES) action plan
- Continuing preparation for the implementation of the Workforce Disability Equality Standard (WDES)
- Improving services by developing person-centred care planning and cultural competency
- Reporting on progress with the three-step plan is reviewed bi-monthly at the Trust's monthly Performance Accountability Review Meetings with a new focus on increasing the quality of equality monitoring data recording

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

The Trust hosted a successful conference on equality and diversity, 'Compassion and Inclusion', in March 2019 and a Black History Month Conference event in October 2018.

The Trust's gender pay analysis was published in March 2019 and is available on the Trust's website: nsft.uk/genderpay

Statement on Modern Slavery

This statement is made on behalf of the Board of Norfolk and Suffolk NHS Foundation Trust with regards to the Modern Slavery Act 2015 which requires large employers to be transparent about their efforts to eradicate slavery and human trafficking in their supply chain.

The principal activities of the Trust are to support and enable people with mental health problems to live fulfilling lives. The Trust provides health and social care services specialising in mental health across Norfolk and Suffolk, including services for working age adults, children, families and young people, dementia and complexity in later life, neurodevelopmental, wellbeing, and secure services.

Our supply chains include procurement of agency staff, medical services, medical and other consumables, facilities maintenance, utilities and waste management.

We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. We continue to develop policies and procedures to reflect our commitment to acting ethically in all our business relationships and to implement effective systems and controls to ensure slavery and human trafficking is not taking place in our supply chains.

Training is provided to those involved in the supply chain and the rest of the organisation as part of the Trust's safeguarding work.

We will work to identify and mitigate risk and put in place contractual terms which will allow the Trust to gain assurance that slavery and human trafficking have no place in our business. We will work with suppliers to ensure that they treat their obligations towards modern slavery with the same importance that we do.

Quality report

Part 1: Statements

2018/19 Statement of directors' responsibilities for 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 2018/19 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 2018 to April 2019
  - papers relating to quality reported to the board over the period April 2018 to April 2019
  - feedback from commissioners dated 1 May 2019
  - feedback from governors dated 1 May 2019
  - feedback from local Healthwatch organisations dated 24 April 2019
  - feedback from Overview and Scrutiny Committee dated 29 April 2018
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27 September 2018
  - the national patient survey 22 November 2018
  - the NHS Staff Survey 26 February 2019
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 20 May 2019
  - CQC inspection report dated 28 November 2018
- 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

Marie Gabriel CBE
Chairman Date: 23 May 2019

Professor Jonathan Warren
Chief Executive Date: 23 May 2019

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 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority 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 2018/19* ('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 Guidance.

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 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, received 17 May 2019;
- feedback from governors, received 17 May 2019;
- feedback from local Healthwatch organisations, received 17 May 2019;
- feedback from Overview and Scrutiny Committee, received 17 May 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2017 national patient survey, published June 2018;
- the 2018 national staff survey, dated February 2019;
- Care Quality Commission Inspection, dated 28 November 2018;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated 7 May 2019; and
- any other information included in our review.

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 2019, 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 non-mandated 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 2019:

- 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 indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
Dragonfly House, 2 Guilders Way,
Norwich NR3 1UB

28 May 2019

Statement on quality from the Chief Executive, 2018/19

It has again been a difficult year for our Trust, which remained in special measures following a Care Quality Commission (CQC) inspection in September. Although we were disappointed with the inspectors' findings, we recognise that the actions we had been taking had not resulted in the rapid progress which both the CQC and our Trust had hoped for, and that there was more to do to improve the services we provide.

Everyone at the Trust shares a real commitment to making the necessary changes in the right way so that we can ensure we provide safe, effective care for people in Norfolk and Suffolk. Since receiving the report, a renewed focus and energy has been placed on driving improvements to quality and safety. Our dedicated staff have shown huge enthusiasm for this work, taking ownership of nearly 30 projects which aim to tackle the specific issues they are facing locally and volunteering for a range of other initiatives designed to positively change the culture of our organisation.

All of these improvement projects have been brought together into a single Trust-wide Quality Improvement Plan. As well as delivering immediate actions to keep service users safe, the plan also recognises the longer-term work which is needed to embed and sustain a culture of continuous quality improvement at NSFT. In addition, we have appointed our own dedicated Quality Improvement Lead to drive this important agenda.

We have also introduced a new, clinically-led approach, which will flatten our previous management structure and give a stronger voice to our clinicians. They will be supported by locally-empowered Care Groups, which will see QI experts work together with service users, giving them the opportunity to make their voices heard when defining and solving problems. We believe this approach will be integral to the success of our Quality Improvement Plan and aim to roll out these groups across the Trust during the coming 12 months.

In addition to this work, quality and safety improvements have taken place in a range of other areas. Our key achievements include:

- Launching 29 Quality Improvement projects across the Trust. Examples include a drive to boost patient care, staff morale and shift coordination on the Glaven Ward at Hellesdon Hospital, and an initiative which saw our adult Community Mental Health Team in west Norfolk reduce waiting lists from 210 to zero in five months. Sue Bridges was also appointed as our Trust's first nurse consultant, and has been tasked with improving the quality of the learning disabilities services we provide in Suffolk and Waveney
- Opening the Kingfisher Mother and Baby Unit at Hellesdon Hospital in Norwich to care for new mothers with serious mental health problems. The £4m unit welcomed its first patients in January and will ensure mums and their babies can stay together while the mother receives inpatient care for conditions such as severe postnatal depression, serious anxiety disorders and postpartum psychosis. More than 30 staff, including mental health nurses, assistant practitioners, therapists, support workers, social workers and nursery nurses, have been recruited to run the service
- Receiving a second "Triangle of Care" gold star from the Carers Trust in recognition of our commitment to ensuring carers are fully supported and involved in decisions about care
- Opening five additional beds at the Dragonfly Unit, at Carlton Court near Lowestoft, after receiving additional funding from NHS England. The inpatient unit, which has been rated as "outstanding" by the CQC, can now offer specialist support to up to 12 young people at a time for conditions such as depression, anxiety, psychosis and eating disorders
- Providing even more new mothers with targeted help for severe post-natal depression and other complex mental health issues after expanding the Suffolk Perinatal Service. Additional staff were recruited following a cash injection from NHS England, which means the service's capacity to support women will almost treble by 2020/21
- Carrying out upgrades at an inpatient unit for people with complex rehabilitation needs thanks to a £300,000 refurbishment project. The work, at the Suffolk Rehabilitation and Recovery Service in Ipswich, came as part of an ongoing programme to improve the environments from which NSFT provides care while also reducing risk to service users and staff
- Launching an extensive culture change programme, called "Getting Better Together", which aims to ensure our Trust can truly build a culture which places our

service users at the centre of everything we do. The project is being driven by staff volunteers, who will decide our priorities and coordinate the work to make sure issues which are important to their colleagues are addressed. The project has been supported by engagement events across the Trust, which give staff and service users the chance to feedback their views on the immediate improvements which could be made to the way we work

- Completing a £3.9m project to transform our secure services. As part of the initiative, wards have been reconfigured and the environment improved, while the Norvic Clinic has also changed its name to Northside House
- Carrying out three four-week rapid improvement cycles to improve our performance around crisis response, access to services, restrictive interventions and rapid tranquilisation. In addition, we appointed a new Professional Lead for Reducing Restrictive Interventions to share best practice and build staff confidence to improve the quality and safety of care
- Starting work on a detailed project which will use special methodology to make sure there are safe staffing levels and the right skill mix in place in all 28 of our inpatient wards
- Beginning a project to reduce waiting times and ensure service users can get timely access to treatment. It is hoped the findings from the project, which is taking place in conjunction with NHS Improvement, will be used to shape changes nationally as part of a drive to introduce access and waiting time standards for mental health which are aligned with those already in place for physical health
- Continuing work on a £4.0m project to create a new 16-bed impatient unit and update existing outpatient facilities at Chatterton House in King's Lynn. The development, which includes a new Section 136 Suite, is due for completion in spring 2019

Although safe staffing levels and vacancies remain a significant challenge for our Trust, this year has seen us recruit sufficient staff to bring beds back into use which had temporarily closed in 2017/18 due to high levels of vacancies. This recruitment drive will continue into next year as we strive to find innovative ways to attract new staff to ensure we can deliver safe, sustainable services.

During 2018/19, we also took every opportunity to value and celebrate our existing staff, who work hard every day to care for our service users. We have provided opportunities for career development and additional training – including in Quality Improvement – to give colleagues the chance to reach their potential. We have moved people into new roles so that they can take on new challenges and make the most of their individual skills, promoting from within, wherever possible. More recently, we celebrated success and thanked our staff for their compassion and commitment during our 2019 Putting People First Awards, which took place in Ipswich in March. We believe that showing gratitude to our staff for their hard work is vital, as it has a positive impact on morale which then motivates everyone to continue to deliver ever increasing levels of quality.

Despite these positive steps, we recognise that we still have a long journey ahead of us and that the wide-scale transformation which is required at NSFT will take time. As such, our focus on quality improvement will continue into 2019/20 and will be driven by four priorities, which are:

- Patient experience / stakeholder engagement
- Clinical effectiveness / improving access to services
- Clinical effectiveness / improving care planning
- Patient safety / safe environments

We remain committed to making the necessary changes in the right way, and to sharing learning and best practice across our Trust. We are confident that we have made positive progress so far and hope that the actions we have taken will result in noticeable improvements when the CQC to return to reinspect our services.

Statement of Accuracy

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

Professor Jonathan Warren
Chief Executive

Date: 23 May 2019

Part 2: Priorities for Improvement

2.1 Our new delivery strategy

We need to deliver quality-driven mental health services, set in an organisational culture of continuous improvement and co-production. This report sets out our strategy to deliver these, underpinned by a motivated workforce and service user and carer co-production at every opportunity, all of whom will be at the forefront of our improvement journey.

Service user safety is our highest priority and at the core of our improvement plans. We will create an organisation with a culture in which every individual and team puts safety, quality, care and compassion above all else.

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Open and honest communication will allow our Trust to take advantage of the expertise and knowledge of our staff and Governors as well as service users and carers to make sure that future plans are realistic and informed.

A strong governance structure that key stakeholders can challenge will make sure we make real progress and help us to understand the impact of our improvement initiatives for our service users.

The Improvement Strategy and its associated plans have been developed alongside the delivery of our Trust's annual objectives including commitments to:

- Striving to make sure that service users and carers have a strong voice in issues regarding quality and safety and how we run our Trust, and that we work together so that we can offer a better service for all
- Developing a culture built around ownership, achievement and accountability
- Developing an environment of continuous learning which supports our approach to quality improvement

Our Strategy will not succeed without the right leadership skills and improvement culture rooted across the Trust. Engaging our service users, carers, workforce, Governors, and the wider community in our Trust's improvement programme is also critical to its success.

We want our service users, carers, Governors and staff to be leading the improvements and translating their ideas into action. Our improvement plans will, therefore, be supported with a focus on service user co-production, clinical leadership and responsive learning within clinical teams.

We recognise that a move to a more clinically-led structure with staff inspired and allowed to make decisions and drive service developments is essential for our aims to be achieved. Clearer roles in the proposed change in the way our leadership structure is set up will mean that individuals can be sure of their responsibilities and will support with managing the performance of our services.

A single, Trust-wide plan

We have developed one plan for the Trust that will deliver the immediate actions focusing on keeping the service users safe, while not losing sight of the longer-term work needed to embed and sustain a culture of continuous quality improvement.

To allow for efficient reporting, the requirements of the Trust's Improvement Plan have been aligned to 14 overarching themes which are filtered by locality and / or service line.

Each locality improvement plan is monitored through its own Mobilisation Group, chaired by the locality leadership and supported by an outcomes dashboard. This approach empowers localities to make operational and clinical decisions. Each improvement plan has been cross-referenced with the 'Must' and 'Should Dos' within the 2018 CQC Inspection Report.

All progress is reported to the Quality Programme Board (QPB) chaired by a Non-executive Director and through this to the Trust Board and External Oversight Groups.

To help ensure our Quality Improvement Strategy is delivered, we will continue to work with our buddy Trust, East London NHS Foundation Trust (ELFT) and other subject-matter experts to develop and establish our approach to Quality Improvement and apply the learning and experience that ELFT and others can offer.

Feedback from staff, Governors, service users and our partner external stakeholders has resulted in the identification of the following enabling work-streams, each led by a member of the executive team:

Enablers
1. Care Planning
2. Electronic Prescribing
3. Patient Flow
4. Access
5. Workforce / Staff Engagement and Culture
6. Estates and Safe Environment
7. Governance
8. Quality Improvement (QI)

While our Enablers will remain constant, the key actions, deliverables and even some of the monitoring measures are likely to develop over time.

The 14 overarching themes are:

Improvement Themes
1. Care Planning
2. Safe Environment
3. Medicines and Supplies Management
4. Reducing Restrictive Practice
5. Equipment
6. Previous Breaches
7. Audit, Governance and Risk
8. Workforce
9. Shared Learning
10. Stakeholder Engagement
11. Mental Health Act
12. Physical Health
13. Access
14. Leadership and Culture

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.

Review of services

During 2018/19 the Trust provided and / or subcontracted seven commissioner contracts for NHS services: adult services, children's services, improving access to psychological therapies (IAPT), learning disability services and older people's services. The Trust also provides forensic, perinatal 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 of these services.

The income generated by the NHS services reviewed in 2018/19 represents 95.5% of the total income generated from the provision of NHS services by the Trust for 2018/19.

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 feedback from service users and carers.

The Trust's quality monitoring systems ensure 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.

(QA1) Quality of care review methods

Data type	Lead	Reported to	Action
Quality and Safety Reviews	Head of Governance	Individual teams Quality Summits Executive Quality Group Quality Governance Committee Trust Board	The Quality and Safety Reviews offer a new approach to engaging colleagues, experts by experience and external stakeholders in discussions, observations and structured interviews with clinical teams enhancing our methods of enquiry. The aim is to gather more in-depth feedback and understanding of innovations, concerns and issues for improvement related to care provided in our clinical teams. The toolkit used incorporates themes within our quality improvement plan.
Quality Improvement Projects	Head of Quality Improvement	Individual teams Locality Governance Meetings Executive Quality Group Quality Governance Committee	The Trust is at the beginning of its QI journey. Project development, progression and analysis is supported by Head of QI and colleagues skilled in and developing skills in QI.
Service User and Carer Away Days	Head of Recovery and Participation	Service User and Carer Trust Partnership Meeting	Each Locality Hub reports into the meeting with any concerns raised in their hubs regarding service user and carer experiences. Actions are delegated appropriately to teams and individuals.
Working Together Groups	Head of Recovery and Participation	Locality Hubs Locality Governance Meetings	Service user groups raise issues and concerns.
Youth Council	Head of Recovery and Participation	Service User and Carer Trust Partnership Meeting	Co-production on various issues including care delivery, service design, recruitment and research.
Complaints Friends and Family Test NHS Choices Compliments	Complaints Manager Head of Participation	Executive Quality Group 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 Governors	Clinical and operational managers	Feedback shared with clinical teams and managers leading to development of an action plan to resolve any issues that arise.

Chart continued over >

> Continued

Clinical Audit	Audit Lead	Executive Quality Group Quality Governance Committee Performance and 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.

2.2 Looking back at our quality priorities in 2018/19

The Quality Account published in 2018 identified three quality targets. This section demonstrates the progress that has been made in the past 12 months.

These important quality and safety issues will continue to be monitored, with further plans for improvement to ensure positive changes continue to be made.

Patient Safety / Physical health monitoring following rapid tranquillisation

To ensure that at least 95.0% of a sample of patients will have had their physiological observations taken post rapid tranquilisation complying with National Institute for Health and Care Excellence (NICE) guidance.

Where we were:

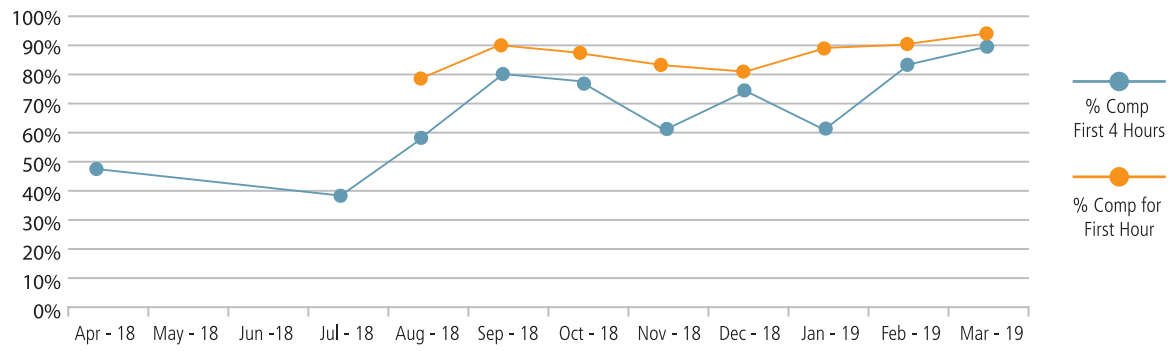
The practice of taking and recording physical health observations has been measured at timelines of one hour and four hours following administration of rapid tranquillisation since August 2018. Prior to that, findings were only reported for the full four hours. We added this extra timeline recognising the importance of monitoring immediately after the medication has been given.

In Quarter 1 (April 2018) audit findings showed that only in 47.0% of cases in which a record could be found observations had been recorded for four hours.

Where we are now:

A Professional Lead for Reducing Restrictive Interventions was appointed in August 2018. They have been working with clinical teams to understand the reasons for using rapid tranquillisation, consider approaches to support any further distress for individuals and to provide guidance for compliance with physiological observations. The number of episodes of rapid tranquillisation being used across the organisation is also closely monitored.

(QA2) Trust-wide compliance with physiological observations post rapid tranquillisation

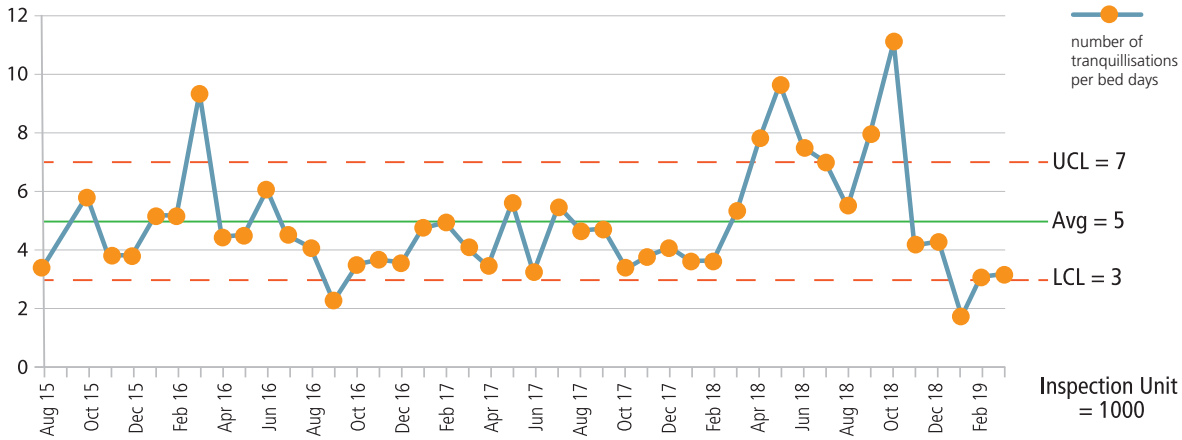


Achievements throughout the year:

- The *Rapid Tranquillisation (RT)* policy has been reviewed and also the documentation to record observations. We are confident that all observations are recorded on the required observation form, noting that at the start of the year this practice was not consistent
- Work continues with teams using quality improvement methodology to try different ideas to improve compliance. Examples of current projects include using alarm clocks to prompt times when observations are required, and white boards detailing the same information
- We are reviewing our training provided to staff and plan to develop practical training using a SimMan (advanced simulator for training in emergencies). We are also providing local training where a need is identified for additional support and will ensure all NHSP / agency staff complete this prior to completing shifts within the organisation
- It should be noted that an audit was conducted quarterly from April to July, monthly from July and weekly from November. The additional criteria of reporting compliance within the first hour was captured from July. Auditing moved to weekly reporting to allow focused support with teams post-incident

In January 2019 the use of RT across the Trust dropped to its lowest level for 12 months and is currently showing 'common cause variation' (a steady but random distribution of output around the average of the data) and remains below the peak seen in October 2018. This is clearly linked to our involvement in the National Centre for Collaboration in Mental Health's (NCCMH) national mental health safety improvement programme which adopts a quality improvement approach to reducing restrictive interventions, in addition to the actions described.

(QA3) Total Trust rapid tranquilisations per 1,000 occupied bed days



Patient Experience / Values-Based Recruitment (VBR)

To increase the percentage of interview panels involving service users or carers by at least 20.0% this year and subsequent years until the target of 90.0% is achieved for all posts that involve contact with service users.

Where we were:

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."* By involving service users in decision making processes regarding the services they receive promotes empowerment and benefits both service users and the Trust.

At the beginning of this year few service users and carers had been trained in Values-Based Recruitment (VBR) and were able to be included on interview panels for clinical, management and support roles within direct care services.

The Trust established a rolling programme of interview training to ensure that training is provided to achieve the target of 90.0% service user and carer involvement over the next three years. The aim was to provide at least four training sessions that would be available for people to book onto during the year. The training would be included within the Recovery College programme for the year.

Where we are now:

A protocol was developed to detail process and good practice in involving service users and carers. This was reviewed by a Co-production panel before being published. This has been later updated and reviewed by service users and carers to include them in the shortlisting process as well.

To date, we have had five Interview Skills Training workshops facilitated and co-produced via the Recovery College, plus one in the forensic service. In total this is 52 people trained in values-based recruitment. On completion of training students are issued with a certificate of attendance and are registered to go on our list of trained service users and carers for interviews. Feedback from the students has been positive but they are requesting to be able to shadow others before they are on their own, which is being accommodated. The other comment from the participants on the interview panels is that staff should be trained in VBR as well.

A Quality Improvement Project was initiated by a team in west Suffolk around improving the numbers of interview panels that have lived experience on them, which is being led by a carer who has found it difficult to get baseline numbers of activity already taking place. The Head of Recovery and Participation and Human Resources have investigated an automated system to track this activity; however, the recruitment system is unable to capture this.

Options continue to be explored and it is expected that this may not be achieved until 2019/20. In the meantime, guidance has been provided on the Trust Intranet to help appointing managers identify people for interview panels who have previously or are currently using our services. This guidance reinforces the importance of always having service users or carers to assist with recruiting all patient-facing roles, and to ensure this is considered as early as possible in the recruitment process.

Clinical effectiveness / Inpatient discharges

To achieve a 10.0% reduction in service users requiring readmission for clinical reasons within 28 days.

Where we were:

The Trust's Improvement Plan in 2017 highlighted recommendations made following the CQC inspection in that year and included actions to ensure that discharge arrangements were effective and promoted recovery. The 2018 inspection report stated that: *'the acute wards reported 253 readmissions within 28 days between 1 June 2017 and 31 May 2018. Of these there was an average of 11 days between discharge and readmission'*.

Reference to two key initiatives were identified to 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. 'Red2Green 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.

This project was allocated to the Patient Flow Programme with other work streams including implementation of the Personality Disorder Strategy, Partial Hospitalisation Project (supporting day treatment), Out of Area Bed Management, reviews of Crisis Resolution and Home Treatment Services and Single Point of Access Services. Progress is reported into the Quality Programme Board.

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

Where we are now:

Following a successful pilot period since November 2018 the Red2Green methodology has been rolled out to a number of wards across the Trust. This includes all adult and older people's wards in Norfolk.

Clear review and escalation processes are in place to unblock the barriers and delays experienced by the wards on a weekly basis. This helps to focus on internal barriers and delays, as well as working with stakeholders to deal with some of the wider system-based delays (such as suitable accommodation).

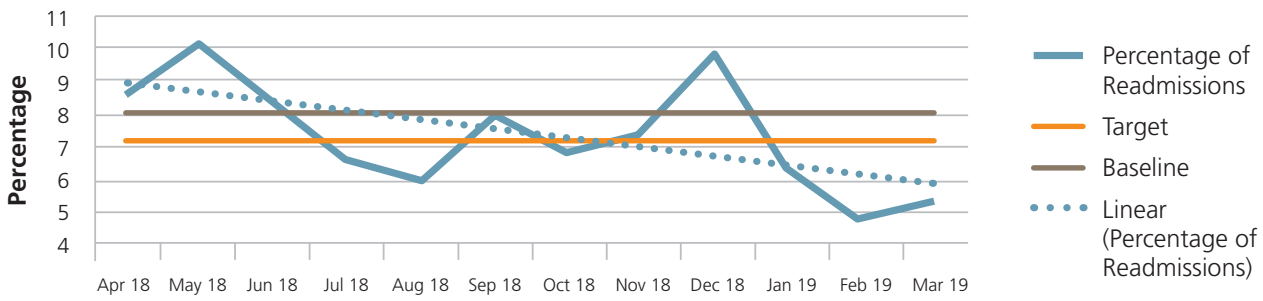
Red2Green dashboards are in place to report daily, weekly or monthly by utilising information recorded. The tool was developed by NHS Improvement and has been adopted by NSFT. Ward based key performance indicators are also reported to help manage ward performance. Time is now being taken to review the dashboard requirements for an individual ward and automate a number of the reporting processes to allow for real time reporting.

The following information relates specifically to Trust-wide data.

The baseline was set as 13 readmissions per month / 156 per annum. The target for achievement is therefore 140 or less and a 10.0% reduction in the number of re-admissions for clinical reasons within 28 days.

The graph below illustrates the percentage of readmissions (number of readmissions / total number of admissions).

(QA4) Percentage of admissions: readmitted within 28 days of discharge



Although in excess of 140 readmissions has been reached we believed that the impact from the various workstreams have not been fully realised at this point. There have been 176 readmissions for 2018/19 which equates to 7.4% for the financial year. This is 0.2% above the target but 0.6% below the baseline.

It should also be noted that the figures are based on the newly-agreed Trust methodology for calculating admissions and only included emergency readmissions within 28 days i.e. excluding planned admissions.

Although there was an increase in the readmission rate between October and December 2018 from 6.6% to 9.0%, this could be accounted for by random variation, or a seasonal pattern. There does not appear to be any significant change to the rate of readmissions. To be more confident of a significant trend, more data would be required.

We consider that 20 months of data will be sufficient to identify such trends.

Continued quality priorities

We have continued to monitor compliance with core assessments, risks assessments and care plans as identified in 2017/18 where the target was not met during the year.

Data reported monthly will demonstrate 95.0% 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 except for 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.

Leadership of ongoing projects including formulation*, quality, compliance and performance data and simplification of CPA documents is being provided by the CPA Mobilisation Group which was set up in October 2018.

Key aims for this group include co-production of care packages, improvements in the quality of care planning, reduced clinical variations in practice and, most importantly, improved patient experience.

* A collaborative and systematic process that makes sense of the person and the difficulties they are experiencing and informs a plan to improve recovery.

Where we are now:

- The latest data available on 26 March 2019
- Core assessments in place: 85.3% (73.6%)**
- Risk assessments in place: 91.4% (83.9%)**
- Care plans in place: 89.3% (92.8%)**

This remains a priority for the Trust and several workstreams are in place and are being monitored by the Trust CPA Mobilisation Group. The worksteams include: simplifying processes and documents, implementation of DIALOG+ to support Quality Improvements in collaborative care planning, a pilot of formulation and reviewing data to understand compliance and also quality of core documents. Improvements in care planning is identified as a quality priority for the forthcoming year.

** The bracketed figures in the bulleted list represent the data at March 2018

2.3 Looking forward to our quality priorities in 2019/20

This is the section of the Trust's Quality Account that looks forward to 2019/20 and identifies our goals for improvement. We describe the reason for these goals being chosen and the actions that will be taken to make improvements. 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.

Our Trust has agreed a number of priorities which support our Improvement Plan in response to the CQC inspection in 2018, all of which are monitored internally within the Trust and with our key stakeholders.

Those selected in this report represent four of our priority change programmes and were agreed by our Board of Directors and Governors.

These priorities also reflect themes in feedback the Trust receives, particularly from our national service user survey, complaints and enquiries.

Patient experience / Stakeholder engagement

Our pledge:

We will ensure that we seek and act on feedback from patients and carers for the purposes of continually evaluating and improving services.

Background:

We are committed to ensuring that all Trust services benefit from the experience of people who use our services and their carers through co-production. At this time of change in our organisation we promise that this remains our priority. We understand that to provide high quality services that meet the needs of our patients, are responsive to their needs, support meaningful recovery and strive continuously to improve we need to engage with people and listen and respond to their experiences. The importance of our Governors' role in accessing and providing service user and stakeholders' views is valued and their model of working is being reviewed to ensure that these insights are effectively communicated.

This year's actions will include:

- A co-produced update of the Involvement and Participation Strategy
- Review and strengthening of our current Triangle of Care arrangements
- Holding at least one carers event in each locality during the year
- Implementation of our new four-way devolved leadership model including People Participation Lead roles
- Reviewing and refreshing our 'Working Together' model with the new Service User Experience Leads in the Care Groups
- Exploring ways of improving responses to our Friends and Family Test (FFT) questions and triangulating with other feedback resources, including PALS feedback and complaints/ compliments
- Holding quarterly Service User and Carer Away Days during the year to engage people with lived experience to become involved in the changes and improvements to NSFT

Clinical effectiveness / Improving access to services

Our pledge:

- We will review the systems for assessing and monitoring risks for patients on waiting lists for triage, assessment and treatment and provide a consistent approach to this across Norfolk and Suffolk. We will ensure there is a robust process in place to demonstrate that we are monitoring and supporting the safety of people waiting
- We will ensure that all teams comply with the four-hour emergency assessment target for referral to assessment. 100% of crisis referrals will be seen face-to-face within four hours unless downgraded for a clinically valid reason

Background:

Our 2018 inspection report indicated that "waiting times from referral to treatment were a serious concern", noting the number of patients who had not been allocated to a care coordinator, those waiting over 18 weeks for treatment, the safety of patients, a lack of management of risks while waiting and the need for clear targets for assessment and waiting times.

We recognise that long waits for mental health support can be both costly and distressing for people and can result in an escalation to crisis situations which can impact on all aspects of a person's life and those close to them.

It was reported that there were concerns that staff were not prioritising face-to-face assessments over telephone contact in crisis services for people whose risks indicated that they needed to be assessed within four hours.

In 2014 a national multi-agency to improve the experience and outcomes for people facing mental health crises was launched as the Crisis Care Concordat. This required those responsible for commissioning, providing and delivering the services to commit to a set of core principles around crisis care, to make sure that people get the help they need when they are having a mental health crisis. An important principle is to ensure that people are treated with the same urgency as a physical health emergency.

This year's actions will include:

- Use of clinical audit for Crisis Downgrades and Breaches
- Use of the weekly Trust-wide "Service User Tracker List" (SUTL) to monitor at locality level the waiting time profiles of the service users, monitor and allocate high risk patients into service as a priority and embed a harm review culture
- Implementing the new Crisis Pathway Standard Operating Procedure
- Staff recruitment into crisis pathways
- Implementation of the revised recording of contacts for assessment and treatment purposes
- Implementation of case management supervision / complex case forums
- Introduction of Clinical Harm Review Standard Operating Procedure
- Introduction of a quarterly external Clinical Harm Review Meeting, with key stakeholders

Clinical effectiveness / Improving care planning

Our pledge:

- We will ensure that staff involve service users in care planning and their individual needs are recorded appropriately
- We will ensure that all service users' risks are assessed and managed. We will support people to become involved as much as they want or are able to in decisions about their care. Risk assessments and care plans will be in place and updated consistently in line with changes to patient needs and risks

Background:

NHS England emphasises that *'supporting patients to be actively involved in their own care, treatment and support can improve outcomes and experience for patients…'*

The assessment of clinical risk in mental healthcare is challenging but provides an opportunity to engage with patients, and their carers and families to promote the patients' safety, recovery and wellbeing (Triangle of Care, Carers Included: A guide to best practice in mental health care in England, 2013).

When health professionals and patients work together, people become truly central to the decisions about their own care and treatment. This ensures that what is important to the person is clearly understood, individuals feel supported and empowered and care or treatment is rightly person-centered.

Our 2018 CQC Inspection Report described that within some of our clinical teams care plans were not always in place, updated when needed, reflective of the person's needs and did not involve patients. It was observed that some risk assessments had not been updated as needed to reflect changes for the person when, for example, their ability to keep safe changed and the level of support needed had to increase or adapt.

This year's actions will include:

- Appointment of a CPA Clinical Lead to provide leadership and clinical expertise to the projects
- Training all inpatient nurses in care planning
- Evaluation of the pilot project regarding the adoption of formulation* and/or DIALOG+** and consideration of a roll-out to other services in the Trust
- Simplifying our core documents for assessment and care planning
- Developing a toolkit for clinicians to use to measure the quality of assessments and care plans in co-production with service users

- Carrying out Quality and Safety Reviews which will incorporate reviews of core documents and shared learning of best practice
- Our Matrons will provide care plan surgeries for inpatient staff to support their day-to-day practice issues

* A collaborative and systematic process that makes sense of the person and the difficulties they are experiencing and informs a plan to improve recovery

** A therapeutic intervention incorporating the DIALOG scale aiming to improve communication between health professionals and a patient and, through that, outcomes of care

Patient safety / Safe environments

Our pledge:

- We will ensure all environmental risks are identified, plans put into place to reduce risks and regular reviews are carried out
- We will ensure that all services have detailed ligature risk audits in place and that any key risks for patient safety are known and lessened, wherever assessed as needed

Background:

Safety is at the centre of all good health care, and a systematic approach to risk assessment and risk management is essential. In mental health this is particularly challenging due to the nature of some of the risks presented by patients, including the risk of suicide and self-harm.

We are committed to patient safety as the highest priority for the Trust and in ensuring inpatient units and other Trust areas provide as safe an environment as possible, consistent with human rights and promotion of dignity.

Our most recent CQC inspection highlighted that not all our ward and community environments were safe, that our assessments varied across services, were not thorough in some areas, lacked clear timescales and that not all of our staff were fully aware of how to manage risks in their settings.

This year's actions will include:

- Review of all completed risk assessments, ligature footprints and local risk registers
- Training to support staff knowledge and skills in environmental risk assessment
- Appointment of Health and Safety Leads
- A programme of environmental reviews
- A programme of work to improve the safety of our premises
- Weekly ward rounds by Matrons
- A programme of Quality and Safety Reviews has begun across the Trust and incorporates monitoring of environmental and patient safety issues

2.4 Participation in clinical audits

During 2018/19, eleven national clinical audits and three national confidential enquiries* covered NHS services that the Trust delivered (in terms of collecting patient-level data).

During that period, the Trust registered for participation 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, identified on the NHS England Quality Accounts list published by Healthcare Quality Improvement Partnership (HQIP) in January 2018 (refer to table QA5) for details of the time of registration and level of participation).

* A national confidential enquiry is a nationwide review of clinical practice which, when completed, leads to recommendations 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 has been one completed SCR involving children known to the Trust in Norfolk and Suffolk (two are ongoing). In addition, one multi-agency review has taken place.

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 Trust services were involved. There has been one SAR completed in

2018 concerning a Suffolk service user known to the Trust (another review is ongoing related to a Norfolk service user).

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2018/19 were:

National clinical audits

The eleven national audits which covered services relevant to NSFT were:

- Falls and Fragility Fractures Audit Programme (FFAP) – National Audit of Inpatient Falls (NAIF)
- Learning Disabilities Mortality Review Programme (LeDeR)
- National Audit of Care at End of Life (NACEL)
- National Clinical Audit of Anxiety and Depression (NCAAD)
- National Clinical Audit of Psychosis (NCAP)
- Early Intervention in Psychosis component of the 2018/2019 CQUIN (Indicator 3a - Cardio metabolic assessment and treatment)
- Prescribing Observatory for Mental Health (POMH-UK): Topic 6d - Assessment of side effects of depot and LAI antipsychotic medication
- Prescribing Observatory for Mental Health (POMH-UK): Topic 7f - Monitoring of patients prescribed lithium
- Prescribing Observatory for Mental Health (POMH-UK): Topic 16b - Rapid tranquillisation
- Prescribing Observatory for Mental Health (POMH-UK): Topic 18a - Prescribing Clozapine
- Prescribing Observatory for Mental Health (POMH-UK): Topic 19a: Prescribing for depression in adult mental health

National Clinical Audit of Inpatient Falls: From 2018 onwards, the audit transitioned from its previous methodology (snapshot audits in 2015 and 2017) to a new methodology that enables continuous audit. The new audit focuses on patients who sustain a hip fracture while in hospital and has a wider scope to include not only acute hospitals, but also community and mental health. The inclusion criteria are: patients aged 60 years or over identified within the National Hip Fracture Database, identified as having sustained the hip fracture as a result of an inpatient fall in an acute, community health or mental health trust in England or Wales.

Learning Disabilities Mortality Review Programme: Includes deaths since the start of the review period of patients aged four years and over with a learning disability. Key elements of the programme are: to drive improvement in the quality of health and social care service delivery for people with learning disabilities; to help reduce premature mortality and health inequalities in this population; to support local areas to conduct reviews of deaths of people with learning disabilities; improving understanding about mortality and reducing premature deaths.

National Audit of Care at End of Life: This is a three-year project, commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). It focuses on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales. The audit is of the practice received in the last admission prior to death including all mental health inpatient facilities.

National Clinical Audit of Anxiety and Depression: Aims to assess and improve the care and treatment of service users with a primary diagnosis of anxiety and / or depressive disorder within NHS funded secondary care services in England. The objectives include improving the delivery of care and treatment, providing comparative data on the quality of care and service user outcomes following treatment, facilitating the development of quality improvement initiatives, and sharing best practice, enabling Trusts / organisations to make the best use of audit. In 2018/19 the audit included a case note audit, followed by a Spotlight audit of Psychological Therapies, requiring a case note audit, therapist questionnaires and a service user survey.

National Clinical Audit of Psychosis: NCAP is a three-year improvement programme to increase the quality of care that NHS Mental Health Trusts in England and Health Boards in Wales provide to people with psychosis. Commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England, NCAP is the next phase in the development of the National Audit of Schizophrenia. The scope of the audit includes both inpatient and community care provided for people with a broader group of severe mental health problems. Key performance areas include the assessment and treatment of physical health, health promotion, prescribing practice, use of evidence-based psychological treatments and access to services at times of crisis. It will also

include a detailed examination of the quality of care provided by Early Intervention in Psychosis teams and forensic mental health services.

Early Intervention in Psychosis component of the 2018/2019 CQUIN (Indicator 3a – Cardio metabolic assessment and treatment): The aim of CQUIN 3a is to improve physical healthcare to reduce premature mortality in people with serious mental illness regarding cardio metabolic assessment and treatment. Eligible patients for audit were identified via the 2017/2018 self-assessment. Questionnaires relate weight gain (Body Mass Index) and delivery of help to stop smoking, where requested.

Prescribing Observatory for Mental Health (POMH-UK): The over-arching aim is 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.

Topics included in the NHS England Quality Accounts list for 2018/19 were:

- **Topic 6d - Assessment of side effects of depot and LAI (long-acting injectable) antipsychotic medication:** Second supplementary data collection scheduled September – November 2018
- **Topic 7f - Monitoring of patients prescribed lithium:** Fourth supplementary data collection scheduled February – March 2019
- **Topic 16b - Rapid tranquillisation:** Re-audit scheduled March – May 2018
- **Topic 18a - Prescribing Clozapine:** Baseline data collection scheduled June – July 2019
- **Topic 19a - Prescribing for depression in adult mental health:** Baseline data collection scheduled May 2019

National Inquiries

The three national inquiries which covered services relevant to NSFT were:

- Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE – UK):
  - Maternal mortality, surveillance and mortality confidential enquiries
  - Maternal morbidity confidential enquiries
- The mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide and Safety in Mental Health (NCISH), including:
  - Suicide, homicide and sudden unexplained deaths
  - The assessment of risk and safety in mental health services
- National confidential enquiry into patient outcome and death (NCEPOD) – young people's mental health

The national clinical audits and national confidential inquiries that the Trust participated in during 2018/19, are listed below, alongside the number of cases submitted to each audit or enquiry, where applicable.

(QA5) National clinical audits and inquiries

Name	Completed / status	Number of cases audited
National Clinical Audits		
Falls and Fragility Fractures Audit Programme (FFAP) – National Audit of Inpatient Falls (NAIF)	Registered in Jan 2019 for participation in the continuous data collection for all eligible cases notified on the National Hip Fracture Database.	No eligible cases since registration
Learning Disabilities Mortality Review Programme (LeDeR) (CCG = Clinical Commissioning Group)	Launched by University of Bristol in April 2017. All deaths of people with a learning disability have been notified to LeDeR since that date. These are identified through Datix reporting. Training undertaken to 12 reviewers. Part of CCG LeDeR steering groups in Norfolk and Suffolk reporting into NSFT Mortality Review Group.	Number of cases NSFT staff reviewed (in other organisations): • Norfolk = 4 • Suffolk = 2 (plus 3 in progress) Number of cases reviewed for NSFT patients: • Norfolk = 1 • Suffolk = 3
National Audit of Care at End of Life (NACEL)	Registered in Jan 2019 for participation in planned audits for 2019.	Awaiting 2019 Audit Plan
National Clinical Audit of Anxiety and Depression (NCAAD)	Core Audit Data submitted 7 September 2018. Final report due Jan-Apr 2019. Spotlight 1 Audit – Psychological Therapies. Data collection closed 11 February 2019.	NSFT sample completed: Case note audit = 85/100* Spotlight 1: Case note audit = 206/485* Therapist survey = 31* Service User survey = 10* (to date)
National Clinical Audit of Psychosis (NCAP)	Spotlight – Early Intervention in Psychosis. Data Submitted 30 November 2018. Final report due June 2019.	NSFT sample completed: Case note audit = 118/118* Contextual audit = 7/7*
Early Intervention in Psychosis component of the 2018/19 CQUIN (Indicator 3a - Cardiometabolic assessment and treatment) (CQUIN – Commissioning for Quality and Innovation)	CQUIN component linked to Spotlight – Early Intervention in Psychosis. Data Submitted 30 November 2018. Final report due June 2019. (BMI = Body Mass Index)	NSFT sample completed: BMI Case Note audit 59/59* Smoking case note audit undertaken within EIP spotlight audit (above)
POMH-UK: Topic 6d - Assessment of side effects of depot and LAI (long-acting injectable) antipsychotic medication	Data submitted 30 November 2018. Report expected second quarter 2019.	NSFT sample completed: Data submitted for 100 patients from across Norfolk and Suffolk from case note audit
POMH-UK: Topic 7f - Monitoring of patients prescribed lithium	Data collection currently ongoing. Data submission by 31 March 2019.	NSFT sample: Ongoing
POMH-UK: Topic 16b - Rapid tranquillisation	Published October 2018.	NSFT sample completed: Case note audit = 55
POMH-UK: Topic 18a - Prescribing Clozapine	Data submitted 31 July 2018. Report expected first quarter 2019.	NSFT sample completed: Case note audit information on number of cases audited not available at point of publication

POMH-UK Topic 19a: Prescribing for depression in adult mental health –	Commences 2019.	Baseline data collection scheduled May 2019

National Confidential Inquiries		
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE – UK)	Registered in Jan 2019 for participation in the continuous data collection for all eligible cases (Maternal deaths of pregnant women and women up to one year following the end of the pregnancy).	No eligible cases identified by MBRRACE in previous 12 months through the Office of National Statistics Database
National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) The mental health clinical outcome review programme: Suicide, Homicide and Unexplained Death	People who die by suicide or commit homicide and were in contact with mental health services in the 12 months before death / offence. Continuous audit.	Number of cases for NSFT (suicide data set): • Q3/17 – from 57, 9 were issued and 9 completed • Q4/17 – from 50, 13 were issued and 12 completed (1 on-going) • Q1/18 – from 69, 16 were issued and 15 completed (1 on-going) • Q2/18 – from 62, 13 were issued, and 1 completed (12 on-going) (Q = Financial Quarter of the year)
The mental health clinical outcome review programme: the Assessment of Risk and Safety in Mental Health Services	Details of main risk assessment tools in use by mental health trusts. Report Published October 2018.	NSFT participation = 1/1

National Clinical Audits		
Safety in Mental Health Services		
National confidential enquiry into patient outcome and death (NCEPOD) – Young people's mental health	Data submitted Aug – Oct 2017. Report due in April 2019 (TBC).	NSFT sample: • Cases included = 9* • Clinical Questionnaires returned = 8* • Case Notes returned = 3* • Organisation Questionnaires requested = 2* • Organisation Questionnaires returned = 2*

* Actual final sample numbers are known once data cleansing is completed by national audit teams and reports published.

The reports of two national clinical audits carried out by the Trust were reviewed in 2018/19 and the Trust intends to take the following actions or has taken action to improve the quality of healthcare provided.

Actions following audit

(QA6) Actions following national audit

POMH- UK: prescribing topics in mental health services (2018-19)

Audits reported in 2018/19	Actions in progress
POMH-UK: Topic 16b – Rapid tranquillisation	Published October 2018 (55 cases audited for NSFT). Presented at Drugs and Therapeutics and Clinical Cabinet. Findings of audit fed into the Reducing Restrictive Interventions project to improve patient safety and clinical practice. On-going audit work reports weekly and monthly regarding compliance for recording physiological observations following the administration of rapid tranquillisation.
POMH-UK: Topic 15b – Prescribing valproate for bipolar disorder	Published April 2018 (57 cases audited for NSFT). Presented at Drugs and Therapeutics and Clinical Cabinet. The audit work has been superseded by a change in prescribing advice from MHRA (Medicines and Healthcare products Regulatory Agency), valproate toolkit now available and NSFT guidelines on the use in women of child bearing age.

Trust clinical audit programme

During 2018/19 NSFT has started moving towards using audit-based quality improvement methods. Therefore, the number of topics audited has been restricted and the number of supplementary data collection cycles has been increased, in some cases to weekly monitoring. The main purpose for this has been to monitor the efficacy of actions in addressing the practice issues. We reviewed 42 local audits in 2018/19 and we intend to take the following actions to improve the quality of healthcare provided in relation to the three topics selected:

(QA7) Trust actions following audit

Audit Title	Actions Taken
Seclusion – quality of documentation	Results from the monthly seclusion audit have been presented on a monthly Seclusion Heat Map; this has supported ward teams to improve their practice. Ward managers have been provided feedback to demonstrate how the Seclusion Heat Map format is used within teams to easily show teams their performance and areas for further improvement. The audit has been reviewed to ensure it covers all aspects of the Mental Health Act Code of Practice. The Seclusion Heat map began on July 2016, showing compliance of 48.0%. The most recent Seclusion Heat map for January 2019 showed compliance of 84.0%. Further work is being completed to: • Review seclusion training provided locally to all inpatient staff • Ensure there is clarity of standards and expectations when caring for someone in seclusion • Confirm how NSFT assess staff to be competent to complete observations for someone in seclusion • Review all NSFT seclusion suites to ensure standardisation of environments • Review NSFT use of data and consider how we use this data intelligently to improve services • Review NSFT current Prevention of Management and Aggression training

Discharge from inpatient services	An audit was requested by the Patient Safety and Complaints Lead in response to a Coroner's question. The request followed a serious incident in 2017 where a 26-year-old service user died from an overdose of prescribed medication. She had an inpatient stay in the months prior to her death, following an overdose. At the inquest held in 2018, the coroner identified concern that the Trust could not clearly demonstrate its decision-making regarding the amount of post-discharge medication provided and its consideration of such set against the risks for the service user. The audit was commissioned to understand the practice across the Trust especially where risk of overdose was part of an individual's presentation. The audit showed a variation in practice, recording and communication with GPs. While the audit focused on adult acute wards its learning has relevance for all inpatient services. The findings highlighted that evidence of an assessment prior to discharge of the risk of overdose for inpatients who had an event of overdose in the reasons for admission was present in just 37.0% of patients in the audit sample. However, 74.0% of patients were provided with less than the standard prescribing period of discharge medication and / or a plan was put in place to limit patients' access to prescribed medication. In 83.0% of audited cases a discharge summary was completed for the GP, and of these, 56.0% included details of any changes to the standard prescribing period of the discharge medication. A pilot inpatient discharge medication form is underway which should improve the information provided to GPs. The Trust has also recently updated Policy C70a Discharge from Inpatient Care. The report on the audit was presented to the Acute Services Forum in January 2019 followed by a Trust alert to all inpatient wards. Teams will be discussing the audit, reflecting on the structures and processes they use in respect of medication prescribing at the point of discharge. Teams will respond with their reflections, good practice and plans they put in place to develop team practice. A supplementary audit was carried out on the audit sample to provide assurance that pre-discharge a Consultant or senior doctor is aware of the discharge and therefore in agreement with it. Compliance was high at 96.0%.

Medical staff involvement in audit to improve quality of practice and care	Medical staff have completed many audits throughout the year and participated in Trust-wide audits. Each report is approved at Clinical Cabinet, chaired by the Medical Director and reports are shared for learning and made accessible throughout the Trust. Topics have included: • Physical health - Wellbeing and monitoring for community patients. This was a reaudit • Quality of history-taking during initial memory assessments by nurses in Dementia and Complexity in Later Life Services in west Norfolk locality • Documentation after Mental Health Act assessments • Re-audit rates of polypharmacy and overdose in Emotionally Unstable Personality Disorder patients compared to patients with other primary diagnoses - Southgate ward, Wedgwood House • Prescribing for depression in children and young people within the Integrated Delivery Team Bury North and South in accordance with current NICE guidelines • Driving and Memory Impairment – Practices in local Memory Clinics • Teratogenic risk and contraceptive advice for women of reproductive age in psychiatric care • Capacity assessment – Bury South Integrated Delivery Team • Evaluate assessment and treatment of depression in children and adolescents using NICE Guidelines Standard CG28 • Re-audit hospital admission, discharge and aftercare: assessment of current practice in old age psychiatry • Compliance with NICE guidelines (CG128) in treatment of depression in under 18 year-olds • ECG monitoring of patients prescribed antipsychotic medication

2.5 Clinical research

1,560 people receiving NHS services provided, or sub-contracted by the Trust from April 2018 to March 2019 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 (CRN), and is an increase of 43.0% on last year's performance.

Research delivery

100% of studies approved by the Health Research Authority received "Confirmation of Capacity and Capability" to go ahead in the Trust within the 40-day target period.

A record number of research participants took part in the CRN Eastern Patient Experience Survey, and 98.0% of respondents strongly agreed or agreed that they had a good experience of taking part in research and would recommend taking part in research to others.

10.0% of active research studies were audited by the Internal Research Audit team. All studies showed a good-to-excellent level of management and oversight, and no critical research conduct findings related to patient safety or scientific integrity. A Research Safety Sub-Committee has been created to oversee clinical research procedures and processes aligned with service improvement projects.

Research Quality and Educational Development Meetings were introduced in 2018 to provide additional training and support to research staff, and the staff member behind this initiative received an award from the Clinical Research Network.

Research development

All streams of research development have made significant progress in 2018/19, with a programme of national research grant applications submitted and under development. The Trust has started implementing three new research grants, in child and youth mental health services, mental health pharmacy and older people's services in collaboration with the University of East Anglia and the University of Cambridge. Further work has included collaborating with the World Health Organisation in improving diagnostic criteria, which has led to a number of publications, national media interest and future research identified.

Trust staff members have also authored over 50 research journal publications in 2018/19, including work in Lancet Psychiatry, BMJ Open and British Journal of Psychiatry. There continues to be a high number of Trust staff undertaking research-based postgraduate and career development studies, such as Collaborations for Leadership in Applied Health Research and Care (CLAHRC) and National Institute for Health Research (NIHR) 70@70 Research Nurse Leader Fellowships, supported by our partner organisations.

An increasing number of staff, trainees or students in the Trust, and through our academic partners, are now undertaking collaborative research and evaluation work which meets the strategic and clinical needs of the Trust.

2.6 Service user feedback

Service user and carer involvement and participation

The main intent within our Trust's strategy is to ensure that service users' and carers' voices are heard and are central to all we do, that people who use our services are meaningfully involved in how our services are run through co-production and that they are an essential part of driving our culture of continuous innovation and quality improvement.

There are various forums across Norfolk and Suffolk which bring people together to discuss and co-produce projects, including the Formulation and Dialog+ project, the Personality Disorder strategy and Values-Based Recruitment training in the Recovery College. Service users and carers were also invited to attend the Quality Improvement launch (November 2018) and the subsequent Improvement Leaders Programme in January 2019.

In this last quarter we are reviewing with service users and carers the various forums and hubs across Norfolk and Suffolk and working together to see how we can improve the participation not only from people who use our services but also by staff in the various localities.

Improving Services Together

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: We will reach out to diverse and other under-represented groups.

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

The service user and carer hubs that were established in Quarter 4 2018/19 are under review as membership has declined and the Central Norfolk Hub was stood down due to poor attendance. Various factors have contributed to this and a review of the Terms of Reference for the Service User and Carers Trust Partnership meeting and the hubs is taking place. The new clinically led management structure will be in place in the Autumn 2019 and will create a four-way leadership team in each Care Group, including a Service User Experience Lead post to ensure co-production is fully adopted.

The actions from last year from the Improvement Plan engagement meetings have partially been completed, an 'Always Event' has taken place with the Central Norfolk Crisis team. Teams have been to visit East London NHS Foundation Trust Participation Team. A logo has been co-designed and is now awaiting sign-off to be used as a stamp of approval for any projects, policies or documents that have been co-produced.

In quarter 4 of 2018/19 we had our first Service User and Carers Away Day. From that event, three priorities were identified:

- Improving communication – internal and external ways to improve awareness of opportunities and developments within the Trust
- The recruitment process and involving service users and carers in the development of job descriptions, shortlisting as well as on the interview panel
- Carers Awareness sessions - to develop and ensure that these sessions are mandatory at induction and updates are mandatory for clinical staff

Triangle of Care and carer involvement

The Trust has submitted the required 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.

After our second gold star from the Carers Trust in March 2018 for continued engagement with the Triangle of Care initiative we have continued our work with local carers leads and champions engaging and offering support to carers across our Trust. There continues to be a drive to ensure that the work the Trust has done under the principles of the Triangle of Care needs to continue, and to continue to use the toolkit set out by the Carers Trust to maintain our standards.

Our local carer's leads have also put on events for carers and for young carers this year and discussions have taken place around having a Carers Awareness Month for the Trust to continue to promote the value of having carers involved not only directly with their loved one's care but also within the development of the Trust.

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 in the service they receive from 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 service users 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'.

(QA8)

Friends and Family Test Information 1 April 2018 – 31 March 2019	
Number of Returns	2,418
Satisfaction (% selecting extremely like or likely)	92.3%
Dissatisfaction (% selecting unlikely or extremely unlikely)	3.7%
Participating Teams	107 out of a total of 154 teams have generated one response or more.

Mental Health Community Service Users Survey 2018

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 Users' Survey involved 56 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 2017 and 30 November 2017.

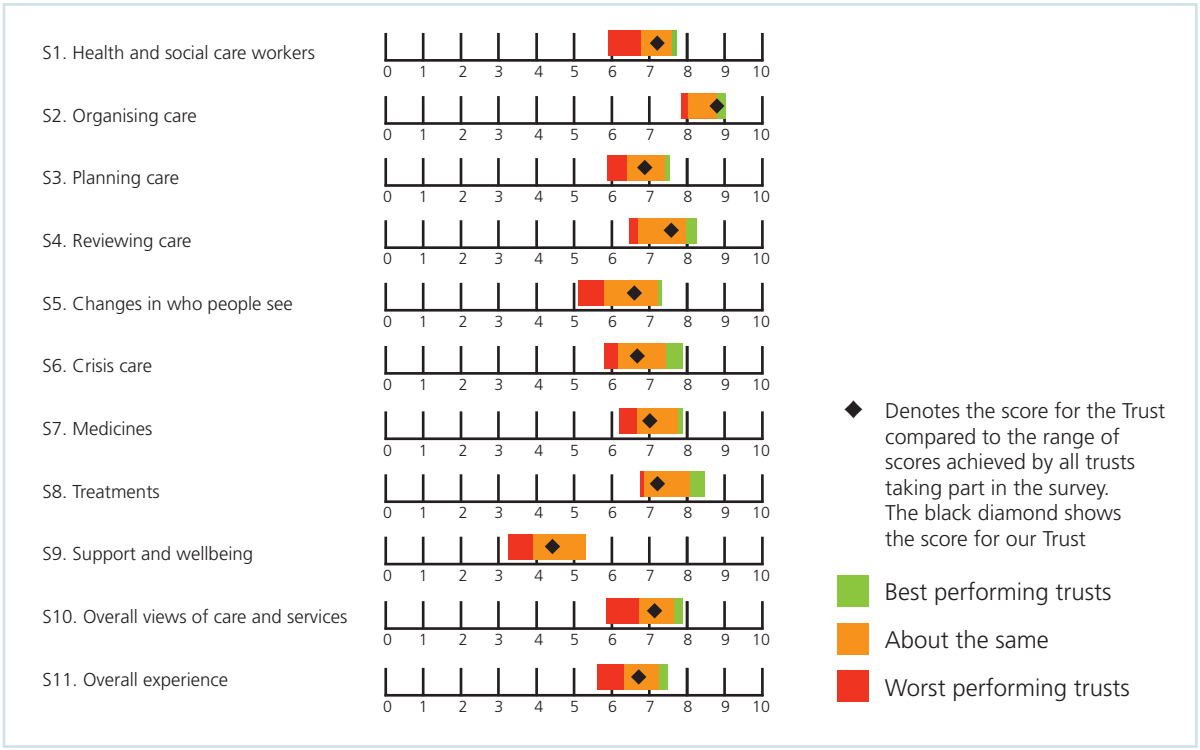
The survey had two major redevelopments ahead of the 2010 and 2014 surveys to reflect changes in policy, best practice and patterns of service which means that the 2018 survey is only comparable with the 2014-2017 surveys. Surveys carried out between 2010 and 2013 are comparable with each other but not with any other surveys.

A response rate of 31.0% was achieved – the national average was 28.0%. This compares with a Trust response rate of 30.0% in the 2017 survey; the national average was 28.0%.

Further information about the survey can be accessed via the CQC website at: http://www.cqc.org.uk/publications/surveys/community-mental-health-survey-2018 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.

(QA9) Section scores



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.

This year's survey returns from service users seen in 2017 showed that NSFT has improved our position relative to other trusts and are in the intermediate 60.0% range for all mental health trusts.

There were three key themes:

1. The need to explore wider aspects of the service users' lives that impact on mental health and wellbeing
2. Frequency of contact and time available for service user contact
3. Improve collaboration with service users and sharing information about treatment options; doing 'with' not 'to'

The full recommendations from the survey have been reviewed and key actions will be sent to relevant working groups to be addressed.

(QA10) Delegated committees responsible for survey recommendations

Questionnaire sections	Recommendation	Assigned working group
Your Care and Treatment	Ensure service users are seen often enough for their needs. Review where this is not happening and take action.	Patient Flow Programme Board
Your Health and Social Care Workers	Ensure that service users' views are taken into account and engaged with effectively when discussing their condition and care and seek to ensure they are given enough time to discuss their treatment plan.	Formulation Steering Group / Patient Flow Programme Board
Planning Your Care	Healthcare professionals should use and adapt the person-centred approach to meet the needs of individual patients so that all patients have the opportunity to be involved in decisions about their care at the level they wish.	Formulation Steering Group / CPA Mobilisation Board
Reviewing Your Care	Promote shared decision-making and self-management so that people using mental health services are actively involved in shared decision-making and supported in self-management. Have, at least, one formal annual review with the patient to discuss how their care is working. Have a developed proforma so that all aspects of support, care and treatment are considered to ensure continuity across disciplines.	Formulation Steering Group / CPA Mobilisation Board / CPA Simplification Sub-group Performance and Accountability Review Meetings
Crisis Care	Review arrangements for ensuring patients know who to contact during out of office hours if they have a crisis. Consider ways of making this information more accessible and understandable. Review range and level of support provided by the out of office hours service. Consider more detailed engagement with patients to understand better what help they needed and their response to the help that was available.	CRHT Realisation Project (Norfolk and Waveney only) Norfolk and Waveney STP Wellbeing Hubs implementation.
Medicines	Seek ways to improve participation of service users in decisions about their medication, paying attention to establishing what level of involvement in decision-making the patient would like. This may include healthcare professionals reviewing their consultation style and adapting this to the needs of the individual service user.	Drugs and Therapeutics and Non-medical Prescribing Groups Clinical Cabinet
NHS Therapies	Seek ways to improve participation of service users in decisions about NHS Therapies. Review what information is given to service users when they are offered new therapies.	CPA Mobilisation Board / Formulation Steering Group
Support and Wellbeing	Review the support and advice offered for finding work or keeping work and access to employment services in light of the links to improved outcomes and numbers of service users who would welcome support on these matters.	Recovery College Course Development Group Employment focused project Individual Placement Employment Support system initiatives (phase 2 via integrated commissioning).

Compliments

The Trust recorded a total of 753 compliments for its staff and services, compared with 614 the previous year, a rise of 139 or 22.6%. Many of the compliments were made by service users and carers.

As with complaints, the Trust regards compliments as learning opportunities. They often highlight areas of best practice and the Trust disseminates compliments widely in order to encourage staff and services to drive up standards and improve quality.

Complaints

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

In the past year the complaint process has been streamlined in an attempt to reduce the handling time and get the responses to our complainants as quickly as possible. All draft responses are now quality checked digitally which means there is no need to print or produce paper files, saving a considerable amount of time.

Once quality checked, drafts are no longer printed by the Complaints Team or physically taken over to the Chief Executive's office for signing. Following the Chief Executive's approval, the Trust Management Team now add an electronic signature, print and send the response. This saves a considerable amount of handling time for the Complaints Team and means that even when the Chief Executive is not in the office to physically sign a draft, responses can be processed reducing the delay for complainants.

As these processes have only recently been put in place and the fact that staffing issues in the past year caused an increase in response times, it is not currently possible to report on the progress made as a result of the new processes.

The Trust received 634 complaints between 1 April 2018 and 31 March 2019 compared to 620 complaints between 1 April 2017 and 31 March 2018.

At the time of reporting, the Complaints Team had responded to 619 complaints compared to 599 for 2017/18. In 2017/18 the Trust had 67 reopened complaints and at the time of reporting, the Trust has had 56 reopened complaints for 2018/19. This means that the percentage of reopened complaints has dropped from 11.0% in 2017/18 to 9.0% in 2018/19.

At the time of reporting 506 of the complaints received between 1 April 2018 and 31 March 2019 have been responded to which equates to 80.0% of those received having been closed.

Of these complaints 114 (12.0%) were upheld, 378 (40.0%) were partially upheld and 358 (38.0%) were not upheld by our Trust. 90 (10.0%) of the complaints were stood down for reasons including confidentiality form not signed by the service user or confirmation of the complaint not being returned. These complaints are passed to the locality / service managers for review and learning.

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.

The subject most frequently raised is access to treatment and medication, a trend which has continued from 2016/17 and 2017/18. The Wellbeing Service accounts for just under a third of these complaints, with waiting times for treatment being the primary cause.

The learning we can take from this is that by communicating with people on waiting lists, we can alleviate some of the anxiety associated with waiting to access treatment. We have also seen a number of complaints in this category relating to service users falling into a gap between teams, whereby their presentation is deemed too complex for Wellbeing yet not complex enough for secondary care.

Teams in Norfolk have put processes in place to ensure that these cases are discussed between the services rather than simply being bounced around between the two.

The attitude of staff is an issue which has repeatedly come up across the Trust over the course of the year. "Rude" and "dismissive" staff members were mentioned by complainants on 53 occasions. In some cases, this was down to staff members not considering the impact of what they were saying and how it would be perceived by the service user. We should always remember the Trust's Visions and Values when communicating with service users and carers and consider how what we say may be interpreted.

Communication is another category which has generated a large number of complaints. There were a number of complaints relating to telephone lines and service users / carers being unable to get through to teams on the phone.

A number of these issues were caused by problems with telephone systems which have since been resolved. One of the other issues which has come up many times is the quality and accuracy of our written correspondence, when communicating internally or with GPs. Complainants have raised issues with comments which have been included in this correspondence which they consider to be untrue or unprofessional. Ensuring the accuracy of any notes taken during reviews or appointments with service users and carers will go a long way to making sure that what is written in our communications is accurate. This also relates to the problem referenced above whereby it is imperative to consider the Trust's Visions and Values when writing letters or email, whether internal or external, and ensuring that what is written is appropriate and not open to misinterpretation.

Following the review of the annual complaints report in October 2017 where the Trust Board set a direction to increase contact with complainants, the Trust is now in a position to report on the progress made. Investigators have been asked to contact complainants, where appropriate, to discuss their complaint during the investigation period. The aim is to reduce the number of reopened complaints and provide a better experience for complainants.

Out of 406 opportunities to communicate with complainants between 1 April 2018 and 18 February 2019, contact was attempted in 247 of these complaints. During this same period, there were 47 reopened complaints. Of these 47 reopened complaints, the investigator had successfully made contact with the complainant in only 12.

The Trust has been informed that, following the response to a complaint, the Parliamentary and Health Service Ombudsman opened investigations into seven complaints between 1 April 2018 and 31 March 2019, compared to 11 during the same period in 2017/18. The Ombudsman concluded nine complaint investigations (including those opened in previous years). Seven of the complaint investigations have not been upheld and one has been partially 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.

The Trust is also working on a new initiative in Great Yarmouth and Waveney called "Talk To Us First" whereby volunteer service users will hold clinics to allow potential complainants to voice their concerns prior to logging a formal complaint. The volunteers will then liaise with the care teams to try and resolve the issues, hopefully reducing the number of formal complaints and giving people who would not have otherwise made a formal complaint a chance to voice their concerns.

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 149 occasions.

2.7 Staff feedback

NHS Staff Survey

Staff engagement

We are aware that there is a link between staff engagement and service user experience and outcomes and are therefore committed to making improvements in this area. To support this, we are undertaking a series of Executive Team-led engagement events across our localities and corporate services to discuss the Trust's vision and priorities and gather views to inform the way forward. Local listening events are also being held.

Our Executive Team has been fully appointed to over the last six months and Directors have increased their visibility within the services.

In support of our Quality Improvement Plans, we have also set up a Culture Steering Group and Culture Working Group involving over a hundred staff.

We are engaging staff in implementing and embedding a quality improvement approach across everything we do. We are testing the impact of some of the changes we have put in place through pulse surveys and ongoing listening events.

We also monitor impact through a range of workforce indicators that are regularly reported to the Organisational Development and Workforce Committee and Board of Directors, such as voluntary turnover and absence.

NHS staff survey

The NHS Staff Survey is conducted annually (between October and December). Questions are grouped into themes and results calculated on a score out of 10, with the indicator score being the average of those.

The response rate to the 2018 survey among Trust staff was 53.5% (2017: 55.5%). The national average was 54.0%.

Scores for each indicator together, with that of the survey benchmarking group (Mental Health / Learning Disabilities), are presented below:

(QA11)

	2018		2017		2016	
	Trust	**MH/LD**	Trust	MH/LD	Trust	MH/LD
Equality, diversity and inclusion	**8.8**	**8.8**	8.7	9.0	8.9	9.0
Health and wellbeing	**5.8**	**6.1**	5.7	6.2	5.9	6.2
Immediate managers	**6.9**	**7.2**	6.7	7.2	6.8	7.1
Morale	**5.9**	**6.2**	n/a	n/a	n/a	n/a
Quality of appraisals	**5.3**	**5.7**	5.2	5.5	5.4	5.5
Quality of care	**6.7**	**7.3**	6.7	7.3	6.9	7.4
Safe environment – bullying and harassment	**7.6**	**7.9**	7.7	8.0	7.8	8.0
Safe environment – violence	**9.2**	**9.3**	9.3	9.2	9.2	9.2
Safety culture	**6.2**	**6.7**	6.1	6.7	6.3	6.6
Staff engagement	**6.5**	**7.0**	6.4	7.0	6.6	6.9

There have been statistically significant improvements for the themes of immediate managers, safety culture and staff engagement, however, these are still significantly below our benchmark group average and require continued concerted focus. These areas of focus are in line with our Quality Improvement Plans. There is no statistically significant change across the other themes.

Future priorities and targets

Our focus over the next twelve months includes:

- Restructuring our operational leadership capacity and capability, particularly with a view to strengthening clinical leadership and service user and carer participation
- Ongoing listening events
- To continue the work of the Culture Steering Group and Working Group, moving from the diagnosis to the action phase of delivery. This work includes, for example, a review of induction and mandatory training and a greater focus on people rather than process
- Implementing and embedding our quality improvement approach

Our target is to make improvements across all themes over the next two years so that we are in line with the national average for mental health / learning disability trusts, if not better. We will monitor progress in the meantime through pulse surveys and the Staff Friends and Family Test.

2.8 Commissioning and Quality Innovation Goals (CQUIN) agreed with commissioners

A proportion of Trust income in 2018/19 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 2018/19 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, the improvement of staff health and wellbeing and integration with acute hospital services.

A further initiative was applied to the Norfolk and Waveney, and the Norfolk Wellbeing contracts: 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. This initiative accounts for the remaining 1.0% 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 pre-defined schemes continuing from 2016/17.

From 2017 to 2019 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 Trust's 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 2018/19 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 75.0% 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 2018/19, is forecast to be £2,372k. This compares with the income received in 2017/18 which was £2,565k.

*Comprising South Norfolk, North Norfolk and Norwich Clinical Commissioning

(QA12) CQUIN Schemes implemented across the Trust in 2018/19

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	✓	✓	✓

NHS England (Specialist) Commissioning 2016/17	
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	

2.9 Regulatory compliance

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'.

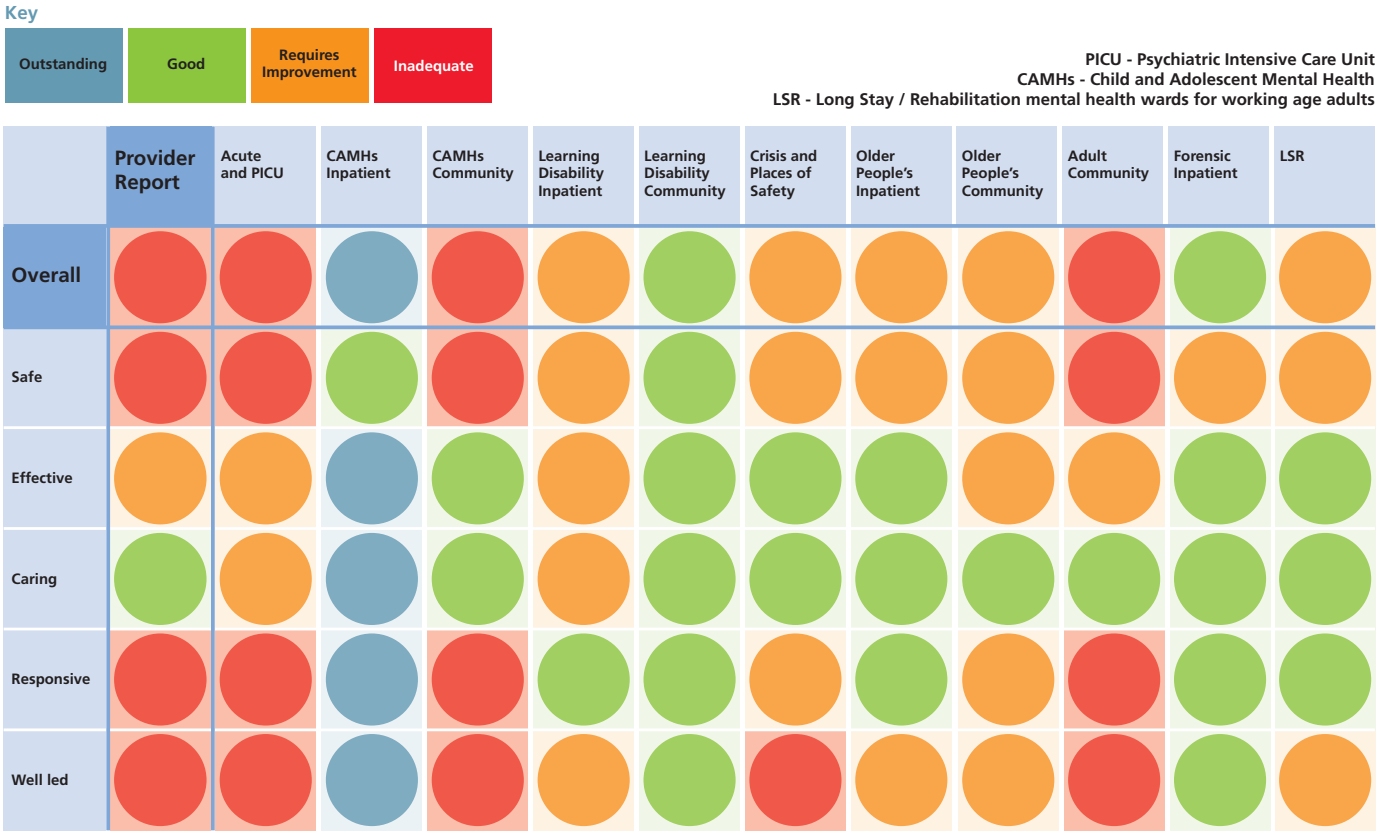
Following an announced inspection in July 2017, the CQC issued a section 29A letter (Health and Social Care Act 2008) requiring the Trust to make improvements by 11 March 2018. The Trust responded within the required timeframe, setting out improvements achieved and those that would be completed in the near future.

Following this submission, an unannounced inspection took place in May 2018 to review progress. A second Section 29A letter was served following this unannounced inspection, acknowledging progress made in some areas, but detailing where improvement was still required.

In September 2018 the CQC undertook a comprehensive inspection of the majority of the services the Trust provides. Following this inspection, a report was published in November 2018 which judged that the Trust remained 'inadequate' and demonstrated a deterioration in the 'responsive' key line of enquiry. The Trust remains in Special Measures.

All of the CQC reports are available at: www.cqc.org.uk

(QA13) Table showing the ratings received by the Trust in the November 2018 CQC Inspection Report:



The Trust recognises this critical position, apologises for it and accepts the report's findings. We also accept the scale of the challenges we face.

While we are pleased that the CQC noted the good quality of care our staff offer, we accept that areas remain where improvement has not been good enough, fast enough or sustained.

We are committed to deliver sustainable organisational change through our locality management structure, thereby ensuring that we have empowered local ownership, common shared views and can use the skills and talents of all our staff. The Trust has, therefore, evaluated both its own and the CQC's findings and, through a variety of staff, service user and carer engagement events, has determined the actions we will take to do better.

Through this work we have implemented a clinically-led approach and incorporated the required work into a single, Trust-wide Quality Improvement Plan. Integral to this plan is the introduction of clinically led leadership teams which will flatten the management structure currently in place and provide locally empowered Care Groups in Norfolk and Suffolk with our specialist service providing Trust-wide and regional services.

This plan is designed to deliver required immediate actions, focusing on keeping service users safe, while not losing sight of the longer-term work needed to embed and sustain a culture of continuous quality improvement. We are committed to ensuring improvement at all levels throughout our organisation, including, crucially, absolute service user involvement in both defining and solving problems.

All plans are monitored monthly at Quality Performance Board and support for the process is provided by the Project Management Office (PMO).

The Trust also continues to be supported by an Improvement Director from NHS Improvement and has appointed a substantive Chief Executive Officer, Chief Nurse, Chief Operations Officer and Human Resources Director. A new Chair has also been appointed from our 'Buddy Trust' which is currently rated as 'outstanding'.

Increased focus on sustaining long-term successful change will come through the introduction of the Trust's approach to Quality Improvement (QI) which in turn will allow for a more effective capture, sharing and transfer of knowledge within our organisation on our ambitions towards 'good' and onwards to 'outstanding'.

CQC Mental Health Act reviews

During 2018/19, the CQC undertook 17 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 Trust-wide. These are being monitored and addressed by teams and localities as well as Trust-wide clinical audits through review of care against standards.

Key themes identified for continued improvement include:

- Co-production and personalisation of care plans
- Supporting service users to understand their Section 132 rights
- Sensitivity to service users' dignity and respect in the transmission of CCTV footage
- Assessing and recording capacity to make decisions about care and treatment
- Assessing for leave and recording outcomes of leave
- Information regarding the right to access and referral to an IMHA

2.10 Learning from deaths

The following section will contain a series of figures and statistics set by a national template. We should remember 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.

During 2018/19, 564 of the Trust's patients died (including those being cared for by the Trust at time of death and up to six months after discharge). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 130 in the first quarter
- 149 in the second quarter
- 134 in the third quarter
- 151 in the fourth quarter

By 2 April 2019, 39 case record reviews and 118 (97 Serious Incident investigations and 21 Structured Judgement Reviews) investigations have been carried out in relation to the deaths indicated above.

In no cases was a death subject 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:

- 58 in the first quarter
- 53 in the second quarter
- 20 in the third quarter
- 26 in the fourth quarter

One case, representing 0.2% 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.

No case record reviews and 48 (47 Serious Incident Investigations and one Structured Judgement Review) investigations were completed during the year 2018/19 which related to deaths which took place before the start of the reporting period (i.e. in the 2017/18 period).

Two cases representing 0.4% of the total patient deaths before the reporting period (i.e. in the 2017/18 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.

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

- **Access to Psychology / Psychotherapy.** With the reduction in numbers of clinical psychologists, the loss of psychological formulation (process of making sense of a person's difficulties and the sense they have made of them) expertise is creating missed opportunities to care plan more effectively. **Action:** One of our senior Clinical Psychologists is reviewing the criteria to access psychological therapy and these will be taken to the senior psychology group for consideration by April 2019. With the Clinical Directors in place, anticipated to be in early autumn 2019, each service area will be responsible for ensuring the full range of therapies will be available for service users

- **Robustness of follow-up.** When promises of actions are made to service users, RCA reports are noting that the promises are not held. These may have had an impact on feelings of rejection and / or may have directly failed to deliver a suicide-preventing intervention. **Action:** Members of Mortality Review group to ask representatives to attend Acute Services Forum and Community Forum to check / discuss the robustness of follow-through on plans mentioned in continuation notes or care plans

- **Confirmatory thinking bias.** Clinicians are only recording information that supports the rationale for a decision. The risk is that this shows a confirmation bias to practice. It may be that the factors against the decision are taken into account, but their absence from notes means we are not assured the full picture was considered. **Action:** When recording decisions, we are asking clinicians to include factors that support and speak against that decision but then give the reasons why on balance they decided on that decision. Messages were sent to Training Department and included in Patient Safety Newsletter

- **Clinical Curiosity: Focus on managing endings - understanding adjustment disorders and the meaning of life events.** The theme of adjustment disorders was discussed in the Suicide Prevention Group related to a case of the home treatment of a service user with a diagnosis of adjustment disorder. The service user did not get access to psychological expertise which they needed at that point. The way our services are set up means there was a gap for this group of people. We needed rapid access to psychological expertise to help understand and formulate the problem and work out immediate support. **Action:** Take the theme of adjustment disorders and funding for consultant psychology to Sustainability Transformation Plan meeting. In addition, a conference with Primary Care took place on 23 January 2019

- **Assessment of suicide risk.** Our clinical assessors have not paid enough attention to the full range of risk information when making a decision. The ability to find and take account of risk information will be taken up in supervision. **Action:** Chief Nurse to review Quality Audit of clinical supervision

- **Deaths on waiting lists.** A review of deaths while waiting was carried out as a deep dive

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 its Learning from Deaths policy in October 2017 which it reviewed in November 2018. It 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 Chief Nurse attends the National Mortality Group and will continue to inform the Trust of the latest guidance and the Medical Director and Chief Nurse 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 was commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England in 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 NSFT Medical Director and LD leads attend multi-agency quarterly meetings.

The MRB reports to the Quality Governance Committee and the Medical Director reports quarterly directly to the Board of Directors.

The MRB reviewed the Themes and agreed the following as the top five priorities:

- Professional curiosity
- Communication with family and carers
- Pathways for people with adjustment disorders
- Quality of handovers
- Service and team capacity (multi-agency working)

On the basis that it would have the widest impact on suicide, the meeting agreed that professional curiosity was the first priority area to focus on. A working group will define and collate data and evidence and find solutions. The current work on formulation and care planning will go a long way to improve clinical curiosity, as well as education in suicide prevention training.

2.11 Reporting against core 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 2018/19 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are part of the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS number was 99.9% for admitted patient care in February 2019:
  - 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 February 2019:
  - Not applicable for outpatient care
  - Not applicable for accident and emergency care

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

(QA14) Seven-day followup

Prescribed information	Related NHS Outcomes framework domain	2018/19	2017/18	2016/17
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 95.0%**	Preventing people from dying prematurely. Enhancing quality of life for people with long-term conditions.	96.5%	96.3%	95.9%

The latest available data produced by NHS England shows that the national average score for the period October to December 2018 was 95.4%. The highest performing area scored 100.0% and the lowest area scored 81.6%.

Admissions to inpatient services for people who had access to 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

(QA15) Admission to inpatient services

Prescribed information	Related NHS Outcomes framework domain	2018/19	2017/18	2016/17
The percentage of admissions to acute wards for which CRHT acted as gatekeeper. This is a national definition reported to NHSI. **Target 95.0%**	Enhancing quality of life for people with long-term conditions.	95.8%	97.9%	97.0%

The latest available data produced by NHS England shows that the national average score for the period October to December 2018 was 97.8%. The highest performing area scored 100.0% and the lowest area scored 78.8%.

Readmission rates (28 days)

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

(QA16)

Prescribed information	Related NHS Outcomes Framework domain	2018/19	2017/18	2016/17
The percentage of patients aged: 0-15	Helping people to recover from episodes of ill health or following injury.	0%	9.1% (Definition 28 days, only emergency readmissions excludes out of area stays. This relates to 1 out-of-area placement)	7.1% (accounting for one readmission to Dragonfly CAMHS Unit which opened in September 2016)
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.		11.1%	8.5% (Definition 28 days, only emergency readmissions exclude Out of Area stays)	8.8%

(QA17)

Key Performance Indicator	2018/19	2017/18	2016/17
Patient safety			
Seven-day follow up of service users following their discharge from inpatient services. **Target 95.0%**	95.8%	96.3%	95.9%
Absconsions of detained patients from adult wards as a ratio of 100 detained patients. **Target 4.1**	8.6	8.2	6.4
Ratio of inpatient serious untoward incidents per 10,000 occupied bed days. **Target 3.8**	5.4 (noting specialist commissioning; secure services and CAMHS inpatient services have added reporting thresholds)	3.8	3.0
Clinical effectiveness			
Access to crisis resolution and home treatment services. **Target 95.0%**	85.3%	97.9%	97.0%
Delayed transfers of care, relating to other support needs (like housing) following discharge from hospital. **Target <7.5%**	5.2%	5.7%	4.3%
Readmission rates: Age 0-15	0%	9.1% (Definition 28 days, only emergency readmissions exclude Out of Area stays. This relates to 1 out of area placement)	7.1% (accounting for 1 readmission to Dragonfly CAMHS Unit which opened in September 2016)
Age 16+	7.4%	8.5% (Definition 28 days, only emergency readmissions exclude Out of Area stays)	8.8%
Inappropriate Out of Area placements for adult mental health services. (figures indicate average number of days per month over the year)	1,011	748	New metric - no previous data

Chart continued over >

> continued

Key Performance Indicator	2018/19	2017/18	2016/17
Patient experience			
CPA patients having formal review within 12 months. **Target 95.0%**	93.8%	96.1%	92.8%
Waiting times. The number of people waiting 18 weeks or greater.	205 (indicator changed to average number of service users per month)	387	120
Number of under-18-year-old admissions to adult acute ward.	5	8	2
Number of under-16-year-old patients admitted to adult acute wards. **Target 0**	0	0	0
Meeting commitment to serve new psychosis cases by early intervention teams. **Target 95.0%**	156.1%	120.4%	150.0%
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 50.0%** Data indicates referrals to existing 14-35-year-olds to early intervention services.	Q1: 83.1% Q2: 79.4% Q3: 77.8% Q4: 83.2%	Q1: 59.7% Q2: 67.5% Q3: 66.3% Q4: 62.8%	Q1: 44.7% Q2: 60.4% Q3: 56.5% Q4: 62.4%
Improving access to psychological therapies (IAPT): - proportion of people completing treatment who move to recovery **Threshold 50.0%**	Q1: 50.7% Q2: 50.1% Q3: 50.9% Q4: 55.4%	Q1: 46.8% Q2: 42.5% Q3: 40.0% Q4: 44.6%	New metric - no previous data
- people with common mental health conditions referred to IAPT programme will be treated within 6 weeks of referral **Threshold 75.0%**	Q1: 87.6% Q2: 86.9% Q3: 88.0% Q4: 85.9%	Q1: 94.0% Q2: 93.8% Q3: 92.7% Q4 89.6%	Q1: 94.2% Q2: 93.0% Q3: 93.1% Q4: 93.2%
- people with common mental health conditions referred to IAPT programme will be treated within 18 weeks of referral **Threshold 95.0%**	Q1: 99.9% Q2: 99.9% Q3: 100% Q4: 100%	Q1: 99.9% Q2: 99.9% Q3: 99.9% Q4: 100%	Q1: 100% Q2: 99.7% Q3: 99.8% Q4: 99.9%
Cardio-metabolic assessment and treatment for people with psychosis in: - Inpatient wards - Early intervention in psychosis services - Community mental health services (people on Care Programme Approach)	Data not available until June 2019	58.3% 11.4% 5.1%	New metric - no previous data

2.12 Data security and quality

The Trust used NHS Digital's former Information Governance (IG) Toolkit assessment to report its performance. The overall score for 2017/18, submitted in March 2018, was 93.0% and was graded 'satisfactory.'

In 2018/19, we will complete the new NHS Digital Data Security and Protection Toolkit (DSPT). We submitted our baseline return in October 2018 and our final submission for the year in March.

A specific action plan was submitted regarding IG Training uptake for staff as we reached 82.0% against a target of 95.0%

Our DSPT submission will be available on the NHS Digital website: www.digital.nhs.uk

Datix is used to record all IG related risks and incidents. All IG incidents are reviewed and, where necessary, investigated by our IG Services team. This is, in turn, reported to the IG Sub-committee and the Non-executive Director chaired Audit and Risk Committee for scrutiny.

The Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

Part 3: Review of quality performance

3.1 Quality initiatives

Key performance and developments during 2018/19

This section allows the Trust to highlight quality matters from 2018/19 in more detail or that have not been addressed elsewhere in the report.

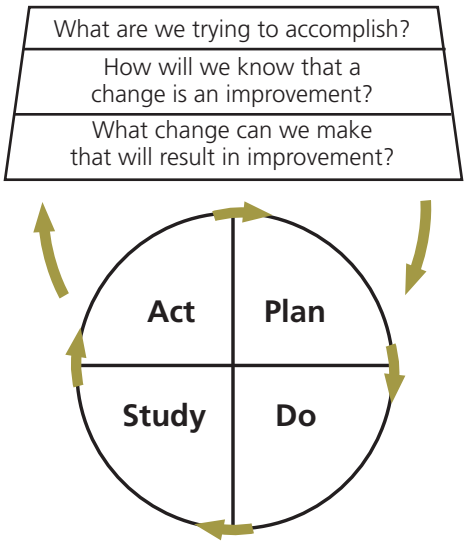
The examples are reported using the three key components of 'High Quality Care for All' where quality is placed as the organising principle in the NHS. Quality is defined in relation to three domains: patient safety, clinical effectiveness and patient experience.

3.2 Evaluation of clinical effectiveness

Quality Improvement (QI)

From April 2018 the Trust has started its journey to embed QI methodology across the Trust to continuously improve the quality of care we offer to our service users and carers as well as create a continuously learning environment. The chosen model is The Model for Improvement.

(QA18) Model for Improvement



Model for Improvement (Langley et al 2009)

This allows us to have a consistent and systematic approach, to involve those closest to the quality issues in discovering solutions to complex problems. The methods and tools used engage people (both staff in clinical / corporate teams and service users and carers) to review and identify the issues, test out the change ideas and use measurements to see if the change has led to improvement.

The NSFT QI launch on 30 October 2018 took place in Ipswich where examples of QI projects across the Trust were presented to staff, service users and carers and other stakeholders.

In January 2019 the first cohort on the Improvement Leaders Programme was facilitated by ELFT QI Team in Norwich. Over the three-day programme 93 staff / service users / carers managed to define and refine 29 projects across the Trust.

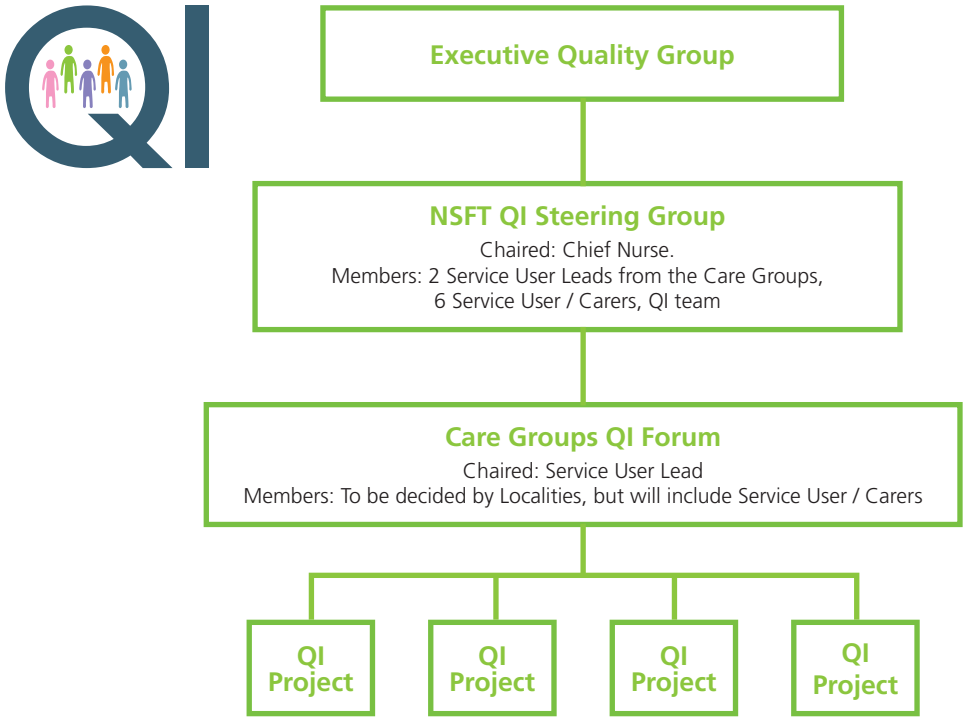
Examples of the themes of some of the projects:

- Three Reducing Restrictive Interventions. All three projects on the national NHSI/ NCCMH programme
- Reducing waiting times in CFYP
- Using EBCD methodology (Evidence-based Co-design) to improve engagement in service improvement
- Payroll processes
- Improving shift coordination
- Improving quality and consistency of risk assessments
- Improving liaison between forensic and community mental health teams

The next cohort will be in June 2019 in Ipswich.

The proposed QI infrastructure to ensure local ownership and good governance is described below and will be out for consultation once the Trust Care Groups have been embedded.

(QA19) QI reporting structure



2019/20 brings further training in the development of a co-produced and co-delivered training programme via the Recovery College, further training and support from ELFT and the development of the central QI team as well as embedding QI experts within the Care Groups.

The Trust has an agreed approach to reviewing National Institute for Health and Care Excellence (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 and raising issues to the Trust Board as well as external partners such as commissioners.

All technology appraisals published by NICE are discussed at our Drug and Therapeutics Committee to ensure that medicines are available when recommended by the prescriber.

NICE guidance

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

NICE guidance published since April 2018 included:

- Updated guidance on diagnosing and managing dementia. It aims to improve care by making recommendations on training staff and helping carers to support people living with dementia
- New guidance on decision-making and mental capacity. This guideline covers decision-making in people 16 years and over who may lack capacity now or in the future. It aims to help health and social care practitioners support people to make their own decisions where they have the capacity to do so. It also helps practitioners to keep people who lack capacity at the centre of the decision-making process
- Updated guidance on post-traumatic stress disorder, updating the 2005 guidance, including recommendations on specific recognition issues for children, supporting transitions between services and drug treatments for children, young people and adults

We share NICE newsletters and NICE Bites summaries with staff through email bulletins to help staff keep up-to-date with notices, reviews and publications. Relevant NICE guidance is always included in the review of clinical policies. For example, the Discharge from Inpatient Care policy requires that summaries are sent to the service user and GP within accepted periods, and the Rapid Tranquillisation policy requires NICE recommended physical health checks.

Gap analysis, either by leads in the Trust or requested from each locality, as well as local and national audit, such as the Prescribing Observatory for Mental Health UK, help us to establish the Trust's compliance against NICE guidance.

For example, a detailed analysis in Suffolk Eating Disorders Services for children and young people identified actions by the service, among other things, to ensure sufficient number of therapy training manuals and how to better offer supervision to therapists. It also prompted a meeting with the service manager, the Trust's Medical Director and local CCG to agree a number of actions on how services are commissioned, access to dietetic and paediatric services, working relationships with local acute hospital trusts and the suitability of premises.

The Professional Lead for Learning Disabilities considered new NICE guidance on learning disabilities and behaviour that challenges. We saw that the Trust was already compliant with 48 out of 49 recommendations.

A POHM-UK audit on prescribing valproate for people with bipolar disorder saw the trust improve on eight out of ten standards compared to the baseline audit in 2015.

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.

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 2018/19 have been:

- Trust staff succeeded in maintaining a low rate of Health Care Acquired Infections (HCAIs) subject to mandatory reporting with nil occurrences of MRSA blood stream infection and nil cases of Clostridium difficile infection within NSFT inpatients
- There were six confirmed outbreaks of Norovirus infection within our inpatient units during 2018/19. Each outbreak was managed according to Trust policy with close liaison with the IPAC nurse for case identification and management
- There were no confirmed cases or ward closures related to influenza infection
- The Trust continues to embed the IPAC link worker programme and annual training has been provided by the IPAC nurse service
- The Trust held a Physical Health and Infection Prevention and Control study day with more than 50 staff attendees discussing topics beneficial to mental health staff in relation to decontamination, sexually transmitted infection, chronic respiratory illness and urinary tract infection in addition to physical health initiatives

Once again, the Trust ran an in-house vaccination campaign of Trust staff to protect them and our service users from influenza. All staff were offered the immunisation and our aim was to vaccinate at least 75.0% of our staff. While the target was missed, the Trust continues to achieve year-on-year improvement in uptake. Prize draws, competitions and use of a charity focus known as '#getajabgiveajab' (purchase of vaccines for developing nations via UNICEF) were organised to incentivise uptake. This year saw an increase in the number of peer vaccinators with 62 Trust staff trained by the IPAC nurse to provide immunisation to colleagues as part of the preparation.

Physical health

Progress for 2018/19 physical health priorities is outlined below and also includes new priorities addressed during this period. Priorities for physical health improvement for 2019/20 are detailed as follows:

Priorities as identified for 2018/19

Physical Health Strategy: The Physical Health Mobilisation Group was established to support a wider consultation period to identify the key areas for the Five-Year Strategy:

- **Deteriorating Patient** - improved recognition and response
- **Health promotion** - improved screening of patients with Severe Mental Illness (SMI)/ Integration of care systems with primary care
- **End of Life** – improved pathway introduction of Recommended Summary Plan for Emergency Care and Treatment (ResPECT) process
- **Pressure Ulcers** – reduction in prevalence

Enabling a culture shift / improving physical health knowledge and resources: Following feedback from staff the physical health form has been reviewed to simplify and reduce complications in recording. A phased approach will be used to implement changes with phase 1 starting in May 2019.

Agreed Quality Improvement Programme for the introduction of NEWS2 in a nationally recognised early warning scoring system to ensure deteriorating patients are recognised and escalated appropriately.

Successful induction of the Physical Health Promotion Nurse role to support the physical health team in developing healthy lifestyle pathways to increase focus on health prevention and promotion that includes:

- Developing stronger partnership working with Public Health Suffolk / Norfolk together with third sector agencies in order to build on a meaningul health promotion resource library
- Short-to-the-point bite-size training sessions including smoking cessation delivered to ward / community via team meetings where staff are readily accessible
- Monthly publication of E-Newsletter 'Health Promotion For You and Health Promotion With You' to embed a holistic care-focused approach

- The formation of a Task and Finish group to co-produce a physical health booklet for service users with information/ explanation / recording of screening results and to help promote the use of the therapeutic relationship to empower individuals to make positive health choices and changes to lifestyle

Improved physical health screening and interventions for patients with Severe Mental Illness: The physical healthcare policy was reviewed with a renewed focus on NSFT responsibility in SMI cardio-metabolic screening.

In line with policy expectations work has been carried out with CCGs for the provision of shared care arrangements, which includes the funding for additional (NSFT) staff to carry out cardio-metabolic screening within community teams.

The Trust's Smokefree Initiative was introduced in April 2018 which dovetails with CQUIN quality improvement in reducing risky behaviours. 95.0% of clinical staff have undertaken (National Centre for Smoking Cessation and Training Very Brief Advice on Smoking) VBA training with 82.0% of service users being screened for smoking status and 77.0% for alcohol status.

A six-month review of the effects of policy implementation was carried out by members of the Nicotine Management Working Group who used 'Clear' a deep dive self-assessment endorsed by Public Health which measures current practice against national and local objectives. Results were shared at a Trust-wide Smokefree problem-solving group with representation from all localities.

A Quality Improvement project will start in April 2019 which will include a ward piloting vaping indoors.

New priorities identified in 2018/2019

All identified areas within community services have acquired a defibrillator with training provided to nominated link persons who disseminated cascade training within teams.

A local resuscitation protocol template for community and inpatient areas has been developed to complement Policy C46: Resuscitation. The template includes information about local resuscitation processes in order to coordinate staff response to a cardiopulmonary resuscitation event.

Freedom to Speak Up

Workers' ability to speak up when patient care is compromised is hugely important. While having a Freedom to Speak up Guardian is mandated in the NHS contract, NSFT has always placed great emphasis on the role and the Guardian has been supported through their tenure to enable issues to be heard where otherwise they wouldn't be. The number of people accessing the guardian is rising as familiarity and confidence in getting results increases.

In 2018/19 (to 31/1/19) 75 cases were raised to the guardian. This is broken down into themes for reporting purposes, all submitted data is available on the National Guardian website https://www.cqc.org.uk/national-guardians-office/content/speaking-data. Colleague attitudes and behaviours including, but not exclusively, bullying and harassment being the highest in number.

Workers in the organisation can access the guardian by letter, email, phone, social media and answerphone where disclosures can be made anonymously. All initial contacts are confidential, actions will be discussed, including the ability to protect identity, with the individuals and times and methods of feedback will be agreed.

In specific circumstances, individuals are protected by law if they suffer detriment because of speaking up. However, it is only after the detriment has occurred that the law comes into force. By having a guardian supporting people to speak up, or doing so on their behalf, will effectively bring issues into the open and therefore prevent anyone from covering them up or silencing individuals.

3.3 Evaluation of patient experience

Community Service User Survey

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

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

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 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.

(QA20)

Prescribed information	Related NHS Outcomes Framework domain	2018	2017	2016
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.	7.2	7.6	7.2

Range of scores: 5.9-7.7
The scores achieved are from a maximum possible score of ten.

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 2018 this demonstrated that the Trust had improved on all 27 standards in a 12-month period and was 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 or have LD and/ or autism themselves and wish to volunteer to drive changes within services. Currently, there are 270 Green Light Champions including service users, parents / carers and staff. There are also a number of champions in our partner organisations such as the county councils, universities and other NHS Trusts.

The Green Light Toolkit also ensures that the Trust is compliant with the NHS England Accessible Information Standards. The Trust is the first in the country to employ a person with a learning disability and autism within the Green Light Team. His role as Peer Support Worker includes responsibility for:

- Producing Easy Read information
- Training staff in how to make information more accessible
- Chairing the service user easy read group

The Trust LD / Autism Strategy entitled 'Green Light for Mental Health Services 2017-2020' drives forward improvements within 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.

The Green Light Champions Network provides a forum to share good practice and education around local, regional and national work to improve the experience of service users with a learning disability and / or autism.

Green Light Champions are developing reasonable adjustment boxes within all teams and have produced a number of resources for other staff which are all housed on the internal intranet page. This year, Champions have developed reasonable adjustments training for administrators and reception staff, reasonable adjustment checklists and posters.

The Trust was selected by the National Development Team for Inclusion (NDTI) as one of five NHS Trusts to be included in a report about the successful implementation of the Green Light Toolkit: https://www.ndti.org.uk/resources/publications/green-light-work-reflections-on-examples-from-five-nhs-trusts

The Trust was commended by NHS Improvement as one of four National NHS Trusts for improvements made to services. As a result, the Green Light Champions were selected to develop a National "improvement grab guide". The grab guides are used to support the NHSI Learning Disability Improvement Standards: https://improvement.nhs.uk/resources/learning-disability-improvement-guides/

National Learning Disabilities and Autism Awards

Our Trust Professional Lead for Learning Disability and Autism, Sue Bridges, who facilitates the Green Light initiative was awarded Learning Disability Nurse of the Year.

The Green Light Champions were nominated as finalists in the Employer category.

Nursing Times Awards

The Green Light initiative was nominated by NHSI and the Trust was selected as a finalist.

Nursing Times Workforce Awards

The NSFT Green Light Team reached the finals for making reasonable adjustments to recruit the first person with a learning disability in the Trust.

Recovery College

The Recovery College is now in year six. (Sept 2018 - Aug 2019).

Recovery Colleges offer educational courses about mental health and personal recovery. The courses aim to support people to gain more knowledge and skills to manage their mental health and range from courses about specific diagnoses to courses around self-management techniques. Co-production is at the core of Recovery College; all courses are co-developed and co-tutored by someone with lived experience and someone with learned experience.

The Recovery College offers courses to people who are in secondary mental health services (or who have been discharged within a year), supporters, carers, staff members and staff members of third sector organisations.

The Recovery College was started in 2013 delivering 17 courses. It has grown considerably over six years, delivering more courses and reaching more students. The college has become a very effective way of exploring recovery and students often use it as an alternative to clinical recovery or as a complement to it, although Recovery College is not therapy.

In 2017/18 a total of 2,371 people attended courses and we offered a total of 31 courses across five localities: East Suffolk, West Suffolk, Norwich, King's Lynn and Great Yarmouth and Waveney.

Of the 2,371 people who attended the Recovery College, 62.0% were service users, 11.0% were supporters, 6.0% were previous service users, 15.0% were NSFT staff, and 6.0% were other.

The Recovery College is keen to be community-facing and to be a champion for personal recovery within the Trust and outside of it. Outside of the usual Recovery College timetable delivered in five localities, we deliver extra training in other environments. The College has delivered a session on Recovery for first year mental health students at both the University of Suffolk and the University of East Anglia. We have also delivered a Recovery session to all social work students at the University of East Anglia.

In academic year five, September 2017 to August 2018, a total of 2,371 people attended courses and we offered a total of 31 courses across five localities: East Suffolk, West Suffolk, Norwich, King's Lynn and Great Yarmouth and Waveney.

It also offers training for teams on away days.

Recovery College has a presence on the wards, delivering informal taster sessions and being involved in groups and conversations about Recovery. In Great Yarmouth, the Recovery College has held 15 taster sessions at Northgate Hospital, reaching 52 people. In Norwich, it has held 12 sessions on Waveney Ward, Hellesdon Hospital reaching 55 people. East Suffolk holds monthly informal discussions and sessions for all staff and patients at Woodlands Unit, Ipswich Hospital.

Student experience of the Recovery College overall and the course attended was collected at the end of each course. There was an option for feedback to be anonymous and relates to the specific courses attended. Overall, the feedback of the Recovery College is excellent. A high percentage of students felt that the courses:

- Were of excellent or good value in terms of their (or someone they support) recovery – **97.0%**
- Exceeded or met their expectations – **90.0%**
- Students also rated the quality of the trainers highly with **99.0%** rating them as excellent or good

Until 31 October 2018, the Recovery College received a total of 310 FFT returns with an overall 98% recommending the service, sitting above average for all other services.

The below table shows a summary of the activity for Year five – the number of places available within the College for students and how many of those places were booked. Across the localities there are different demographics and population resulting in some areas being busier than others.

In Norwich, all places are filled very quickly and in other localities not all classes can become full. The declined places pertain to courses where all the spaces are filled and where there is a waiting list and students have not been able to be offered a place. The table highlights that in the past year there has been a larger number of people who did not attend the courses once they booked on. Students can enrol in several courses a term.

(QA21)

	Year 5	Year 5	Year 5	Year 5	Year 5	Year 5	Year 5
	Places available	Declined places	Booked places	Attended	Did not attend	Cancelled number of courses	Unfilled places
Term 1	1,742	83	1,467	889	479	7	275
Term 2	3,082	160	2,179	1,185	894	24	903
Term 3	2,935	293	2,301	1,152	1,035	15	634
	7,759	**536**	**5,947**	**3,226**	**2,408**	**46**	**1,812**

Our local coordinators review, monitor and plan the timetable based on continuous feedback from staff and students and try to predict what courses and how many of a specific course to offer each term based on demand in previous terms. From September 2019 we will be changing the enrolment process, in line with a standard educational model, which we anticipate will help to define a student's journey over a three-term period and therefore make this process more accurate. We also hope this new process will improve the Did Not Attend (DNA) rates.

Equality and diversity initiatives

Our stepped approach in implementing the Equality Delivery System (EDS2) across the Trust has progressed.

Our localities have a new equality governance structure which ensures that locality managers are kept appraised of progress against the locality's equality action plan by an equality coordinator. These positions, like the position of equality lead, receive regular skills, knowledge and development updates in equality network meetings. Leadership skills are employed to influence teams, and best practice knowledge is acquired and disseminated to teams, helping to embed equality in everything we do.

This year has seen leads proactively booking speakers to engage with teams from a service user, carer, or clinical perspective, sharing insights on providing care and strategies to outreach to protected characteristic groups. The Performance and Accountability Review Meeting (PARM) has proved a useful arena for localities to take ownership of equality targets.

The Trust is proud to be taking part in an NHSI culture change programme 'Getting Better Together'. The programme, developed by Professor Michael West, embeds a focus on inclusion in its approach and the equality team is proud to be involved in NSFT's steering group which will apply the programme within our Trust.

The EDS grading approach we are implementing before financial year-end will enable local services to understand how well they are performing against their equality objectives and where they need to improve after consulting with their stakeholders. Feedback can then inform equality impact assessment where localities can devise plans to identify and address inequalities for staff and service users.

This year has seen overwhelmingly positive feedback from our Black History Month conference in Wherstead Park, Ipswich. The experiences shared by our staff and speakers were described as "inspirational".

The annual Diversity Conference took place on 29th March 2019 and put service users and carers at the heart of it. The theme of Compassion and Inclusion focused on driving compassionate care and compassion in the way we support our colleagues. The themes of compassion and inclusion go to the heart of the culture change work at NSFT and incorporated the latest evidence-based research from Professor Michael West, ensuring that compassionate and inclusive leadership translates into excellent patient care. The conference explored what compassion and inclusion meant from different perspectives including service-users and carers and a range of viewpoints from people of different ethnic and gender identities, religions, sexual orientations, disabilities and roles within our Trust. All staff attending were invited to pledge to change one aspect of their practice as a result of their experience at the conference.

During 2018/19 the Open Mind group, which consists of service users and staff, worked alongside the Ipswich Hindu Community Centre to raise awareness about mental health. The group has broadened its remit to include LGBT, and BME service users and carers sharing their experiences. The group delivered workshops which were co-developed by staff and service users working alongside the Recovery College and Wellbeing service and covered a series of presentations ranging from mental health issues to what services are provided by our Trust.

Open Mind's 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. Feedback has been very positive. This is three-yearly training and we have so far trained approximately 88.0% of our workforce with a target of 100% compliance in 2019.

Patient-Led Assessments of the Care Environment (PLACE)

PLACE assessments are an annual self-assessment of non-clinical services which contribute to healthcare delivered in both the NHS and independent / private healthcare sector in England. Through focusing on the areas which matter to patients, families and / or carers, the PLACE programme aims to promote a range of principles established by the NHS Constitution, including:

- Putting patients first
- Actively encouraging feedback from the public, patients and staff to help improve services
- Striving to get the basics of quality of care right
- A commitment to providing services in a clean and safe environment that is fit for purpose

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 across Norfolk and Suffolk and involved staff, current service users, former 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 Table below shows the National averages for 2017 and 2018 and how our Trust compares.

(QA22)

	2018			2017	
	NSFT Overall Score	**National Averages for all NHS Trusts**	**National Averages for Mental Health Trusts only***	**NSFT Overall score**	**National Averages for all NHS Trusts**
Cleanliness	99.5%	98.5%	98.4%	98.9%	98.4%
Food	99.2%	90.2%	90.6%	94.9%	89.7%
Organisational Food	98.4%	90.0%	88.8%	91.0%	88.8%
Ward Food	99.8%	90.5%	92.3%	98.0%	90.2%
Privacy Dignity and Wellbeing	94.5%	84.2%	91.0%	92.5%	83.7%
Condition, Appearance and Maintenance	98.2%	94.3%	95.4%	97.5%	94.0%
Dementia	92.9%	78.9%	88.3%	90.5%	76.7%
Disability	97.6%	84.2%	87.7%	93.3%	82.6%

* No data is available for 2017 National Averages for Mental Health Trusts

At an individual site level there were mixed results. Most demonstrated improvements on the 2017 results though some have decreased, but in all cases by less than 1.0%. Action plans will address minor issues raised, such as standards of cleaning, some internal and external maintenance issues and privacy, dignity and wellbeing. It is noted that there were changes in the assessment criteria and scoring methodology. However, the Trust scored higher than the national average in 2018 in all aspects and has also improved its score on all the individual areas assessed compared to 2017.

The Trust are performing well nationally against other NHS Trusts and those NHS Trusts that specialise in solely providing care to patients with a learning disability and mental health issues. In some areas we are the top performer and again scored higher than the national average for all aspects assessed and against other NHS Trusts in Norfolk and Suffolk we are either the top performer or in the top three in all aspects assessed.

NSFT individual site scores attained were as follows:

(QA23)	Cleanliness		Food		Organisational food		Ward food	
Location	2018	2017	2018	2017	2018	2017	2018	2017
Wedgwood	99.9%	99.9%	98.7%	95.5%	96.7%	90.6%	100%	99.3%
Carlton Court	99.3%	98.3%	97.5%	96.1%	99.3%	90.3%	96.2%	99.5%
Fermoy Unit	99.4%	99.5%	99.1%	96.6%	97.9%	93.0%	99.6%	98.9%
Hellesdon Hospital	99.5%	97.6%	99.1%	95.7%	97.6%	89.2%	100%	100%
Woodlands	100%	99.8%	99.7%	94.7%	99.3%	90.0%	100%	98.5%
Foxhall House	99.4%	99.5%	99.3%	97.7%	99.3%	95.2%	99.4%	99.4%
The Julian Hospital	99.0%	98.8%	99.6%	90.2%	99.0%	91.5%	100%	89.4%
The Norvic Clinic	99.6%	98.9%	99.4%	96.0%	98.4%	90.1%	100%	99.7%
Northgate Hospital	98.7%	98.9%	99.7%	96.7%	99.3%	93.0%	100%	98.6%

Location	Privacy, Dignity and Wellbeing		Condition, appearance and maintenance		Dementia		Disability	
	2018	2017	2018	2017	2018	2017	2018	2017
Wedgwood	96.9%	85.9	98.7%	98.3	90.4%	88.9	96.6%	87.4%
Carlton Court	94.1%	95.0%	98.6%	97.3%	98.4%	97.3%	98.2%	95.9%
Fermoy Unit	94.5%	90.4%	96.6%	99.2%			96.7%	97.4%
Hellesdon Hospital	92.9%	95.0%	97.7%	97.0%			98.2%	98.6%
Woodlands	93.0%	93.5%	98.3%	94.9%	89.5%	85.1%	96.3%	82.7%
Foxhall House	95.3%	95.4%	96.8%	97.7%			96.0%	96.3%
The Julian Hospital	95.8%	94.8%	98.7%	98.3%	97.7%	97.0%	99.6%	98.8%
The Norvic Clinic	94.4%	92.0%	99.3%	99.4%			99.4%	97.8%
Northgate Hospital	97.7%	89.7%	97.1%	97.5%			93.6%	92.1%

(Note: grey sections indicate those areas not providing dementia services)

3.4 Evaluation of patient safety

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 Executive Quality Group

Serious incidents are managed in accordance with national guidance.

(QA24) Table showing the ratings received by the Trust

Related NHS Outcomes Framework domain	1 April 2018 to 30 September 2018	1 October 2017 to 31 March 2018	1 April 2017 to 30 September 2017	1 October 2016 to 31 March 2017	1 April 2016 to 30 September 2016
Treating and caring for people in a safe environment and protecting them from avoidable harm.	5,513 incidents reported	4,787 incidents reported	6,312 incidents reported	5,146 incidents reported	4,405 incidents reported
	93.01 incidents per 1000 bed days**	73.95 incidents per 1000 days**	97.4 incidents per 1000 days	77.55 incidents per 1000 days**	65.21 incidents per 1000 days**
	1 incident (0.0%) led to severe harm	0 incidents (0.0%) led to severe harm	2 incidents (0.0%) led to severe harm	3 incidents (0.1%) led to severe harm	3 incidents (0.1%) led to severe harm
	National average 0.3%	National average 0.3%	National average 0.3%	National average 0.3%	National average 0.3%
	36 incidents (0.7%) led to a death	35 incidents (0.7%) led to a death	30 incidents (0.5%) led to a death	20 incidents (0.4%) led to a death	25 incidents (0.6%) led to a death
	National average 0.8%++	National average 0.8%++	National average 0.8%++	National average 0.8%++	National average 0.8%++
	** The reporting rate of 93.01 incidents is rated 3rd out of 46 mental health organisations (Trusts who have reported data per 1000 bed days)	** The reporting rate of 73.95 incidents is rated 9th out of 53 mental health organisations and puts the Trust in the top 25.0%	** The reporting rate of 97.4 incidents is rated 3rd out of 53 mental health organisations and puts the Trust in the top 25.0%	** The reporting rate of 77.55 incidents is rated 5th out of 54 mental health organisations and puts the Trust in the top 25.0%	** The reporting rate of 65.21 incidents is rated 10th out of 55 mental health organisations and puts the Trust in the top 25.0%

++ 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).

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 October 2017 to September 2018 shows that the Trust is in the middle range (50.0%) of 53 mental health trusts in that period.

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 25.0% 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 25.0%. 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.

In August 2018 our Professional Lead for Reducing Restrictive Interventions (RRI) was successful in an application for the Trust to be part of the NHSI / NCCMH (National Centre for Collaboration in Mental Health) RRI national project. The three wards that are part of this are Great Yarmouth Acute services; Waveney Ward; Hellesdon Hospital; and Lark Ward, Woodlands Unit, Ipswich Hospital. The official launch was in November 2018 and since then the teams have attended East London NHS Foundation Trust's Improvement Leaders Programme, an action learning set in London and received QI Coaching by an external coach. Within this short period of time the teams have already seen a reduction in their use of RRI by using different change ideas from co-production of discharge plans, to increase activities in the evenings and a focus on positive morning routines. The wards are all using the Life QI platform to monitor their progress using run charts, and record their Plan Do Study Act (PDSA) cycles. This is a long-term project and lessons learnt from these three wards will be shared with other inpatient areas across the Trust.

In west Suffolk an Experience-Based Co-Design (EBCD) pilot project is underway.

Experience-Based Co-Design is a methodology being used to explore patient and staff experiences of restrictive interventions. We have interviewed 12 patients and 12 staff, and are currently completing a thematic analysis on the transcripts. The project has been co-produced from the very beginning and at every stage. We are in the process of arranging dates for the co-design workshop and celebration events, which are anticipated to be in March and June 2019.

Serious Incidents (SIs)

The Trust continues to report all Serious Incidents (SIs) in accordance with national guidance. The Trust SI process and policy have been revised in collaboration with our CCGs and in line with the national framework. Regular meetings take place with our CCGs across both counties to review incidents and ensure learning is fully implemented.

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, these are considered as part of the Mortality Review process under the national Learning from Deaths Guidance.

From April 2018 to 31 March 2019 187 SIs have been reported of which 107 were unexpected deaths involving service users who were accessing a range of 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.

This compares to 2017/18 (full financial year) whereby 190 SIs were reported, of which 137 were unexpected deaths.

The Trust uses Root Cause Analysis methodology to consider the timeline and factors that influenced an incident. A panel analysis of the incident identifies learning actions for services. Learning is shared Trust-wide through a number of communication channels such as workshops, newsletters, alerts and meetings.

Suicide prevention

The Trust's Suicide Prevention Strategy was launched as a five-year strategy in February 2017 and focuses on five key domains. In addition to this, in 2018 the Secretary of State announced a Zero Suicide Ambition for all NHS inpatient mental health units in England. There have been many achievements indicating progress with the strategy and the ambition:

Clinical Pathways

Work continues to review the safety of internal, third sector and external clinical pathways into the Trust to ensure that the appropriate help is delivered at the right time. The Trust has hosted events aimed at increasing the awareness of male suicide and engaging men in mental health services. A Standard Operational Procedure for Crisis Resolution and Home Treatment Teams has been agreed which confirms the teams' admission and discharge pathways along with a self-referral route.

Working with family and carers

Funding and support from the National Suicide Prevention Programme has commissioned a QI study into the support carers need from the Trust when looking after a loved one who is suicidal. A series of focus groups engaging staff, carers and services users in the Great Yarmouth and Waveney locality have been held to inform future co-produced interventions to enable families and carers to feel supported and have their needs met. The learning from this will be taken Trust-wide.

Supporting staff with the most up to date skills and knowledge

All staff employed by the Trust are required to complete a Suicide Prevention eLearning course. Classroom Suicide Prevention Training is now included into the Clinical Update Day which allows Practice Educators to deliver bespoke suicide prevention training in teams' own clinical areas as advised by team leaders. A co-produced Suicide Awareness training module is being developed by the Recovery College.

Working with others

The Trust continues to be an active member of both Norfolk and Suffolk Suicide Prevention Groups as well as assisting in delivering the additional National Suicide Prevention Funding to the Norfolk and Waveney STP. To recognise the need to increase partnership working the Trust is holding a series of networking events to focus on Suicide Prevention.

Inpatient Zero Suicide Ambition

We have submitted a draft plan to the National Advisory Team addressing how we plan to deliver the Zero Suicide Ambition to our inpatient units. This includes an increase in safety planning and contributing to a pilot study of contacts made within 48 hours of discharge from an inpatient unit.

Out of Area placements

It has been recognised that a system-wide response is required to reduce the current level of Out of Area placements. It has been agreed with all CCGs that this response will include a co-produced review of the current community, crisis and home treatment offer, ensuring that people are supported in a timely way when they are most distressed and avoids hospital admission. The community offer will be developed in partnership with local alliances and will support the implementation of local neighbourhood integrated teams which will be wrapped around the developing Primary Care Networks.

A system-wide action plan to support people in the right place at the right time has been produced. This is chaired by the Chief Operating Officer of the Trust and includes a wide range of partners including support from NHS England. This piece of work is reporting to the Trust Board and also to both STP Boards. The plan includes a refreshed trajectory to eliminate inappropriate out of area placements by 2021. This includes:

- Increase in acute inpatient beds
- Increased clinical support to monitor current Out of Area placements
- System-wide agreed process regarding delayed transfers of care
- Implementation of a dedicated pathway for people with a Personality Disorder
- Review of current gatekeeping process for an inpatient admission
- Increased community rehabilitation and recovery support

Feedback from our Trust's localities

West Norfolk Locality

Waiting List Project

From May 2018 to December 2018 the unallocated waiting list for people accessing community services was reduced from 210 service users to 0. This has been achieved through workforce development / recruitment and restructuring of the team.

Initial audits were undertaken to establish a baseline position around the impact on patient safety of having an unallocated waiting list. These were service users who had been assessed but not allocated to a Lead Care Professional or Care Coordinator due to the capacity and demand issues. Dedicated resource was then given to the waiting list to review all the service users awaiting allocation and treatment and to ensure there was regular contact in place while the workforce development and recruitment was undertaken. A successful business case supported increasing the registered and non-registered workforce which included a skill mix review leading to more Assistant Practitioners and Psychology posts being created. The outcome was the ability to discharge some service users who no longer required secondary services and to allocate the remaining to new staff and to robustly manage all new referrals and assessments to make sure service users were allocated to the most appropriate professionals following assessment.

Acute pathway project

A project to centralise adult acute mental health services in King's Lynn is underway with a new facility due for completion at the Chatterton House site in June 2019.

Alongside the redevelopment, there have been numerous staff and service user engagement projects to support the design of the ward itself and some of the acute pathways which will improve patient care. West Norfolk have piloted a "day hospital" option for a small number of service users (up to 4) at any one time to access the ward activity programme and have partial hospitalisation. In addition, service users are involved in developing a therapeutic environment on the new ward and in designing the new ward logo for Samphire Ward.

Improving learning from SIs

West Norfolk are involved in a pilot with the Patient Safety Team to improve learning from SIs. The pilot involves a different approach to developing recommendations within SI reports. The investigator will complete the investigation but then meet with local teams and managers to develop the actions to ensure that these are meaningful and can be embedded in a way that impacts on practice and culture to support patient outcomes.

Homeless Outreach Worker

WNCCG / NSFT and West Norfolk Borough Council are involved in a pilot two-year project to introduce a mental health outreach worker to support the homeless community in west Norfolk. This is to support this vulnerable group to access mainstream mental health services in a way that supports them to have better mental wellbeing, reduce mental health crisis and work closely with secondary, statutory and third sector services to build a support network for the homeless population in this area.

West Norfolk Crisis Hub Pilot

This has been running for one year in March. This is a joint pilot funded by WNCCG and NSFT – operated by West Norfolk MIND. It offers psycho-social support for people in crisis who may otherwise need to attend A & E or primary care services. The hub operates daytime, evenings and weekends and offers both community and buildings-based support. To date, the number of repeat admissions at A&E following referral to the hub has fallen. The feedback from service users attending the hub has been overwhelmingly positive.

Central Norfolk

Services for adults of working age

The Central inpatient wards remain committed to providing patient-centred care based on best practice. In order to have engaged and knowledgeable staff, we have adopted bespoke training programmes across the site and provide training that is specific to the needs of our staff and care delivery. Red2Green has been piloted across two wards in October 2018. This will further enhance clinical prioritisation and patient flow. The plan is to extend this pilot to the remaining wards.

The inpatient wards continue to develop a culture of least-restrictive practices which is evident with the reduction of incidents of rapid tranquilisation and seclusion.

Across the central inpatient wards we are actively working with Art Branches (a social enterprise). and are currently applying for funding to support a collection of paintings from professional artists and the community to sit alongside service users' work.

The implementation for the re-launch of Safewards with a view to embed this long-term is being pursued. The re-introduction of Star Wards is also being implemented; this project provides tools and ideas that have potential to improve patients' quality of time and treatment outcomes.

Daily Safety Huddles (brief and routine meetings for sharing information about potential or existing safety issues) across all four acute wards are now normal practice, and they are taking place with support from Matrons.

- **Green Walking Group** – Glaven Ward has been picked as part of this national project led by Centre for Sustainable Healthcare, in partnership with the Royal College of Psychiatrists. As well as giving patients the change to take part in physical activity and enjoy time away from the ward, it is hoped that traditional activities – such as photography or other arts or carrying out nature studies – will be incorporated into the walks to bring even more benefit
- **Healing Garden Project** – A group of volunteers have transformed the garden area and front entrance to Thurne Ward into a calming space designed to boost emotional, physical and mental wellbeing and help with recovery.

  The project has seen the area landscaped to make sure every bedroom can enjoy an attractive view, with new paths and seating areas created and extensive planting added to ensure the garden remains colourful all year round
- **QI projects** – Waveney Ward are starting to use care plans to carry forward community activities when patients are discharged from service. This initiative was included on an away day. It is also part of a national project which runs to 2020. The long-erm view is to roll this out to all wards
- **Glaven Ward** – Has introduced the shift coordinator role, supported by the development of a document which helps staff to co-ordinate the shift safely, enhancing communication / safety culture and service user engagement.

  Also, on Glaven Ward there is proactive staff ownership of Nicotine Replacement Therapy

  education to service users a couple of hours into admission and also staff education
- **Rollesby Ward** – Are currently having works within the unit to install a sensory room, which will help with de-escalating distressed service users, in a least-restrictive way. Also, all wards have now a Safety Pod (these pods are specially designed bean bags that allow physical restraint to be carried out in a safer way during challenging situations by providing an individualised response to head and neck support) which is being used frequently on Thurne Ward with positive results

Crisis Resolution and Home Treatment (CRHT) and Bed Management and Discharge Facilitation (BMDFT) Teams

- **CORE Fidelity Review** (a whole service audit that measures team performance against national best practice) – This was carried out on 22 February 2019 and has highlighted areas for quality improvement. The analysis of this is underway and will inform QI projects within CRHT and BMDFT teams

- **4-hour Emergency response** – This was addressed as part of a four-week sprint (focused project) in January 2019. CRHT now routinely offer a face-to-face assessment of referred service users and when this cannot take place within the timeframe a safety plan is formulated with the referrer, service user and carer. Assessment appointments are routinely offered at the Weavers base which has increased the team's capacity to respond to demand. Home assessments are still available where indicated
- **Gatekeeping** – Work has begun on improving the gatekeeping process. Currently the Key Performance Indicator is measured by a documented 'contact'. This does not measure the quality of the contact or if an alternative to admission has been considered / offered to service users. Any referrals for a bed request will now be preceded by a consideration for home treatment and accompanied by a specified purpose for the admission. This has started and will be audited weekly
- **New Team Model** – CRHT will revert to an integrated model of care: two locality teams will be formed (City and County). Each team will incorporate the assessment, gatekeeping, home treatment and in-reach functions; this will optimise consistency and smooth transition of the service user's journey through acute services. The estimated timescale for this is April / May 2019

Older People's Services

The wards remain committed to providing patient-centred care based on best practice. In order to have engaged and knowledgeable staff, we have developed a bespoke training programme across the site and provide training that is specific to the needs of our staff and care delivery. Red2Green has been piloted across two wards and there are plans in place for the remaining wards to pilot Red2Green at the beginning of March 2019. This will further enhance clinical prioritisation and patient flow.

Ongoing for a year, the wards at Hammerton Court remain committed to Dementia Care Mapping, reflecting and evaluating on the positive impacts that mapping has had in providing care specific to each individual. Sandringham ward continues to develop the cultural ethos of SafeWards and a lot of work has been done on developing and sharing life stories. This has had a positive impact on patient outcomes, as well as increased involvement from families.

The wards continue to develop a culture of least restrictive practice and this is evident in the reduction of restraint, and the very limited use of rapid tranquilisation and / or seclusion during the past year. While recognising the challenges of the holistic complexities for service users admitted to the Julian Hospital wards, pressure ulcers are at an all-time low and remain far below the national average. This has been achieved through continued staff ownership, continued on-site education, reflection within practice and sharing learning.

The wards at the Julian hospital have been using the Collaborative Learning in Practice (CLiP) model with significant success and were the first clinical area in a UK Mental Health Trust to use the model. This has had a significant impact on clinical learning and outcomes across the wards. The story of CLiP from the perspective of an in-patient setting will be presented at a national conference in May 2019.

The locality is using a QI approach aiming to increase the North Older People's Team's visibility and profile among the local population and partner organisations.

Anticipated achievements will include:

- Having clear information about our service in a number of formats (electronic, paper, media, social media etc)
- A programme of face-to-face meetings with partners (initially GP practices) where we promote our service
- Ensuring we are part of local health initiatives and events and have suitable materials to promote our service

We are re-launching our team and base this year with physical improvements to the building and infrastructure. The aim will be to do this in a media event, in the summer.

Great Yarmouth and Waveney

Improving responsiveness of services:

- **An innovative new Occupational Therapy-informed day service** – Following a full consultation process St Catherine's Way in Gorleston, formerly an inpatient rehabilitation unit, has undergone an exciting redevelopment journey. It provides therapeutic day services for service users with complex needs accessing care from

Great Yarmouth Adult Community Team. The service has the capacity to provide Occupational Therapy-informed interventions seven days a week, 8am to 8pm

- **A new Recovery Information Centre (RIC) Pathway** – Following the successful implementation of this innovative care pathway in Waveney Adult Community Service, the RIC pathway has been rolled out in the Great Yarmouth community team. This fast-track service aims to allocate and action the needs of those service users with lower/ managed safety needs but having needs requiring secondary services. The RIC works in partnership with a number of 3rd sectors agencies and social care to provide a range of support
- **Changes to our model of care for older people's services** – Over recent months we have developed and informally piloted a model which will meet the local need for dementia care. We envisage that this new way of working will: reduce admissions and length of stay; improve service user and carer experience by working closely with other agencies and providers; enable, support and sustain placements and support carers and family members to cope and access the services they need. The model includes an inpatient unit, complimented by an outreach and in-reach team who will work closely with carers and care homes and deliver enhanced therapy provision
- **Learning and improving together: lived and learned experience** – Improving participation is a key priority. The locality recognises the importance of increasing participation of people who use our services in service development and quality improvement. As a locality we have invested in this aim and are delighted to report we have appointed a temporary Great Yarmouth & Waveney Peer Participation Lead. During their six-month secondment they will focus on widening service user engagement in the Localities Forums and Hub as well as developing partnerships with other forums and third sector colleagues.
- **Our Recovery College goes from strength to strength** – As a locality we are very proud of our Recovery College. The team is both passionate and innovative in its work. Following service user feedback, the local team are co-reviewing / re-developing the course, which is planned for roll-out later this year.
- **The Quality Improvement Team is trained** – The locality has invested in the development of a Quality Improvement Team, who recently have completed the East London NHS Foundation Trust Quality Improvement Leaders' Programme. The team are already putting this learning into action and are undertaking two formal QI projects to improve the quality of complaints and access to assessment in Adult Community services. The team will support all stakeholders to develop the skills and experience in using QI methodology in improving service user experience.

East Suffolk

In east Suffolk there have been a number of quality initiatives. Our community services teams in Coastal Integrated Delivery Team have led on a formulation project and use of dialog+ in order to enhance approaches taken by staff in engaging collaboratively with service users to understand their story and how this provides context to the needs that mental health services can support.

Central IDT have focussed on engagement which has included developing a welcome pack for new service users, working alongside Suffolk User Forum to understand concerns and issues which service users and carers wish to raise and facilitating engagement events to ensure that service developments are undertaken in a way that is informed by the experiences and ideas of service users, carers and staff.

Across the locality there has been introduction of an Early Intervention in Psychosis Team, the Neurodevelopmental Pathway Team has become centrally located and the Suffolk-wide Physical health team has been formed. These teams provide a focused approach to working with individuals with specific needs.

In acute services the crisis response team has been created to enhance the overall ways in which service users requiring assessment and support at points of crisis can access this. The Psychiatric Intensive Care Unit has reopened and is part of a national Quality Improvement programme which focuses on reducing the use of restrictive interventions. Early results are indicative of enthusiasm and success in adopting different practices.

Inpatient areas has collaborated with the Hospital Rooms charity which has brought museum quality art into areas to improve the therapeutic environment.

The Psychiatric Liaison Team has expanded their service and now work with the wards in addition to A&E and the emergency areas. They have introduced an Advanced Nurse Practitioner post to enhance the team and have formalised a partnership with the Samaritans following a very successful pilot project.

West Suffolk

This year a new Matron was appointed for the wards at Wedgwood Unit and a new service manager for our Crisis and Home Treatment Teams which have enabled more visible leadership. We have introduced another Clinical Team Leader in Psychiatric Liaison services which means there has been an uplift in band 7 senior staff. Psychiatric liaison services have recruited two new registered nurses which now means we are able to support individuals through psychiatric liaison services daily until 21:30.

Wedgwood Unit are working on their plan which has included the senior leadership team meeting with 83 members of staff in collaboration with service users to think about what 'World Class' looks like and how this will be achieved. The plan will then be put up on display in the reception area to ensure everybody is aware of the intentions.

Matron surgeries have now been introduced to ensure that carers and service users have access to senior staff as and when they need.

Specialist Services

Tier 4 Child and Adolescent Mental Health Services (CAMHS)

- Dragonfly Unit, Carlton Court
  – The Dragonfly Unit was rated as Outstanding in the 2018 CQC inspection.

  The unit now has a full nursing establishment and all 12 beds have been opened.

  In 2018/19 Dragonfly Unit was part of the CYP-IAPT training pilot with the Anna Freud centre in London along with three other units from London and Cambridge. This enabled the team to access national and local training and all the staff are to have accredited training in Dialectical Behaviour Therapy skills.
- Kingfisher Mother and Baby Unit, Hellesdon Hospital
  – The Trust was awarded £3 million to develop the Mother and Baby Unit for the region which is one of four in the country commissioned by NHS England as part of its investment into improving access to specialist treatment for new mothers in regional areas with the most limited inpatient services. It takes referrals from across Norfolk, Suffolk and Cambridgeshire, as well as other parts of the country.

  The new eight-bedded Mother & Baby Unit (MBU) officially opened its doors in January 2019 and is a specialist inpatient unit for new mothers with serious mental health problems which will ensure mothers and their babies can stay together while the mother receives care for conditions such as severe postnatal depression, serious anxiety disorders and postpartum psychosis. It will accept women in late pregnancy (who require acute psychiatric inpatient care) and until the baby is one year old.

  The Trust recruited more than 30 mental health nurses, assistant practitioners, therapists, support workers, nursery nurses, Speciality Doctor and Consultant Psychiatrist to work in the service. The team complements the Trust's new Community Perinatal Teams in Norfolk and Suffolk, which provide specialist care within the community as well as perinatal teams in Cambridgeshire and Peterborough. The Unit will be working in partnership with health professionals across mental health, midwifery, health visitors and beyond. It provides a range of therapeutic services.

  The team has completed a range of specialist training to make sure they can provide high quality, evidence-based care to new mums and their babies. Staff have also visited other MBUs across the country so that they can learn from others and bring back best practice to benefit patients here in East Anglia. Trained peer support workers – people who have personal experience of perinatal mental ill health – will also offer support and practical help to patients.

  The MBU will accept referrals from existing specialist perinatal teams, health visitors, midwives and GPs from across Norfolk, Suffolk and Cambridgeshire, as well as other parts of the country.

Secure Services

- Our Liaison and Diversion Service (LaDS) was named as a finalist in the Howard League Community Awards. LaDS helps to identify and reduce the factors that contribute to offending behaviour, such as debt, mental ill health, accommodation problems, substance

misuse and learning disability, and supports the police and courts to deliver sentences that promote recovery from a life of crime.

The LaDS Team has a good working relationship with the mental health trained control room staff in Norfolk and Street Triage staff in Suffolk (employed by NSFT) who work closely with police to help identify anyone with mental health difficulties who come into contact with the criminal justice system. We work with subcontracted partners Julian Support and Project Nova who deliver recovery-focused support to people in the community, courts and Police Investigation Centres.

LaDS services for children and younger persons (CYPs) are provided in conjunction with the Youth Offender Teams (YOT) and services (YOS) in Norfolk and Suffolk. We work closely with YOS, gathering information prior to assessment and informing them of outcomes.

The service achieves above national average in rates of engagement with detainees, female / youth / young adult screening rates, identify risks of abuse, accommodation problems, financial need, suicide and self-harm risks.

- The Psychologically-Informed Planned Environment (PIPE) Service at HMP Wayland was commended in the NHS Collaboration Award of the Health Business Awards. The success of this service has been acknowledged by its commissioners and the service has been asked to extend and develop its service for the 2019/20 contract. We have been asked to recruit to an Enhanced Support Service (ESS).The purpose of ESS is to target the small minority of prisoners in the establishment who demonstrate severe and persistent violent and disruptive behaviour that has not responded to existing management strategies and interventions. Staff will work intensively with offenders in a collaborative manner to develop motivation and positive coping skills in order to reduce negative behaviours. The team will work in a psychologically informed manner and be supported by formulation based on understanding of the prisoners with whom they are working. The team will work directly with HMPS and prison healthcare staff, as well as the existing pathway services to increase understanding and appropriate management of these prisoners.
- Secure Services has successfully bid to retain its L&D Service and the IAPT Wellbeing service which operates in HMPs Bure, Wayland and Norwich but in addition from 1 April we will also be providing the Mental Health provision in HMP Norwich. This will enhance the pathway for offenders, enabling people to be supported who need our service from police custody through prison and back into the community again, offering secure hospital care for those who require it.

National / Regional awards

- GreenLight Team: See page 101

Commissioner and stakeholder comments

At the beginning of April 2019, a lead contact for each of these groups and organisations was sent a draft copy of this Quality Account for review in order to respond with statements commenting on the accuracy, interpretation and representativeness of the content. There is a 30-day window permitted from receiving the first draft to receipt of statements. The first draft circulated does not contain end of year data as it is not available at this point. A second draft was distributed later in the month including data.

Trust Governors

We welcome the opportunity to add our observations on the Trust's Quality Account which sets out a review of work done in 2018/19 and

that planned for 2019/20 to improve the quality of Trust services.

The latest report comes at a time of continued challenge within the Trust in terms of its various responses to the latest and previous Care Quality Commission (CQC) inspections and reports which found the Trust's overall performance 'inadequate' with the result that it finds itself requiring 'Special Measures'. We are very reassured that the CQC found the staff as caring in their inspections. We are very conscious of the enormous efforts being made by all staff to address the fundamental issues raised in these reports and are eager to make our contribution towards its improvement. It will be vital that the Trust maintains a focus on quality improvement during the current period of organisational change. Our comments on the Quality Account are focused on a range of important issues that concern the overall strategy for improvement, the priorities and some more detailed observations on particular areas for action.

We applaud the overall recognition within the Report that the Trust must both focus in the short term on dealing with a range of important safety issues and at the same time move the culture and organisational framework for improvement onto a new footing; one where staff, service users and carers are the focus for identifying and dealing effectively with quality of service issues. We believe the new Care Group structure will help with this.

Service users and their carers are rightly highlighted as needing to be at the centre of this work as their needs and experiences should drive action. We comment further on this below, when looking at the priorities for improvement in the coming year.

We have been encouraged by what we have learnt about the 'Quality Improvement' approach now being adopted by the Trust. The Trust's current approach to quality rightly appears to be wide-ranging, and to an extent complex. It is also in the process of moving from a system that was centrally driven to one that engages and empowers local staff, service users and carers. Information flows and decision-making arrangements will need to be adjusted and we hope that a simplified organisation for quality improvement will result.

The Report, especially in respect of its proposals for future action, needs to place as much emphasis on securing quality in community as well as inpatient services.

Greater emphasis needs to be placed on distinguishing between areas where there is a good understanding of the factors that influence quality of care (so targets for improvement are realistic) and those where further investigation is required to provide the knowledge base that is needed to act effectively. Use of Action Research in some of these areas may be an effective way forward where there is a need for urgency.

With the increasing moves towards integrating care (especially in community settings), driven by the Sustainability and Transformation Partnerships (STP) and Integrated Care Systems (ICS), it is important that the Trust engages partner organisations and bodies in its approach to quality improvement, with joint service user and carer involvement helping to record and analyse service experiences across complete care pathways.

Quality Priorities 2018/19

The Report indicates a mixed set of results for the four priorities chosen for particular action in the last year. We are pleased to see significant progress in the increased use of physiological observations made after episodes of rapid tranquilisation and are also encouraged with the progress made on use of restrictive practices and the review of crisis teams. The initial data presented in the Quality Account looks very promising and we look forward to seeing these advances continuing.

There has also been progress in the training and involvement of service users and carers in staff interviews, but further action is needed here. As we comment below, the Trust's expanded emphasis on service user and carer involvement, while strongly supported, would benefit from a more coherent and wide-ranging approach, and one which emphasises giving service users and carers the skills and confidence that they might need as well as staff the skills and time to properly engage in 'Co-production'.

The work on reducing readmission rates appears to require further time and possibly research to establish effective practices, and this is clearly an area where engaging with other partner organisations and practitioners is of central importance.

It is disappointing to see little if any clear improvement in the rates of Core Assessment, Risk Assessment and Care Plan completion. Work is in hand on these areas, and we would emphasise that this must include the quality of the processes and feature co-production wherever possible.

We are concerned at the number and duration of 'out of area placements' by the Trust because of a lack of capacity in local services and appreciate the efforts with commissioners to address this important issue. Likewise, the capacity of services to cope with demand is an ongoing issue, and one which requires a 'whole system' approach. Staff recruitment and retention remains critical to these issues and we support the efforts of the Trust to adopt a range of methods to reduce staff vacancies and support staff once in post.

Quality Priorities 2019/20

We welcome the clear allocation of an Executive Director lead responsibility for each of the priorities listed and would suggest that a Non-executive Director also be allocated, so that we as Governors have a clear point of contact to hold the Board to account for performance on these priorities.

With regard to Patient Experience/Stakeholder engagement we strongly support the Trust's strengthened approach to service user and carer involvement. However, as noted above, the emerging approach would benefit from having a clearer strategic shape and coherence. This should include a broadening out of the methods of gathering service experiences from a reliance on forums, meetings and events to include systematic research and analysis of findings and the effective use of qualitative (e.g. service user and carer stories) as well as quantitative information. We welcome the acknowledgement of Governors' role in contributing feedback on service experiences and look forward to developing this during the year. As already noted above, we strongly support moves towards developing effective co-production wherever possible. We also suggest that opportunities for more integrated service experience research and stakeholder engagement should be sought with Commissioners, Healthwatch, STP etc.

The proposed attention to improving access to services is welcomed, and as is noted this should both seek to address underlying issues of service capacity and balance (e.g. having adequate preventative and low-level support available so as to reduce the chance of deterioration and the need for more intensive help), as well as finding and implementing ways of supporting those waiting for a clinical intervention. This topic is obviously one where close joint working with other health care providers, commissioners etc. is of vital importance.

We have already commented above on the work underway on improving Care Planning. Involvement as equal partners by service users is of primary importance, but we recognise that this is not always possible. We suggest that efforts are also required to ensure that carers are involved in this process.

The Trust has invested significant sums in removing ligature and other risks from inpatient and community service bases, in order to provide safe environments. We support the move towards a more consistent and thorough approach to assessing risk but feel that this approach needs to incorporate an assessment of benefit as well as risk. The quality of our environment and its potential to aid recovery must be taken into consideration along with the risks that this might impose. This approach should include consideration of potential ways of managing isks beyond physical changes, where a benefit from a physical feature is evident and it should, if possible, be retained.

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 CCGs (Norwich, North Norfolk, South Norfolk, West Norfolk and Great Yarmouth & Waveney), supports the Trust in its publication of the 2018/19 Quality Account.

Having reviewed the mandatory detail of the report, the CCGs are satisfied that the Quality Account incorporates the mandated elements that are required. The CCG would however recommend that the 'pledges' made in relation to Patient Safety are reviewed and consideration given to the safety of those patients who are placed Out of Area, not least as these are increasing in number as there is limited assurance currently provided to the CCGs regarding the efficacy of these placements and the Trust has limited capacity to undertake the care reviews required.

The CCG recognises that NSFT has undertaken to develop and deliver a significant number of quality improvement initiatives. The CCG notes that the Trust intends to monitor individual improvement plans through their own Mobilisation Groups and welcomes the empowering approach taken to encourage localities to make operational and clinical decisions. The CCG would however like assurance that there will be strategic oversight at Board level to ensure that there is parity of provision across all localities within the STP.

The CCGs recognise the challenges experienced by the Trust having been placed back into special measures in 2018/19 and the impact that this has had on the organisation as a whole, not least on its frontline staff. The CCG welcomes the work being undertaken, and progress being made, in addressing the challenge of improving the organisation's culture. We support the Trust in its observation that this is a complex area to address and that any identified improvements required will take time to be implemented and embedded.

The Trust has continued 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 also offered additional support and will continue to do so to enable the delivery of a fully assured clinical harm review process. The CCG recognises the level of ambition displayed by the new Executive Team in addressing patient safety and that there is further work to do and as such we will

continue to support quality assurance and quality improvement at the Trust through an agreed schedule of planned visits and via the Clinical Quality Review Group meetings (CQRG).

Quality Priorities 2018/19

Patient Safety:

To ensure that at least 95.0% of a sample of patients will have had their physiological observations taken post rapid tranquilisation complying with National Institute for Health and Care Excellence (NICE) guidance.

The CCG recognises the significant improvement made against this priority and while the Trust has not achieved the 95.0% target the CCG is assured that the Trust will do so during Quarter One 2019/20 as the trajectory continues to be on an upward trend.

Patient Experience

To increase the percentage of interview panels involving service users or carers by at least 20.0% this year, and subsequent years, until the target of 90.0% is achieved for all posts that involve contact with service users.

The Trust has not achieved this ambition during 2018/19 and as such the CCG recommends that this continues to be a priority area for NSFT.

Clinical Effectiveness

To achieve a 10.0% reduction in service users requiring readmission for clinical reasons within 28 days.

The Trust has reported that the impact from the various work streams put in place to deliver this priority have not been fully realised and there have been 176 readmissions for 2018/19, which equates to 7.4%. This is 0.2% above the target but 0.6% below the baseline.

The CCGs recognise that some progress has been made but that further improvement is required. The CCGs recommend that this remains a Quality Priority for 2019/20.

Continued monitoring to demonstrate 95.0% compliance with core assessments, risk assessments and care plans as identified in 2017/18 priorities and where the target was not met during that year.

SNCCG notes the progress made as below:
Core assessments in place: 85.3% (85.7%)
Risk assessments in place: 91.4% (91.8%)
Care plans in place: 89.3% (91.0%)

And welcomes the fact that this remains a priority for the Trust.

Quality Priorities 2019/20

The CCGs are in support of the key quality priorities for 2019/20 and the alignment with the ongoing delivery of the CQC's 'must-do's'.

SNCCG notes that the priorities are defined 'pledges' and that there are no quantitative measures defined. NSFT should ensure that there are SMART action plans put in place with a combination of qualitative and quantitative measures so that success can be demonstrated objectively.

The CCGs will continue to work with the Trust to monitor and review progress on the areas identified and have made the following recommendations:

Patient Experience

Your pledge:
We will ensure that we seek and act on feedback from patients and carers for the purposes of continually evaluating and improving services.

The CCGs agree that this Quality Priority is essential for the ongoing improvement of services and outcomes for patients. The CCG asks that the Trust confirm how it will objectively demonstrate that this pledge has been delivered.

Clinical Effectiveness

1. Improving access to services

Your pledge:
We will review the systems for assessing and monitoring risks for patients on waiting lists for triage, assessment and treatment and provide a consistent approach to this across Norfolk and Suffolk. We will ensure there is a robust process in place to demonstrate that we are monitoring and supporting the safety of people waiting.

We will ensure that all teams comply with the four-hour emergency assessment target for referral to assessment. 100% of crisis referrals will be seen face-to-face within four hours, unless downgraded for a clinically valid reason.

The CCGs fully support this Quality Priority and the ambition to ensure that 100% of crisis referral with be seen face to face within four hours, unless downgraded for a clinically valid reason. The CCGs note that some service lines are performing worse than others, for example, Children, Families and Young People and Eating Disorders. The Trust should consider how it will

demonstrate success across individual service lines, including those service users who are at the highest risk of harm.

2. Improving care planning

Your pledge:
We will ensure that staff involve service users in care planning and their individual needs are recorded appropriately.

We will ensure that all service users' risks are assessed and managed. We will support people to become involved as much as they want or are able to in decisions about their care. Risk assessments and care plans will be in place and updated consistently in line with changes to patient needs and risks.

Care planning, risk assessments and management plans have been identified as a cause for concern within CQC reports. The CCGs note that the Trust has not consistently met the Care Programme Approach (CPA) and non CPA performance standard and audits of completed documentation has flagged poor co-production and quality of assessment and planning. The rate of recovery of these actions against the target have remained below trajectory. As such the CCGs welcome this continued quality priority. The Trust is asked to confirm how it will objectively demonstrate success and delivery of this key priority.

3. Patient Safety

Your pledge:
We will ensure all environmental risks are identified, plans put into place to reduce risks and regular reviews are carried out

We will ensure that all services have detailed ligature risk audits in place and that any key risks for patient safety are known and lessened, wherever assessed as needed.

While the safety of patients and the environment that they are cared for in is fundamental to everything the Trust does the CCGs expect this to be core business as a provider of mental health services. The CCGs recommend that this pledge is reviewed and consideration given to the safety of those patients who are placed Out of Area (OoA). These patients are increasing in numbers and there is limited provision by NSFT for assurance of the efficacy of these placements. As a Trust you have also identified that length of stay in OoA is increasing but there is limited capacity within the current NSFT team to monitor these placements and undertake the care reviews required.

The Trust continues to demonstrate high levels of reporting for serious incidents and is open and transparent on all matters of patient safety. The CCGs have welcomed the review of the organisation's internal serious incident reporting processes and notes the new approach to engaging with service users and their families / carers in this process.

NSFT has continued to make progress against the delivery of the CQC Action Plan however it is acknowledged by all stakeholders that there areas that require further improvement. The ongoing work into key areas identified by the CQC are reflected in the pledges noted above.

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 to improve services. Whilst outcomes from some of these measures for example FFT response rates, continue to show signs of improvement there is further work to be done. The CCGs' recognise that the Trust continues to explore different ways of improving feedback from, and engagement with, service users.

The CCGs continue to support the Trust in reducing the number of Out of Area placements with new commissioning strategies, however, the number of admissions to non-NSFT beds continues to cause concern. NSFT should ensure that Quality Assurance processes are in place to ensure that these providers are safe and that patients are receiving high quality care. The CCGs will continue to monitor this and work with NSFT to ensure that patient safety, effectiveness and experience is not compromised.

The CCGs will continue to provide support to ensure that all waiting lists are being triaged effectively and that no patient is experiencing harm whilst waiting for assessment or treatment. This will be achieved and supported by a local CQUIN during 2019/20 to enable the implementation of the new Clinical Harm Review process developed in partnership with SNCCG.

Finally, the CCGs recognise that while the recent staff survey was undertaken at the time when the Trust returned to special measures, there are areas of concern. NSFT has previously worked hard to improve staff satisfaction through a robust Workforce and Organisational Development Strategy, however, it is clear there is more to do and the CCGs welcome the progress being made in respect of this.

SNCCG looks forward to continuing to work in a positive and collaborative manner with the Trust to ensure improvements in patient care are delivered during the coming year.

Ipswich and East Suffolk Clinical Commission Group

Ipswich and East Suffolk Clinical Commissioning Group and West Suffolk Clinical Commissioning Group, as the commissioning organisations for Norfolk and Suffolk NHS Foundation Trust, confirm that the Trust has consulted and invited comment regarding the Quality Account for 2018/2019. This has occurred within the agreed timeframe and the CCGs are satisfied that the Quality Account incorporates all the mandated elements required.

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

Ipswich and East Suffolk Clinical Commissioning Group and West Suffolk Clinical Commissioning Group are currently working with clinicians and managers from the Trust and with local service users to 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 Groups endorse the publication of this account.

Norfolk Health Overview and Scrutiny Committee

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 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 2018/19. 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

Healthwatch Suffolk response to the Norfolk and Suffolk NHS Foundation Trust Quality Account 2018/2019.

Healthwatch Suffolk (HWS) thank the Trust for the opportunity to comment on the Quality Accounts for 2018/19, and we welcome the detailed and comprehensivereport this year.

Overall, we welcome the emphasis on co-production and the commitment to improved communication with service users, family carers and stakeholders in order to improve the effectiveness of care. We are pleased that the management structure is to be flattened and clinically led. We look forward to working with the locality leads in Suffolk and, in particular, to having continuity of engagement with our Mental Health and Emotional Wellbeing Focus Group, which provides a unique forum.

We are in support of the priorities identified, especially the improvements to coproduced care planning and accessing services (especially for those in crisis, children, young people and their families, and IAPT services). We hear from service users and their carers of the great distress and harm that can follow when services are not responsive and timely.

We are hugely supportive of the quality reviews being undertaken in Suffolk under the auspices of the CCGs together with stakeholder input. We believe this creates opportunities to identify good practice, highlight areas where improvements need to be implemented, and for the commissioners and the Trust to work together to improve services for the people of Suffolk.

2018/19 priorities

Restrictive Interventions
It is good to see the Trust working closely with the National Centre for Collaboration Mental Health's safety improvement programme, which the Trust links to. We also welcome the reduction in restrictive interventions. However, from the information supplied we are unable to assess how close the Trust is to its target of 95.0% of patients having the requisite physiological observations.

Patient experience
The Trust's intention to ensure service users and carers are included in staff shortlisting and interviews is widely supported. Given the level of recruitment, we are concerned that it will be difficult for the Trust to meet its target with a rolling programme of four training sessions per year, given that in the last year, six courses led to 52 service users or carers being equipped to take part in staff selection.

It should also be noted that Friends and Family is a simple and quick way to establish at least some sense of a service user's experience. We're disappointed to see that seemingly 47 teams across the Trust had zero FFT responses.
We look forward to the Trust being able to provide evidence of how many interview panels incorporate service users or carers.

2019/20 priorities

Stakeholder engagement and service user feedback
HWS looks forward to being actively engaged in considerations about improvements to the inclusion and participation arrangements in Suffolk. We appreciate the timeliness of reviewing the current locality hubs.
HWS is keen to develop good working relationships with the Suffolk locality leads about to be appointed.

Clinical effectiveness / improving access
The Trust's pledge to improve access is singularly important. One of the most consistent concerns we hear expressed is to do with accessing services, particularly for those in crisis, children, young people and their families, and IAPT 1:1 counselling.

It is particularly important that the Trust has now committed to 100% of crisis referrals being seen face-to-face within four hours unless clinically downgraded, and that such clinical downgrades will be both carefully communicated to the individual and rigorously monitored.

We have some concern that it may prove challenging for the Trust to recruit sufficient suitably-experienced staff to meet this demand and the forthcoming nationally-required improvements to 24/7 access to crisis services.

Care Planning
All of the initiatives to improve the experience and effectiveness of care, especially improving the quality and inclusiveness of care plans, is rightly a top priority.

We encourage the Trust to pursue all these initiatives to ensure person-centred care planning, including with carers, becomes embedded.

Discharge from inpatient services
The detailed consideration of effective, well-planned and well-communicated discharges is so crucial in patient-safety terms. Recent press reports in Suffolk of coroner's court proceedings have generated concern that pressures on staff may lead to discharges being less than well-planned and communicated on occasions.

Service user feedback
It is encouraging to see improvements in the feedback regarding community services.

We appreciate the Trust highlighting the predicament some service users face if their needs are deemed too complex for Wellbeing and yet not complex enough for secondary services, and we look forward to the Trust finding ways to ensure this gap is closed.

We applaud the West Suffolk initiative to hold Matron Surgeries to create open access for service users and family carers to senior staff leaders.

Staff engagement
We were most interested to hear about the work of the Culture Working Group at a recent NSFT Board meeting. We trust this work will lead to a much-needed improvement in the experience of staff, with particular regard to the high rates of bullying staff currently report.

Healthwatch Norfolk

Healthwatch Norfolk (HWN) welcomes the opportunity to review the draft Norfolk and Suffolk Foundation Trust (NSFT) Quality Account for 2019-20 and to comment on the quality of the services commissioned locally to meet the needs of residents in the Norfolk and Suffolk area.

At the time of our review the year end data was not available and hence this is reflected in our review. The data was subsequently provided to us but there was insufficient time for this to be included in our comments.

We note that the last CQC inspection report, dated 28th November 2018, rated the Trust as overall inadequate. Whilst we appreciate there are areas of concern, we are encouraged to note that also identified were areas of outstanding practice identified, together with the rating of caring as good. We are aware of the Trust's commitment to delivering high quality care and to focus on continuous improvement and acknowledge the work that is currently taking place to make the required positive changes.

At this time of significant drive for improvement, unprecedented change to both the national and local healthcare provision underpinned by the NHS Long term plan – all against a backdrop of significant financial constraints, the need for a strong underpinning quality governance strategy and structure has never been greater.

2.1 Our new delivery strategy: The QA explains in broad terms NSFT's Improvement strategy. HWN welcomes NSFT's acknowledgement the need for a strong governance and a 'flatter' clinical leadership structure.

It would be very helpful to include an organochart at this point, detailing lines of management and governance accountability and delegation. This would provide greater clarity on the roles, responsibilities, reporting and communication flows up and down the organisation and provide greater assurance on the Trust's open communication pathways and shared decision making and learning opportunities.

It would also be helpful to understand how the Trust's Quality Programme Board fits in to the organisation's overall Board, Executive and Senior management reporting structure, again to assure of the opportunities for trust-wide sharing information and learning.

We note that the Trust has developed a single Trust-wide plan to deliver the Improvement strategy and trust that it will outline the direction and plan to allow NSFT to achieve a CQC 'good' and 'outstanding' where possible over the next 5 years. This plan has been aligned to 14 overarching themes across 7 enabling work streams.

Although further in the document, reference is made to the CQC's most recent report, at this juncture, there is no direct reference to any matrices between these themes/workstreams and the findings of the last inspection nor the findings of the recently published Norfolk and Waveney Mental Health Strategy (NWMHS) 2019. HWN would like to understand more about how these two fundamentally important documents have informed these themes and work streams. This would provide clarity on how the requirements that address the deficit in the CQC standards are directly linked to the Trust's quality improvement strategy and plan.

Referencing from NWMHS is of special interest to HWN containing as it does, direct input from service users and the public.

Due to its huge importance and fundamental correlation to all other improvement processes, we also suggest that 2.9 be added to 2.1 rather than detailed separately as it currently is, later in the report.

HWN would also like to see more information about the service user's/patient's role in developing the quality improvement methodology and in particular, how patients can become involved in the development and implementation of ongoing service improvements. In addition, we would like to see an explanation of how the priorities identified through the recent listening exercises are going to directly influence the quality improvement plan and programme.

2.2 Looking back at our quality priorities in 2018/19: We note that the 3 quality priorities for 2018/19 were:

- Patient safety
- Patient experience
- Clinical effectiveness

Due to much of the text requiring update on current draft, it has been difficult to provide a contemporaneous critique of the report. Based on the information available however, there has been some positive change across the 3 areas of practice detailed.

As per last year's QA, the format used in this section is 'where we were' and 'where we are now'. As we commented last year (and in 2017), it is not always clear where was the starting point of the service evaluation and whilst there is much detail of the processes that have been put in place, the actual outcomes (quantitative and qualitative) are not evident.

It would be extremely helpful if the whole section were simplified into an appraised assurance

framework wherein a set of measurable key performance indicators were identified against each priority. In turn, progression against the KPIs could be detailed in a further column, with the fourth detailing next steps towards full compliance and a final column for shared learning outcomes?

This would render the whole section far more meaningful – and easier to understand!
It would appear there still remains some improvement with regards core assessments and it is disappointing to see the limited progress made in regards inpatient discharges. It is however encouraging to see there are plans in place to continue with the improvements towards achievement target – though the timeline on this appears woolly.

2.3 Looking forward to our quality priorities in 2019/20: HWN notes that NSFT has agreed a number of priorities that support the Improvement Plan in response to the CQC inspection of 2018. It would be helpful to understand if the recently published Norfolk and Waveney Mental Health Strategy has also been referenced.

Patient Experience/Stakeholder engagement: Is it NSFT's intention to directly involve service users and carers in the update of their Involvement and Participation strategy? We would welcome meaningful and ongoing involvement and would also welcome greater understanding and input into the development of the new role of 'People participation Lead' and 'Service User Experience Leads'.

Patient safety/Safe environments: HWN notes the future focus on the assessment and evaluation of risks and also notes the CQC's concerns raised relating to lack of mitigation of identified risks. It would be helpful to have greater understanding of how risks are managed and controlled at executive/senior management level together with lines of accountability. Can the Trust also confirm that Health and Safety Leads are also now in place as this is an obligatory requirement?

2.4 Participation in Clinical Audits: HWN is unable to comment on this section as it awaits update.

2.6 Service User feedback: Whilst reference is made to past forums that have taken place, there are no clear plans cited in terms of improved participation. HWN would welcome participation in the strategic planning of user forums and involvement. The QA makes no mention of the recent engagement work undertaken in support of the development of the 2019 Mental Health Strategy.

This feedback has proved vitally important in terms of the development of the strategy and as such, HWN is surprised that no reference has been made to building on this intelligence.

It is also very disappointing to learn that membership of the service user and carers hubs have declined over the last year. The QA references the implementation of a new clinically led management structure by June 2019, to include a Service user experience lead. HWN would be interested to know if this post is now appointed (it would also be helpful to have sight of the job description) – and how links will be made with HWN to enable increased service user involvement at the earliest opportunity.

Friends and Family Test: The QA reports that 92.0% of returns expressed satisfaction with the service. This seems to be at odds with the findings of the recent Mental Health review engagement events where 95.0% of respondents felt that services fail to meet the needs of the mentally ill.

Complaints: The descriptor in this section is extremely lengthy. Again, it would be helpful for this information to be tabulated to permit easier review. HWN also notes that no mention is made of the CQC's concerns regarding the length of time the Trust takes to initially respond to a complainant. The QA makes no mention of how trends are evaluated and reported; nor does it mention any changes in practice based upon complaints/trending evaluations or how shared learning in this regard takes place.

2.7 Staff Feedback: NSFT states there is a link between staff engagement and service user experience. HWN would go further and state that the absolute key to the provision of high-quality services is the staff. As such, the Trust's performance for staff engagement must be a top priority. Without doubt the staff will feel both demoralised with the CQC findings and also under extreme pressure to raise standards. HWN feels that special focus should therefore also be placed on their wellbeing ongoing. This has not been mentioned as a future priority.

It would be helpful to understand more the purpose and terms of reference/reporting lines of the Culture Steering Group.

2.11 Reporting against core indicators: Due to the incompleteness of the draft, HWN is unable to comment on NSFT's performance against national and local KPIs.

Presentation of the Quality Account:

- The draft for comment did not include Part 1. HWN assumes that this will include:
  - a signed statement/executive summary from the CEO detailing progress to date and future priorities
  - Index
  - Service overview
  - Independent assurance engagement results
  - Details of how to obtain the document in large print, Braille or another language
- There are large amounts of data missing or yet to be provided, rendering the document almost impossible to assess quantitatively.
- A move to more tabulated formats/ organocharts would assist greatly in easier reading and understanding
- There are no appendices. Where some descriptors are extremely lengthy, HWN suggests they be pulled out of the main piece and referenced as appendices to enable easier reading flow

Conclusion

It would appear that following the last 2 CQC inspections, there has been a great deal of work begun in many areas of governance and quality, not least the change to a clinically led management model. HWN commends the Trust on its development of a Trust wide Improvement strategy, though remain unclear and indeed concerned how the multiple steering/working groups identified throughout the QA will all feed into the Trust wide plan and work together/share learning to enable the necessary rise in quality standards. We are also unconvinced that the priorities for improvement as set out in this draft QA are significantly comprehensive, challenging and robust to drive the required improvement. The presentation and layout of the document also makes it unclear how improvement has been measured in the past and how it will be continuously evaluated against KPIs in the future.

Overall, HWN welcomes the Trust's quality improvement measures. We look forward to continuing to work with NSFT in ensuring that the views of patients, their families and carers are central to the Trust's Quality agenda and improvement work and to make recommendations for change as and when appropriate.

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

Key

BoD	Board of Directors
CAMHS	Child and Adolescent Mental Health Service
CCGs	Clinical Commissioning Groups
CLiP	Collaborative Learning in Practice
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
EBCD	Experience Based Co-Design
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
IMHA	Independent Mental Health Advocate
IPAC	Infection Prevention and Control
LD	Learning Disability
LeDeR	Learning Disability Mortality Review Programme
MHA	Mental Health Act
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
NSFT	Norfolk and Suffolk NHS Foundation Trust
PALS	Patient Advice and Liaison Service
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
QIP	Quality Improvement Plan
RCA	Root Cause Analysis
SAR	Safeguarding Adult Review
SCR	Serious Case Review
SI	Serious Incident
SMI	Severe Mental Illness
SPoA	Single Point of Access
STP	Sustainability and Transformation Plan
TPM	Trust Partnership Meeting

NHS
Norfolk and Suffolk
NHS Foundation Trust

Annual accounts

for the year ended
31 March 2019

Statement of the Chief Executive's responsibilities

as the accounting officer of Norfolk and Suffolk NHS Foundation Trust

The National Health Service 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, as set out in the NHS Foundation Trust accounting officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor 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 and Social Care Group Accounting Manual and in particular to:

- Observe the Accounts Direction used 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 and Social Care 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;
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for services users, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy; 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 property discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed: 

Professor Jonathan Warren, Chief Executive

Date: 23 May 2019

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 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and 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 2019 and of its 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 2019 and the Department of Health and Social Care Group Accounting Manual 2019.

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: financial statements as a whole	£4.4m (2017/18:£3.3m) 1.9% (2017/18: 1.5%) of operating income

Risks of material misstatement		vs 2017/18
Recurring risks	Valuation of land and buildings	◄►
	Recognition of NHS and non-NHS income	◄►
	New: Fraudulent expenditure recognition	▲

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:

	The risk	Our response
Land and buildings £121.2m (2017/18: £113.0 m) *Refer to pages A26 to A29 (accounting policy) and pages A44 to A47 (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 2019. 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 2019 was appropriate. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole.	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; — **Test of detail:** 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 Trusts 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: £237m (£227m; 2017/18) Refer to page A25 to A26 (accounting policy) and pages A35 to A37 (financial disclosures).	**Recognition of NHS and non-NHS income** Of the Trust's reported total income, £222 million (2017/18, £213m) came from commissioners (Clinical Commissioning Groups (CCGs) and NHS England). Seven CCGs and NHS England make up 96% of this income stream. 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: £237m (£227m; 2017/18) Refer to page A25 to A26 (accounting policy) and pages A35 to A37 (financial disclosures).	In 2018/19, 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 £3.9million transformation funding (2017/18: £3.1 million). 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 £14.6 million (2017/18: £13.9 million) from other activities, primarily education and training, research and development, and other activities. There is a risk that the Trust recognises income to which it is not entitled.	Our procedures included: — **Test of detail:** 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 actual income recognised in the year and agreed variances to source documentation; — **Test of detail:** we agreed a sample of items relating to other income activities to source documentation and agreed their treatment; — **Test of detail:** we assessed the Trust's assumptions behind the provision against available data on historic payment performance of counterparties and our own knowledge of recent bad debts affecting the NHS sector; and — **Test of detail:** We reviewed invoices and credit notes raised around the year end date to ensure the income had been recognised in the correct accounting period.

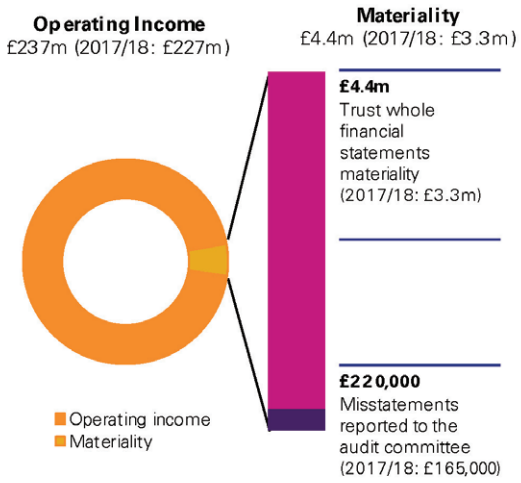
	The risk	Our response
Fraudulent expenditure recognition Accruals: £11.4m (£13.0m; 2017/18) Provisions: £14.5m (£12.8m; 2017/18) Refer to page A32 (accounting policy) and pages A49 and A51 to A52 (financial disclosures).	**Effect of irregularities:** There is a risk that the Trust may seek to improve its financial position from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period through understatement of liabilities at year end). We consider the risk to specifically relate to accruals and provisions, as they represent the key mechanism for management to manipulate year-end outturn. These areas can also be a key area of judgement, especially where there is dispute with commissioners.	Our procedures included: — **Segregation of duties:** we have considered the application of appropriate segregation of duties in the accounts payable process (i.e. the approval of purchase orders and invoices for payment) between those responsible for delivering services and those preparing the financial statements (Finance Team) which helps to prevent fraudulent manipulation of expenditure; — **Test of detail:** we compared provisions and accruals recognised at the previous year-end against actual outturn, to evaluate management's ability to accurately estimate year-end liabilities and performed a year-on-year review of accruals and provisions, and sought explanation for significant movements; and — **Test of detail:** we tested payments made and invoices received in April 2019 to identify whether they indicate that an accrual or provision should have been recognised at the balance sheet date. We performed a sample test of accruals and provisions to supporting evidence to ensure these were complete and accurate. We critically appraised the basis on which provisions were made and considered the appropriateness of significant estimates supporting the provisions.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £4.4 million (2017/18: £3.3 million), determined with reference to a benchmark of operating income (of which it represents approximately 1.9% (2017/18: 1.5%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £220,000 (2017/18: £165,000), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was performed at the Trust's headquarters in Norwich and Ipswich.



4. We have nothing to report on going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not 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. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Trust's business model, including the impact of Brexit, and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement in page A9 to the financial statements on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Trust's 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, and we did not identify going concern as a key audit matter.

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 2018/19.

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 Trust'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 2018/19, 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.

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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. They are also responsible for: 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.

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 2019.

Basis for adverse conclusion

The Trust remains in special measures after an inspection by the Care Quality Commission (CQC), rated the trust as 'overall inadequate' in October 2017.

The Trusts latest CQC inspection in November 2018 rated the Trust as "overall inadequate". Key areas highlighted for improvement were in respect of the safety culture across the Trust, risk assessment processes and access to service including management of waiting lists.

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 December 2018, 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 for securing 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 overleaf together with the findings from the work we carried out on each area.

KPMG

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 Trusts latest CQC inspection in November 2018 rated the Trust as "overall inadequate". Key areas highlighted for improvement were in respect of the safety culture across the Trust, risk assessment processes and access to service including management of waiting lists; and • 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.

SBeans

Stephanie Beavis
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
Dragonfly House
2 Gilders Way,
Norwich,
NR3 1UB
28 May 2019

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 2019 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 of Directors. Leadership is given to the risk management process through a number of measures:

Strategic risks are designated to Executive Directors with Non-Executive Directors leading the Board committees which scrutinise the effectiveness of risk mitigation relevant to their terms of reference.

The Board of Directors is responsible for the Board Assurance Framework (BAF) with the Trust Secretary having delegated responsibility for ensuring the management of the BAF. This is the scheme of reservation and delegation, standing financial instructions and the allocation of responsibility to specified post holders across the organisation.

The Audit and Risk Committee has delegated responsibility for gaining assurance on the effectiveness of the overall risk management system.

All managers have responsibility to identify and manage risk within their specific areas of control in line with the management and accountability arrangements within the Trust. These risks are regularly reviewed at locality and service governance meetings.

The Risk Management team 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, Datix. Training is provided by the team and is also included in the Trust's mandatory training requirement. In year, additional training was provided by an external company with two staff workshops in November 2018 and workshops for the Executive in February and March.

The Service Governance team is responsible for the dissemination of good practice and lessons learned from incidents or near misses through information sharing, cascading of information in newsletters and via the groups and committees within the governance structure. The Trust has commenced quality and safety reviews, implemented a trust-wide clinical harm review and liaising with service users and families at every stage of the serious incident process. This learning informs the risk register.

4. The risk and control framework

Key elements of the Risk Management Strategy

Management of risk and risk appetite is embedded within the Trust's Risk Management Strategy, providing a framework for the management of clinical (patient-related) and non-clinical risk to ensure safe services and

environments for service users, their families and carers, visitors and staff. The strategy provides a framework for managing organisational risks locally and Trust-wide.

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, as determined by the Trust's risk appetite. It sets out the organisational structure for reporting and review of risks at all levels and sets the tone of the risk management culture.

Each Locality or corporate team assesses their services and identifies and records risks that threaten their services. Risks and risk profiles are evaluated and 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 and controlled at the level at which they are owned and escalated according to the level of the risk rating (versus risk appetite), to the relevant executive director or Board committee. Risks are scored using a 5x5 risk assessment matrix. The Board of Directors has agreed broad risk classifications that identify the degree of action required within set timescales, which determines the risk appetite. The executive team reviewed the Trust's overall risk appetite at a workshop in March and this will be considered at a Board development session and set the tone of the newly revised Risk Management Strategy.

The Risk Management team provides support, and oversight of the process is provided by the Audit and Risk Committee.

The Board of Directors reviews its governance structure regularly. Following the PwC Governance review, published in May 2018, a detailed programme of work to improve risk management at every level of the Trust commenced, which supplemented the quality improvement plan to address the issues identified in relation to the CQC well-led framework. In the past year, work to improve risks management has been undertaken including improving risk escalation, improving the recording and monitoring of risk and reviewing the BAF. Although Internal Audit recognised that a great deal of work was underway, the partial assurance opinion for risk management arrangements demonstrates there is more to do, and the programme of change continues at pace, supported by East London Foundation Trust (ELFT).

The Trust has quality governance arrangements in place. The Chief Nurse is the executive lead for quality. The Board receives reports on progress against the Quality Improvement Plan and on quality issues at each meeting. The quality of performance information is assessed through the annual Quality Account audits and assurance on compliance with CQC registration requirements is obtained through the role of the Quality Governance Committee and its sub-groups; the Performance and Finance Committee, through the monitoring returns and exception reporting to NHS Improvement in accordance with the Single Oversight Framework; and assurance from the NHS Improvement Oversight and Assurance Group (OAG) and Performance Review Meeting (PRM) oversight meetings.

The Trust's major risks are highlighted in the BAF and are regularly monitored by the Board and relevant committees. They are summarised below, along with mitigation plans for reducing these risks to their risk appetite level:

- Risk of poor quality and unsafe services – urgent improvements made to safety in response to CQC inspection findings; the 100-day high-level plan runs until 31 May 2019 to provide pace and is supported by a detailed, longer term Quality Improvement Plan ensuring a sustainable safety and continuous quality improvement culture. The Quality Improvement Plan is monitored by the executive and Board, with oversight by NHS Improvement. Further improvements include training on quality improvement is being rolled out to staff; quality and safety reviews are underway; safer staffing monitored daily; update of the serious incident process with involvement of families at every stage; improved service user and carer engagement.

- Risk of not addressing the CQC findings and PWC governance review – as detailed above. The Quality Improvement Plan is monitored closely by NHS Improvement; the governance framework is being reviewed with support from ELFT, including Board development and review of board committees; a new Chair and CEO and a number of new executive posts have been appointed.

- Risk to delivering high quality, responsive services due to historic lack of investment in workforce – the new management and leadership structure in localities is being recruited to, providing additional clinical support and the process has included service user and carer involvement. This will particularly strengthen the role of clinical

leadership in our services and help to address the internal audit findings regarding Consultant job planning. Organisational Development and culture change programmes are underway, addressing findings in the staff survey; focus on staff recruitment and retention; launch of band 6 apprenticeship scheme; staff listening and engagement events.

- Risk of potential harm to service users through not accessing services in a timely way – a new Director has been appointed to focus on accessing services and addressing service user waiting times. Controls have already been put in place to reduce this risk, including the introduction of a clinical harm review process; weekly audit of Crisis Service User tracker; high level Performance Dashboard and Safer Staffing reports reviewed by the Board, which include waiting times. The Trust recognises the high number of Out of Trust placements and plans are being developed jointly with commissioners to reduce these through the use of alternative local service provision. There are longer term plans being developed to implement the STP mental health strategies and the transformation of mental health services in primary care.

Foundation Trust Governance

As an NHS Foundation Trust, the Trust is required by its licence to apply relevant principles, systems and standards of good corporate governance. In order to discharge this responsibility, the Trust has a clear Board and committee structure which is undergoing a full review in line with the PWC governance recommendations and with support from ELFT. Responsibilities of the Board and committees are set out in formal terms of reference and responsibilities of directors and staff are set out in job descriptions. There are clear reporting lines and accountabilities throughout the organisation.

The Board receives regular reports that allow it to assess compliance with the Trust licence and to have clear oversight over the Trust's performance. The format and content of reports are being strengthened.

The principal risks to compliance with the NHS Foundation Trust licence condition 4 (FT governance) include the effectiveness of the governance framework and of the Board and its committees, as detailed in the PWC governance review and the CQC well-led inspection. The Trust has benefited from an NHS Improvement appointed Improvement Director, the appointment of a new Chair and CEO and intensive support from ELFT.

The Trust is assured of the validity of its Corporate Governance Statement, required under NHS Foundation Trust condition 4(8) (b) through: regular review of its governance framework; through the PWC governance review carried out in 2018 with resulting action plans to address the recommendations; through OAG and PRM meetings with NHS Improvement.

Embedding risk management

Risk management is embedded throughout the Trust's operational structures, with emphasis on ownership of risk within the localities and services. Risks are reviewed at local governance committees and Performance and Accountability Review Meetings (PARMs). The implementation of incident and other risk-related policies and procedures ensure the involvement of all staff in risk management activity. Externally provided risk training in year further embedded robust risk management processes. The Trust continues to strengthen its management of cyber-security to address any risks. Equality impact assessments are integrated into core trust business. Incident reporting is openly encouraged across the Trust. The Freedom to Speak Up Guardian provides support to staff and themes are reported to Trust Board.

Public stakeholders

The Trust engages with its public partners in a number of ways relating to risk, including:

- Sustainability and Transformation Partnerships (STPs) to develop and implement shared proposals to improve health and care in the local economy, including the STP adult and children mental health strategies.

- Through local commissioners via Commissioning Quality Review Group – a commissioner / provider forum to discuss and address issues of quality and risk

- Through scrutiny meetings with local authority Health Overview and Scrutiny Committees

- The Council of Governors represents the interests of members and wider public and holds the Trust Board to account for the delivery of strategic objectives

Workforce Strategy

The Trust is developing a People Strategy which will address issues identified in the Staff Survey. There is a renewed focus on medical and nurse recruitment and an Allied Health Professional Strategy. The new management structure in localities will enhance clinical leadership and is part of a wider culture change programme with flexibility and autonomy to increase and decrease staffing devolved to local teams based on acuity and complexity of patients. Safer staffing reports are reviewed by the Trust board monthly (moving to bi-monthly) as part of the quality report. Safer staffing data is reported to the Chief Nurse daily and dedicated staff are allocated to review safe staffing and staff rostering.

Care Quality Commission (CQC)

The Foundation Trust is not fully compliant with the registration requirements of the Care Quality Commission. Following a CQC inspection in September 2018, the Trust was rated as "inadequate" overall in November 2018 and as a result it remains in special measures by NHS Improvement (Monitor). The rating across the five domains was as follows:

Safe – Inadequate

Well-led – Inadequate

Responsive – Inadequate

Effective – Requires Improvement

Caring – Good

The Trust has published the full report via a link from its public website home page: www.nsft.nhs.uk

On 28 January 2019, the Trust and NHS Improvement agreed to modify the additional licence condition imposed on the 19 February 2015 following this CQC report to ensure the Trust has in place: an effectively functioning board and board committees; sufficient and effective board; management and clinical leadership capacity and capability; and appropriate governance systems and processes to enable it to successfully meet the undertakings set out at paragraphs 1 to 7 of the Enforcement Undertakings agreed by the Licensee dated 23 January 2018 (as varied).

Managing Conflicts of Interest

The Foundation Trust has published an up-to-date register of interests for decision making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

NHS Pension Scheme

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.

Equality and Diversity

Dedicated staff are in post to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Carbon Reduction

The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its 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

As Accounting Officer, I have overall accountability for delivery of the Annual Plan and I am supported by the Executive Directors with delegated accountability and responsibility for delivery of specific targets and performance objectives.

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 and is supported by the wider senior management team and 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. The budgetary control system is complemented by Standing Financial Instructions, the Scheme of Delegation and financial approval limits.

The Board approves the strategic and operational plans, taking into account the views of the Council of Governors. The Trust Board receives regular finance and performance reports which enable it to monitor progress in implementing the operational plan and to ensure value for money is obtained. The Performance and Finance Committee provide further scrutiny.

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 is a member of the NHS Improvement Mental Health and Community Procurement Savings Collaborative, along with other cohort Trusts which aims to help improve procurement capabilities in Trusts and identify and realise savings in non-pay expenditure. The Trust is working with other Trusts within the STP areas to identify efficiency savings.

6 Information Governance

The Trust manages its information risks by undertaking an annual information governance audit. This year was the first year for the new NHS Digital Data Security and Protection (DSP) Toolkit assessment. Unlike its predecessor, the DSP Toolkit does not have a percentage score but measures compliance across assertions. The Trust is compliant on all but one of the assertions, with 82.0% of staff undertaking mandatory IG training as opposed to the 95.0% requirement. As such, there is an action plan in place to address this as a matter of urgency.

During 2018/19, there were no data breaches that required reporting to either the Department for Health and Social Care or the Information Commissioner. The Trust is fully compliant with the EU General Data Protection Regulation (GDPR). The internal management has been re-structured so that the Information Governance, Information Rights, Information Security and Health Records teams comes under the Data Protection Officer's (DPO) management. The IG sub-group reports quarterly to the Audit and Risk Committee. The Senior Information Risk Owner is the Director of Finance and the Caldicott Guardian is the Deputy Medical Director. Policies are in place which are compliant with NHS guidelines and incident reporting procedures are in place.

The DPO remains the Chair of the Suffolk and North East Essex STP Clinical Information Assurance Group and the Norfolk and Waveney STP IG Peer Group to ensure that the Trust is well placed to influence, support and develop the IG agenda across both STP areas.

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 2018/19. The information contained in this report uses data from the same systems that underpin the Trust's 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 Chief Nurse. 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 (KPIs). Workforce and education and training KPI data analysis is provided by separate staff within those teams.

Throughout the year the Quality Governance Committee 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 now 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 2018/19 work plan for the Trust's Internal Audit service included several audits that tested assurance on elements supporting the Quality Report. These included risk management arrangements, clinical incidents, temporary staffing and Out of Area placements. 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 and Council of Governors were asked to give feedback on the Trust's draft Quality Account prior to the draft being disseminated to stakeholders for comment as required in the guidance.

The priorities for improvement for 2019/20 are:

1. Patient experience and stakeholder engagement to continuously improve services

2. Improving access to services and waiting times and ensuring the safety of people waiting

3. Improving care planning, involving service users and carers at every stage

4. Providing safe environments

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 and the Quality Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust Board is accountable to the independent regulator NHS Improvement for performance and control issues and submits regular monitoring returns and exception reporting to NHS Improvement in accordance with the Single Oversight Framework. 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. The Board reviews the BAF and receives reports from its committees in relation to the effectiveness of the systems of internal control. In 2018/19 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
- Organisational Development and Workforce Committee

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 Audit and Risk Committee scrutinises the effectiveness of the risk management framework.

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 joint membership. The Audit and Risk Committee and the Board of Directors regularly receive risk management reports that incorporate information from all the above sources.

The Quality Governance Committee is chaired by the Senior Independent Director. A report is made to the Trust Board following each committee meeting. The Quality Governance Committee reviews learning from serious incidents, mortality reviews, safeguarding, Health & safety, infection control complaints and clinical audits. There are close links between all the committees due to cross membership.

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 financial 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 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 and acts as a host for other NHS Trust charitable funds. A report is made to the Trust Board 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 and risks 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.

The CQC report on the Trust's services, published in November 2018, following the inspection in September 2018, gave an overall opinion of inadequate. The inspection and subsequent report stated that whilst action has been taken to improve safety, risk management, governance and leadership, there has been a lack of progress in delivering sustained improvement, especially in some key areas of safety. The Trust continues to implement the Quality Improvement Plan, with support from ELFT to address all areas of concern.

In March 2018 a governance review of the Trust was commissioned from PWC by NHS Improvement to provide the Trust with an external insight into its governance arrangements and identify areas for improvement in support of the Trust's plans to address the concerns raised by the CQC. This review concluded that whilst some action had been taken by the Trust to strengthen risk management procedures, further work was required to establish a robust risk management framework and embed a stronger risk-based approach to prioritisation and decision making. The action plan to address the recommendations is being implemented with support from ELFT.

Internal Audit services are outsourced to Grant Thornton who provide an objective and independent opinion on the degree to which risk

management, control and governance support the achievement of the organisation's strategic objectives. Individual audit reports include a management response and action plan. Progress against outstanding actions are monitored by the Audit and Risk Committee. This year's audit programme was developed to reflect areas which were being reviewed under the CQC action plans.

The Trust has a counter fraud service and the Audit and Risk Committee receives regular reports from the Local Counter Fraud Specialist.

The Trust benefits from the views of service users and carers, from the Council of Governors and from the wider membership on the services it delivers.

Monthly Performance Review Meetings have been held with NHS Improvement and other key stakeholders during 2018/19 as part of the quality improvement plan to address CQC recommendations.

Internal Control Issues

The Foundation Trust is not fully compliant with the registration requirements of the Care Quality Commission and remains in special measures by NHS Improvement (Monitor).

The Head of Internal Audit Opinion for the period 1 April 2018 to 31 March 2019 states:

"Our overall opinion for the period 1 April 2018 to 31 March 2019 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 Out of Area placements and the adequacy of the Trust's arrangements for Consultant job planning.

The internal control issues identified by internal audit are as follows:

- Risk management – partial assurance opinion. The risk management strategy is being reviewed, with a draft reviewed by the Audit and Risk Committee in March 2019. Risk training workshops were held in November 2018 and in February 2019 and further training will be provided for the new locality leadership teams. A new BAF is in place but will undergo further refinements and the information on Datix is being reviewed to consolidate the corporate risk register. The new Board committees will continue to receive risk reports, but their format is being improved.

- Performance Management and Reporting – partial assurance opinion. The Quality Improvement Plan continues to be monitored by the Board, with increased scrutiny of safety. A new dashboard has been developed with clearer reporting on key performance indicators. OAG and PRM provides additional level of performance scrutiny whilst the Trust remains in special measures. The PARMs reviewed performance in year but will be refined with the reconfiguration of locality leadership. The Board committees are being redefined, with support from ELFT.

- Procurement – partial assurance opinion. The Procurement Policy has been updated, and the Procurement Strategy is under review, the scheme of reservation and delegation is being reviewed, and all single tender waivers are reviewed for value for money and quality impact. These are reported to the Audit and Risk Committee. Procurement cost improvement plans are monitored by the Performance and Finance committee.

- Temporary Staffing and Safer Staffing Reports – partial assurance opinion. The lead nurse for each locality is being recruited and a full induction programme will be in place. Safer staffing reports are reviewed by the Board. Work is underway to review medical locum cover.

- Mandatory training – partial assurance opinion. Re-launch of statutory and mandatory training programme, updating the Trust's Mandatory training policy and monitoring compliance in PARMs.

- Disaster recovery arrangements – partial assurance opinion. The disaster recovery arrangements are being reviewed to ensure all systems are supported by formal disaster recovery plans and training provided on these.

- Clinical incidents – partial assurance opinion. Improvements are being made to recording of incidents and learning on the system.

- Out of Area placements – no assurance opinion. Investment has been agreed with commissioners to develop alternative services locally, which will reduce the need for acute admissions and the knock-on impact this has on external placements.

- Consultant job planning – no assurance opinion. The new locality leadership structure is being appointed to, which will ensure that services are clinically led. This will deliver clinical accountability for job planning in the localities, along with the regular review and management of those job plans to ensure medical resources are efficiently and effectively used.

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 current BAF (as of 31 March 2019) has four red-rated risks:

- risk of not addressing the CQC findings and PwC governance review

- risk of poor quality services, unsafe services

- risk to delivering high quality, responsive services due to workforce issues

- risk of potential harm to service users through not accessing services in timely way

Action plans are in place and are summarised in the BAF. These risks are monitored by the relevant committee and the Board. The Board is refreshing its BAF and its risk appetite statement for the new financial year, in line with the PWC governance recommendations.

9 EU Exit

The current uncertainties around EU Exit could have an impact on the healthcare sector in relation to the cost of pharmaceuticals, medical devices and the availability of workforce. Whilst we acknowledge that these risks are predicted to have a limited impact on the operational delivery of the Trust, the overall impact to providers and the health economy as a whole could be more severe. The Department of Health has published EU Exit Operational Guidance which requires local level planning and risk assessment. The Trust has liaised with national and local teams to ensure compliance with EU Exit planning, and the Resilience team continues to work on ensuring that the requirements of this guidance are in place for the Trust and operations are prepared for a No Deal EU Exit.

10 Conclusion

There have been no significant internal control issues identified other than those referenced above, recognising the significance of the weaknesses in controls relating to delivering improvements with out of area placements and the adequacy of the Trust's arrangements for Consultant job planning.

The Trust continues to implement its Quality Improvement Plan and the governance action plan, working closely with NHS Improvement and ELFT so as to improve services for local people and to improve the CQC rating with a view to leaving special measures. The Trust Board and Board Committees will continue to monitor these areas closely.

Signed: 

Professor Jonathan Warren
Chief Executive

Date: 23 May 2019

Foreword to the accounts

as the accounting officer of Norfolk and Suffolk NHS Foundation Trust

These accounts, for the year ended 31 March 2019, 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: 

Professor Jonathan Warren
Chief Executive

Date: 23 May 2019

Statement of Comprehensive Income for the year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	222,229	213,273
Other operating income	4	14,563	13,938
Operating expenses	6, 8	(232,241)	(222,558)
Operating surplus from continuing operations		**4,551**	**4,653**
Finance income	11	96	35
Finance expenses	12	(905)	(909)
PDC dividends payable		(2,956)	(2,637)
Net finance costs		**(3,765)**	**(3,511)**
Other gains / (losses)	13	1,449	(76)
Surplus for the year from continuing operations		**2,235**	**1,066**
Surplus for the year		**2,235**	**1,066**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(3,242)	-
Revaluations	16	3,415	-
Other reserve movements		-	-
Total comprehensive income for the period		**2,408**	**1,066**
Of which:			
Sustainability and Transformation Fund Income (STF)	4	(3,992)	(3,197)
Underlying financial performance excluding STF		**(1,584)**	**(2,131)**

Statement of Financial Position

for the year ended 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	14	125	219
Property, plant and equipment	15	133,311	124,726
Total non-current assets		**133,436**	**124,945**
Current assets			
Inventories	17	83	91
Receivables	18	12,141	20,082
Non-current assets held for sale / assets in disposal groups	19	-	224
Cash and cash equivalents	20	13,627	14,640
Total current assets		**25,851**	**35,037**
Current liabilities			
Trade and other payables	21	(23,712)	(28,328)
Borrowings	23	(1,635)	(1,222)
Provisions	25	(9,687)	(9,911)
Other liabilities	22	(551)	(10,567)
Total current liabilities		**(35,585)**	**(50,028)**
Total assets less current liabilities		**123,702**	**109,954**
Non-current liabilities			
Borrowings	23	(15,986)	(12,372)
Provisions	25	(4,831)	(2,931)
Other liabilities	22	(245)	(293)
Total non-current liabilities		**(21,062)**	**(15,596)**
Total assets employed		**102,640**	**94,358**
Financed by			
Public dividend capital		90,917	85,043
Revaluation reserve		37,796	37,623
Income and expenditure reserve		(26,073)	(28,308)
Total taxpayers' equity		**102,640**	**94,358**

The notes on pages A24 to A58 form part of these accounts.

Signed: Jonathan Warren.

Professor Jonathan Warren, Chief Executive

Date: 23 May 2019

Statement of Changes in Equity

for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**85,043**	**37,623**	**(28,308)**	**94,358**
Surplus for the year	-	-	2,235	**2,235**
Impairments	-	(3,242)	-	**(3,340)**
Revaluations	-	3,415	-	**3,415**
Public dividend capital received	5,874	-	-	**5,874**
Taxpayers' equity at 31 March 2018	**90,917**	**37,796**	**(26,073)**	**102,542**

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**
Suplus 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**

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 trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the 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 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus		4,551	4,653
Non-cash income and expense:			
Depreciation and amortisation	6	7,591	7,448
Net impairments	7	149	-
Decrease / (increase) in receivables and other assets		7,941	(2,222)
Decrease / (increase) in inventories		8	(21)
(Decrease) / increase in payables and other liabilties		(15,099)	4,598
Increase in provisions		1,676	1,507
Other movements in operating cash flows		-	9
Net cash generated from operating activities		**6,817**	**15,972**
Cash flows from investing activities			
Interest received		96	35
Purchase of property, plant, equipment and investment property		(15,588)	(11,132)
Sales of property, plant, equipment and investment property		1,670	887
Net cash (used in) investing activities		**(13,822)**	**(10,210)**
Cash flows from financing activities			
Public dividend capital received		5,874	3,207
Movement on loans from the Department of Health and Social Care		4,152	(1,057)
Capital element of PFI, LIFT and other service concession payments		(165)	(153)
Interest on loans		(327)	(300)
Interest paid on PFI, LIFT and other service concession obligations		(581)	(568)
PDC dividend (paid)		(2,964)	(2,089)
Cash flows from other financing activities		3	56
Net cash generated from / (used in) financing activities		**5,992**	**(904)**
(Decrease) / increase in cash and cash equivalents		**(1,013)**	**4,858**
Cash and cash equivalents at 1 April - brought forward		**14,640**	**9,782**
Cash and cash equivalents at 31 March	20	**13,627**	**14,640**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust 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 2018/19 issued by the Department of Health and Social Care. 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 the accounts.

1.1.1 Accounting convention

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

1.1.2 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.

Note 1.2 Critical judgements in applying accounting policies

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

1.2.1 Judgements made in the application of IFRS 15 to Research and Development contracts to determine the amount and timing of revenue recognised. The accounting treatment varies from contract to contract dependent on the terms of the service provided.

1.2.2 Judgements made in the application of IFRS 15 to the Provision of Healthcare contracts to determine the amount and timing of revenue recognised. Healthcare services are deemed to be a continuous service provided over time and as such income from the block contracts are recognised consistently over the financial period.

Note 1.3 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- Income provision assumptions on CQUIN achievements
- The desktop valuation is a fair value for direct replacement cost of sites where extensive CQC Anti-Ligature Works to Property, Plant and Equipment has taken place. The has resulted in a £3m impairment of assets which has been offset by the release of the revaluation reserve
- The useful economic life of the Fermoy unit would be extended for 3 years following a Board decision to retain Churchill ward (based at Fermoy) and provide additional acute beds in Norfolk

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 15.

Note 1.4 Income

1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Where the effects of other practical expedients mandated by the GAM are material, these have been disclosed as follows:

(1) As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less.

(2) The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

(3) The GAM has mandated the exercise of the practical expedient offered in C7A of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of revenue for the Foundation Trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. At the year end, the Foundation Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

1.4.2 Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

1.4.3 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. The value of the benefit received when accessing funds from the Government's apprenticeship service 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.

1.4.4 Other income

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.

Note 1.5 Expenditure on employee benefits

1.5.1 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.

1.5.2 Pension costs

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 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 though it is a defined contribution scheme.

Employer's 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 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

1.7.1 Recognition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- It is expected to be used for more than one financial year
- 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 a 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 lives.

1.7.2 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 where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs 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.

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.

1.7.3 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, ie:
  - 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.

1.7.4 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.

1.7.5 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 up-to-date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

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

An annual finance cost is calculated by applying the implicit interest rate in the lease on the operating lease liability for the period, and is charged to "Finance Costs" within the Statement of Comprehensive Income. The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance 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 costs 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.

1.7.6 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 1.8 Intangible assets

1.8.1 Recognition

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

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. 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, e.g, an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g., application software, is capitalised as an intangible asset.

1.8.2 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 lives in a manner consistent with the consumption of economic or service delivery benefits.

1.8.3 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 1.9 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 1.10 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 1.11 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, ie, 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.

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

1.11.1 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"

1.11.2 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument and, as a result, has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations, which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office for National Statistics (ONS).

This includes 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 and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.11.3 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income.

Financial liabilities are classified as subsequently measured at amortised cost or fair value through income and expenditure.

Note 1.11.4 Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows, where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

1.11.5 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.

1.11.6 Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as 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.

Note 1.11.7 Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime

expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The methods used to determine the expected credit losses for each class of financial asset is as follows:

- Payroll overpayment debtors - % of payroll overpayments written off in the previous 12 month period ending 31 March 2019
- Other non NHS debtors - credit loss is calculated upon notification of potential dispute with the customer

The Trust does not normally recognise expected credit losses in relation to other NHS bodies, but reflects the potential loss through a transaction price adjustment.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.12 Leases

1.12.1 The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The 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 charge 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

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

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

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.

1.12.2 The Trust as lessor

Finance leases

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

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 1.13 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 24.2 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 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

Note 1.15 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 and Social Care (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 1.16 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 1.17 Corporation tax

The Trust has determined that there is no corporation tax liability.

Note 1.18 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 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,
- 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 1.19 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 1.20 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 1.21 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 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018/19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019/20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration:

- 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
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019

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 33 to the accounts, Related Party Transactions.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1.

Note 3.1 Income from patient care activities (by nature)

	2018/19	2017/18
	£000	£000
Mental health services		
Block contract income	206,294	199,575
Clinical partnerships providing mandatory services (including S75 agreements)	1,383	9,412
Clinical income for the secondary commissioning of mandatory services	2,228	2,228
Other clinical income from mandatory services	9,206	1,884
All services		
Agenda for Change pay award central funding	2,091	-
Other clinical income	1,027	174
Total income from activities	**222,229**	**213,273**

Note 3.2 Income from patient care activities (by source)

	2018/19	2017/18
	£000	£000
Income from patient care activities received from:		
NHS England	19,233	17,485
Clinical commissioning groups	193,727	185,305
Department of Health and Social Care	2,091	-
Other NHS providers	50	97
NHS other	-	114
Local authorities	4,604	12,276
Non NHS: other	2,524	(2,004)
Total income from activities	**222,229**	**213,273**
Of which:		
Related to continuing operations	222,229	213,273

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	992	1,381
Education and training (excluding notional apprenticeship levy income)	4,588	4,888
Non-patient care services to other bodies	557	858
Provider sustainability / sustainability and transformation fund income (PSF / STF)	3,992	3,197
Other contract income	3,626	3,035
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	462	194
Rental revenue from operating leases	346	385
Total other operating income	**14,563**	**13,938**
Of which:		
Related to continuing operations	14,563	13,938

Note 5 Additional information on income

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in contract liabilities at the previous period end.	556

Note 5.2 Transaction price allocated to remaining performance obligations

	2018/19
	£000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	
- within one year	504
- after one year, not later than five years	-
- after five years	-
Total revenue allocated to remaining performance obligations	**504**
Of which:	

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 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:

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	209,906	211,215
Income from services not designated as commissioner requested services	12,323	2,058
Total	**222,229**	**213,273**

Note 5.4 Profits and losses on disposal of property, plant and equipment

The following assets held for sale were disposed during the year:

	2018/19
Blomfield House	**£000**
Sale Proceeds received	1,670
Net Book Value	(223)
Profit on disposal	**1,447**
Transit Van sale proceeds	2
Profit on disposal	**2**

Blomfield House was deemed surplus to requirement for the provision of commisioner requested services in 2017/18 and subsequently disposed in 2018/19.

Note 6 Operating expenses

Note 6.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,845	1,753
Purchase of healthcare from non-NHS and non-DHSC bodies	17,799	18,377
Staff and Executive Directors costs	170,202	161,830
Remuneration of Non-executive Directors	136	147
Supplies and services - clinical (excluding drugs costs)	718	838
Supplies and services - general	6,706	6,444
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	2,560	2,714
Consultancy costs	736	314
Establishment	1,748	647
Premises	7,973	9,401
Transport (including patient travel)	2,628	2,670
Depreciation on property, plant and equipment	7,497	7,354
Amortisation on intangible assets	94	94
Net impairments	149	-
Movement in credit loss allowance: contract receivables / contract assets	111	
Movement in credit loss allowance: all other receivables and investments	-	15
Increase in other provisions	3,192	487
Audit fees payable to the external auditor		
audit services - statutory audit	79	83
other auditor remuneration (external auditor only)	-	-
Internal audit costs	130	120
Clinical negligence	621	475
Legal fees	363	571
Insurance	234	200
Education and training	1,323	1,813
Rentals under operating leases	2,991	3,295
Redundancy	-	162
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,240	1,199
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	-	-
Car parking and security	208	232
Hospitality	26	12
Losses, ex gratia and special payments	152	-
Other services, eg external payroll	458	435
Other	322	876
Total	**232,241**	**222,558**
Of which:		
Related to continuing operations	232,241	222,558

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1,000k (2017/18: £1,000k).

Note 7 Impairment of assets

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Unforeseen obsolescence	149	-
Total net impairments charged to operating surplus	149	-
Impairments charged to the revaluation reserve	**3,242**	**-**
Total net impairments	**3,391**	**-**

Note 8 Employee benefits

	2018/19	2017/18
	£000	£000
Salaries and wages	123,018	116,409
Social security costs	12,147	11,627
Apprenticeship levy	596	568
Employer's contributions to NHS pensions	15,707	15,062
Pension cost - other	17	-
Termination benefits	-	162
Temporary staff (including agency)	18,717	18,164
Total staff costs	170,202	161,992

Note 8.1 Retirements due to ill-health

During 2018/19 there were six early retirements from the Trust agreed on the grounds of ill-health (eight in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £234k (£426k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 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 2019, is based on valuation data as of 31 March 2017, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 10 Operating leases

Note 10.1 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.

	2018/19	2017/18
	£000	£000
Operating lease revenue		
Minimum lease receipts	346	385
Total	**346**	**385**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease receipts due:		
- not later than one year	342	360
Total	**342**	**360**

Note 10.2 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.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	2,991	3,295
Total	**2,991**	**3,295**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,271	2,987
- later than one year and not later than five years;	4,059	6,272
- later than five years.	3,919	4,982
Total	**10,249**	**14,241**

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19	2017/18
	£000	£000
Interest on bank accounts	96	35
Total	**96**	**35**

Note 12 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	324	341
Main finance costs on PFI and LIFT schemes obligations	269	281
Contingent finance costs on PFI and LIFT scheme obligations	312	287
Total	**905**	**909**

Note 13 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	1,449	12
(Losses) on disposal of assets	-	(88)
Total gains / (losses) on disposal of assets	**1,449**	**(76)**
Total other gains / (losses)	**1,449**	**(76)**

Note 14 Intangible assets

Note 14.1 Intangible assets - 2018/19

	Software licences	Total
	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**1,041**	**1,041**
Gross cost at 31 March 2019	**1,041**	**1,041**
Amortisation at 1 April 2018 - brought forward	822	**822**
Provided during the year	94	**94**
Amortisation at 31 March 2019	**916**	**916**
Net book value at 31 March 2019	**125**	**125**
Net book value at 1 April 2018	**219**	**219**

Note 14.2 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)**
Valuation / gross cost at 31 March 2018	**1,041**	**1,041**
Amortisation at 1 April 2017 - 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 15 Property, plant and equipment

Note 15.1 Property, plant and equipment - 2018/19

	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 2018 - brought forward	**11,444**	**94,309**	**3,985**	**8,340**	**5,097**	**325**	**14,787**	**6,554**	**144,841**
Additions	-	-	-	16,057	-	-	-	-	**16,057**
Impairments	-	(3,401)	-	-	(13)	-	(6)	(13)	**(3,433)**
Reclassifications	-	11,252	-	(14,591)	228	-	2,199	912	**-**
Revaluations	-	3,415	-	-	-	-	-	-	**3,415**
Transfers to / from assets held for sale	-	-	-	-	-	(37)	-	-	**(37)**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2019	**11,444**	**105,575**	**3,985**	**9,806**	**5,312**	**288**	**16,980**	**7,453**	**160,843**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**4,538**	**492**	**-**	**3,374**	**325**	**8,917**	**2,469**	**20,115**
Provided during the year	-	4,486	89	-	215	-	2,174	533	**7,497**
Impairments	-	(29)	-	-	(5)	-	(5)	(4)	**(43)**
Transfers to / from assets held for sale	-	-	-	-	-	(37)	-	-	**(37)**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2019	**-**	**8,995**	**581**	**-**	**3,584**	**288**	**11,086**	**2,998**	**27,532**
Net book value at 31 March 2019	**11,444**	**96,580**	**3,404**	**9,806**	**1,728**	**-**	**5,894**	**4,455**	**133,311**
Net book value at 1 April 2018	**11,444**	**89,771**	**3,493**	**8,340**	**1,723**	**-**	**5,870**	**4,085**	**124,726**

Note 15.2 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 15.3 Property, plant and equipment financing - 2018/19

	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 2019									
Owned - purchased	11,444	95,556	3,404	9,806	1,728	-	5,893	4,456	**132,287**
On-SoFP PFI contracts and other service concession arrangements	-	926	-	-	-	-	-	-	**926**
NBV total at 31 March 2019	**11,444**	**96,482**	**3,404**	**9,806**	**1,728**	**-**	**5,893**	**4,456**	**133,213**

Note 15.4 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 16 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. The desktop review carried out by Montagu Evans LLP as at 31 March 2019 has resulted in a £3.4m revaluation of current Land and Buildings in use.

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 2019 showed a significant change in valuation of the current Land and Buildings in use.

Therefore £3,242k impairments have been recognised in the 2018/19 financial year and offset by the revaluation surplus previously held in the revaluation reserve.

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 (eg, 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.

Note 17 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	83	91
Total inventories	**83**	**91**

Inventories recognised in expenses for the year were £2,560k (2017/18: £2,474k).
Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 18 Receivables

Note 18.1 Trade receivables and other receivables

	31 March 2019	31 March 2018
	£000	£000
Current		
Contract receivables*	9,424	
Trade receivables*		13,003
Accrued income*		4,589
Allowance for impaired contract receivables / assets*	(191)	
Allowance for other impaired receivables	-	(440)
Prepayments (non-PFI)	1,376	1,382
VAT receivable	734	746
Other receivables	798	802
Total current trade and other receivables	**12,141**	**20,082**
Total non-current trade and other receivables	**-**	**-**
Of which receivables from NHS and DHSC group bodies:		
Current	8,223	14,301

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 18.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 April 2018 - brought forward	-	-
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	440	(440)
New allowances arising	157	-
Reversals of allowances	(46)	-
Utilisation of allowances (write offs)	(360)	-
Allowances as at 31 March 2019	**191**	**(440)**

Amounts written off in the year are still subject to enforcement activity, particularly where there is continued communication with the debtors.

Note 18.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result, it differs in format to the current period disclosure.

Note 19 Non-current assets held for sale and assets in disposal groups

	2018/19	2017/18
	Total £000	Total £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**224**	**975**
Assets classified as available for sale in the year	-	224
Assets sold in year	(224)	(975)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**224**

Note 20 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.

20.1 Cash and cash equivalents movements

	2018/19	2017/18
	£000	£000
At 1 April	**14,640**	**9,782**
Net change in year	(1,013)	4,858
At 31 March	**13,627**	**14,640**
Broken down into:		
Cash at commercial banks and in hand	74	104
Cash with the Government Banking Service	13,553	14,536
Total cash and cash equivalents as in SoFP	**13,627**	**14,640**
Total cash and cash equivalents as in SoCF	**13,627**	**14,640**

Note 20.2 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the 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 2019	31 March 2018
	£000	£000
Bank balances	192	209
Total third party assets	**192**	**209**

Note 21 Payables

Note 21.1 Trade and other payables

	31 March 2019	31 March 2018
	£000	£000
Current		
Trade payables	3,807	7,656
Capital payables	2,992	2,523
Accruals	11,364	12,986
Social security costs	930	886
Other taxes payable	2,353	2,203
PDC dividend payable	-	8
Accrued interest on loans		42
Other payables	2,266	2,024
Total current trade and other payables	**23,712**	**28,328**

Note 22 Other liabilities

	31 March 2019	31 March 2018
	£000	£000
Current		
Deferred income: contract liabilities	504	10,447
Deferred grants	-	74
Lease incentives	46	46
Total other current liabilities	**551**	**10,567**
Non-current		
Deferred income: contract liabilities	6	10
Lease incentives	239	283
Total other non-current liabilities	**245**	**293**

Note 23 Borrowings

	31 March 2019	31 March 2018
	£000	£000
Current		
Loans from the Department of Health and Scoial Care	1,455	1,056
Obligations under PFI, LIFT or other service concession contracts (excluding lifecycle)	180	166
Total current borrowings	**1,635**	**1,222**
Non-current		
Loans from the Department of Health and Scoial Care	12,791	8,999
Obligations under PFI, LIFT or other service concession contracts	3,195	3,373
Total non-current borrowings	**15,986**	**12,372**

Note 24 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**10,055**	**-**	**-**	**3,539**	**13,594**
Cash movements:					
Financing cash flows - payments and receipts of principal	4,152	-	-	(165)	**3,987**
Financing cash flows - payments of interest	(327)	-	-	(268)	**(595)**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	42	-	-	-	**42**
Application of effective interest rate	324			269	**593**
Carrying value at 31 March 2019	**14,246**	**-**	**-**	**3,375**	**17,621**

Note 25 Provisions for liabilities

Note 25.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Pensions: injury benefits*	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**1,263**	**1,809**	**460**	**9,310**	**12,842**
Arising during the year	180	255	144	8,768	**9,347**
Utilised during the year	(254)	(140)	(12)	(2,205)	**(2,611)**
Reversed unused	-	-	-	(5,060)	**(5,060)**
At 31 March 2019	**1,189**	**1,924**	**592**	**10,813**	**14,518**
Expected timing of cash flows:					
- not later than one year;	251	129	-	9,307	**9,687**
- later than one year and not later than five years;	621	515	-	1,505	**2,641**
- later than five years.	317	1,280	592	1	**2,190**
Total	**1,189**	**1,924**	**592**	**10,813**	**14,518**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within Pensions:early departure costs.

The pension' provision relates to the NHS Pensions Agency in respect of early retirement award, payable to former 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 £1,924k 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 25.2 Clinical negligence liabilites

At 31 March 2019, £3,696k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Norfolk and Suffolk NHS Foundation Trust (31 March 2018: £4,910k).

Note 26 Contingent assets and liabilities

	31 March 2019	31 March 2018
	£000	£000
Value of contingent liabilities		-
NHS Resolution legal claims	60	-
Gross value of contingent liabilities	**60**	-
Net value of contingent liabilities	**60**	**-**

Note 27 Contractual capital commitments

	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	3,672	3,659
Total	**3,672**	**3,659**

Note 28 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 2019	31 March 2018
	£000	£000
- not later than 1 year	6,824	2,440
- after 1 year and not later than 5 years	4,176	-
- paid thereafter	-	-
Total	**11,000**	**2,440**

Note 29 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 has been calculated using the Department of Health approved template incorporating a 2.5% annual inflation uplift for future years. Past years' inflation is calculated to bring the annual unitary charge in line with the amount actually paid.

Note 29.1 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 2019	31 March 2018
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**11,736**	**12,478**
Of which liabilities are due		
- not later than one year;	767	744
- later than one year and not later than five years;	3,300	3,205
- later than five years.	7,669	8,529
Finance charges allocated to future periods	(8,361)	(8,939)
Net PFI, LIFT or other service concession arrangement obligation	**3,375**	**3,539**
- not later than one year;	180	166
- later than one year and not later than five years;	870	807
- later than five years.	2,325	2,566

Note 29.2 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 2019	31 March 2018
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**31,894**	**33,878**
Of which liabilities are due:		
- not later than one year;	2,044	1,985
- later than one year and not later than five years;	8,807	8,551
- later than five years.	21,043	23,342

Note 29.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the Trust's payments in 2018/19.

	2018/19	2017/18
	£000	£000
Unitary payment payable to service concession operator	**1,986**	**1,920**
Consisting of:		
- Interest charge	269	281
- Repayment of finance lease liability	165	153
- Service element and other charges to operating expenditure	1,240	1,199
- Contingent rent	312	287
Total amount paid to service concession operator	**1,986**	**1,920**

Note 30 Financial instruments

Note 30.1 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 18.1 "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 30.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total
	£000	£000
Carrying values of financial assets as at 31 March 2019 under IFRS 9		
Trade and other receivables excluding non financial assets	10,031	10,031
Cash and cash equivalents at bank and in hand	13,627	13,627
Total at 31 March 2019	**23,658**	**23,658**

	Loans and receivables	Total
	£000	£000
Carrying values of financial assets as at 31 March 2018 under IAS 39		
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**

Note 30.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total
	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	14,246	14,246
Obligations under PFI, LIFT and other service concession contracts	3,375	3,375
Trade and other payables excluding non financial liabilities	20,429	20,429
Total at 31 March 2019	**38,050**	**38,050**

	Other financial liabilities	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	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**

Note 30.4 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	22,063	26,412
In more than one year but not more than two years	1,610	1,236
In more than two years but not more than five years	4,924	3,796
In more than five years	9,453	7,339
Total	**38,050**	**38,783**

Note 31 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses:				
Cash losses	1	1	2	-
Stores losses and damage to property	2	-	2	-
Total losses	**3**	**1**	**4**	**-**
Special payments:				
Compensation under court order or legally binding arbitration award	9	29	9	107
Ex-gratia payments	13	1	23	4
Total special payments	**22**	**30**	**32**	**111**
Total losses and special payments	**25**	**31**	**36**	**111**
Compensation payments received		5		-

Note 32 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £42k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in no change to the carrying value of receivables as at 1 April 2018. The probability of write off was calculated for salary overpayment debtors and the carrying value as at 31 March 2019 was reduced by £24k to allow for credit losses under the expected loss model.

Note 32.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 33 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 (2017/18 - £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 £12,517k of expenditure with NHS Professionals for temporary staff costs (2017/18 - £13,341k). 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.

33.1 Related parties

	Receivables		Payables	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Department of Health and Social Care	-	-	35	65
NHS England	2,800	2,500	-	49
NHS Foundation Trusts	137	324	514	188
NHS Trusts	90	45	50	99
Clinical Commissioning Groups (CCGs)	4,536	11,232	169	10,494
Health Education England	22	118	-	-
Other NHS bodies	448	82	460	24
Local Government and other WGA bodies	1,528	1,850	5,464	4,812
Total	**9,561**	**16,151**	**6,692**	**15,731**

	Income		Expenditure	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Department of Health and Social Care	2,223	-	0	6
NHS England	-	2,500	11	2,500
NHS Foundation Trusts	967	1,159	2,478	2,120
NHS Trusts	248	220	385	664
Clinical Commissioning Groups (CCGs)	217,755	205,453	400	(1,611)
Health Education England	5,032	5,071	5	13
Other NHS bodies	728	395	1,515	1,312
Local Government and other WGA bodies	5,060	13,053	42,140	41,175
Total	**232,013**	**227,851**	**46,934**	**46,179**

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