NHS
Norfolk

2010/11 Annual report

Bold and Ambitious
Year 2 update

Fit for the future
Changing the way we do things for the better

Care closer to home
The right care at the right time, in the right place

Have your say
Get involved and help to shape your local NHS

Service improvement
Improving health outcomes for NHS patients

excellent health | outstanding care | best value

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Foreword

Two years ago we launched our strategic plan, 'Bold and Ambitious'. Its clear focus on delivering high quality care closer to patients' homes remains at the heart of everything we do and everything we have achieved in 2010/11.

This year we can report solid progress in delivering some of the pledges we made in 'Bold and Ambitious'. We have put in place new and innovative services with the accent firmly on preventing illness, where possible, and offering quality healthcare to patients when they need it. Some of these developments are set out on pages 17 to 24.

Making best use of our £1.2bn budget to improve patient outcomes is a huge and demanding challenge; it would be in any year. However, this is also a year which has seen modernisation and change within the NHS on a previously unseen scale. We have responded to that change.

Organisationally, our most significant challenges were contained in the Health White Paper 'Equity and Excellence: Liberating the NHS' in July 2010 and subsequently in the Health and Social Care Bill. This set out the timetable for abolishing Primary Care Trusts by April 2013 and handing over responsibility for more localised commissioning to GP consortia.

By the end of 2010/11 we saw GP Commissioning Consortia emerge in North Norfolk, West Norfolk, Norwich and in South Norfolk. They all have very clear intentions to develop local services for their patient populations. We too have clear intentions to support them as they develop and to deliver a legacy of sound finances for their future.

Andrew Morgan
Chief Executive

Dr Ian Mack
Clinical Executive Chair

We restructured NHS Norfolk internally, replacing Programme Boards with more focused Delivery Units. The intention is to align the way we work and, in some cases, our staff to GP Consortia.

With a finite timeframe ahead of us, NHS Norfolk has 'clustered' with our neighbouring PCT, NHS Great Yarmouth and Waveney. This has led to the creation of a single management team and closer working which will offer mutual support during transition.

A word from the Chair

Sheila Childerhouse
NHS Norfolk Chair

"This has been a year when we have welcomed a transforming Chief Executive, Andrew Morgan. Andrew has refocused NHS Norfolk and created a fitter, more responsive organisation. We were also preparing to bid farewell to Ian Mack who has chaired our Clinical Executive so effectively, as he moved on to join our former provider arm Norfolk Community Health and Care NHS Trust as Medical Director in May 2011. A special word of thanks too, to Andrew Egerton-Smith who has been with us as a non-executive director since inception in 2006 and stepped down in June 2010.

"Above all this has been a turbulent year for our staff. They have weathered changes required by modernisation, the imminent abolition of PCTs, the creation of GP Commissioning and a reduction in running costs which led to a number of redundancies. All this in one year; and yet throughout they have continued to work on behalf of our 757,000 patients to develop and improve health services.

"I am proud that they have more than demonstrated their expertise in both commissioning and in the vital support roles which make the NHS work for patients when they need it."

About us

What we do

NHS Norfolk was established as a Primary Care Trust on 1 October 2006. It covers the majority of Norfolk and serves a population of 757,000 people.

Our vision

Our vision is to offer 'excellent health, outstanding care and best value.'

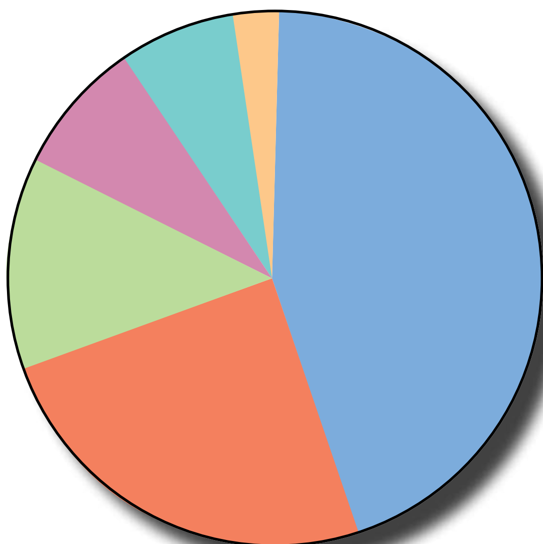
This means that we will make sure that whoever you are or wherever you live, you will receive high quality, safe healthcare services and we will use our money as efficiently as we can to deliver this to you.

Our core functions

- We commission health services for our patient population. This means planning what services we need and agreeing contracts with GPs, hospitals, mental health trusts and voluntary organisations to provide care for patients within the budget we are set.
- We work with partner organisations and providers to improve the health and wellbeing of our population.
- This year a key role has been to support the development of GP Commissioning Consortia, with the aim of delivering to them financial balance in 2013 and a robust, responsive health system.

This year our budget was £1.2bn. This was a sum of money given to us by the Department of Health to pay for all NHS care for our patients.

The pie chart shows where that money was spent.



	Million
Secondary care	£540,386
Primary care and prescribing	£296,469
Mental health and learning difficulties	£150,497
Community services	£101,343
Other health services	£82,711
Administration and estates	£31,440
TOTAL	**£1202,846**

Our Public Health team are responsible for a wide range of projects to support people who want to live healthier lives. Much of this falls into the Change4Life movement.

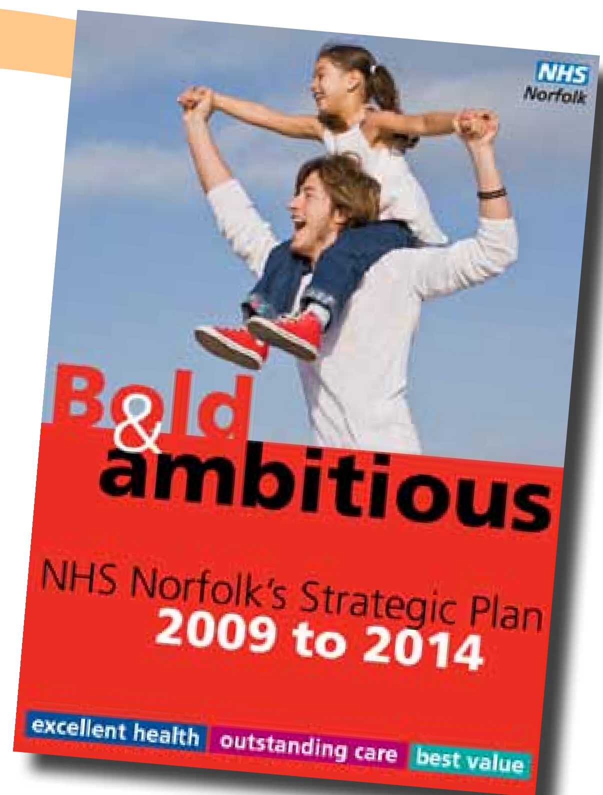
However, our Public Health team has also commissioned 29,584 Health Checks for 40-74 year olds at GP practices, pharmacies and in workplaces; helped transform individuals' lives through the Health Trainers programme; managed screening programmes and worked to reduce hospital or community-acquired infections.

Our priorities for 2011/12

In 2010/11 NHS Norfolk continued to focus on the patient experience and build on the improvements made in target performance seen in the previous year. Significant improvements were made in stroke and cancer services as well as reductions in waiting times for planned hospital care. The management of winter pressures and delays has resulted in the lowest number of black alerts (which signify extreme pressure) ever.

The NHS faces unprecedented challenges over the next few years, with a move to personalised service with the core purpose to improve health outcomes for NHS patients. In addition, NHS Norfolk must ensure excellent services continue while supporting the major structural change set out in the Health and Social Care Bill.

The requirements of the National Operating Plan 2011/12 are still in-line with our strategic objectives in 'Bold and Ambitious'. Therefore, we will continue to deliver improved outcomes for patients through care closer to home by greater personalisation and choice, and deliver services with the right care at the right time, in the right place. To continue this service transformation, the delivery of savings for re-investment remains important, both to make the necessary changes in light of rising demand and changing demography, but also to ensure our local system is transferred to GP Consortia on a strong financial and service footing.



A major challenge in 2011/12 is to lay the foundations for the new health and social care system set out in 'Equity and Excellence: Liberating the NHS', as well as making sure that day to day services are maintained. The cluster with NHS Great Yarmouth and Waveney supports this challenge and allows both of us to secure the capacity needed to deliver core services, while providing the flexibility needed to support GP Commissioning during this transition period.

The delivery of our strategic ambition and the clinical improvements set out in the East of England's clinical vision, 'Towards the best together' requires determination, particularly in the current economic climate. Our recent move to Delivery Units (see page 16) supports the need for this focus and accountability, and the transition to GP Consortia.

The 2011/12 Operating Plan sets out these three main focus areas: continuing to deliver high quality care for patients, our plans for improved efficiency and service reinvestment and our plans for transition and reform. These are supported by enabling plans such as HR, finance, IT and emergency planning and performance.

During 2010/11 we have set the foundations for improved focus and accountability through the establishment of Delivery Units. These new structures will be critical to the delivery of the National Operating Plan in 2011/12 and the increasing involvement of the emerging GP Consortia.

Caring for our environment

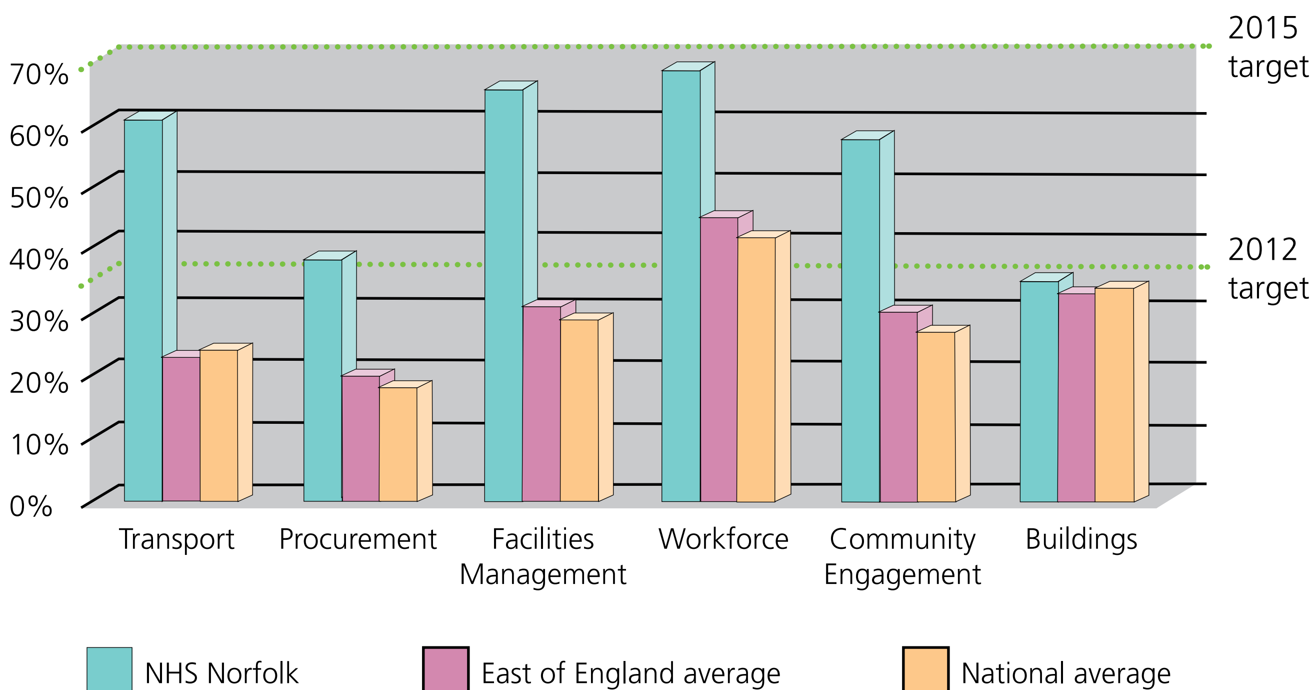
NHS Norfolk commissions for sustainable development to benefit staff and patients, and save resources and money. We have worked closely with providers of health services to make sure that their role in improving the sustainability of healthcare is carried out.

The NHS Carbon Reduction Strategy gave the NHS a mandate to reduce its carbon footprint. Cutting carbon emissions is a legal requirement, with the UK Government committed to a 34% reduction in emissions by 2020 and an 80% reduction by 2050.

During 2010/11 we have:

- Used our buying power to minimise our carbon footprint.
- Maintained our Sustainable Development Management Plan.
- Maintained our scores for the Good Corporate Citizenship Assessment model – see chart on page 10.
- Set a Carbon Footprint baseline (2007 = 2,146 tonnes of CO_2e). This enables us to monitor our energy usage now and take steps to reduce it in the future (for example, via our Cycle to Work scheme and the assurance from our main provider of services that they are compliant with BS2014).
- Developed a Sustainable Development Health Leads Forum with our partners to share best practice and encourage sustainable action.
- Actively participated in Carbon 10:10 and WWF Earth Hour to raise carbon awareness within the organisation. Early indications show a minimum reduction of 6% during 2010.
- Encouraged staff to improve the quality and sustainability of our services and those we commission. Ideas are investigated for their cost effectiveness as well as sustainability. One idea relates to the way we use printers which could save the organisation £30,000 a year.

During 2011/12 we will encourage GP Commissioning Consortia to commit to the Sustainability Agenda and provide them with the tools to do this.



Good Corporate Citizen NHS Norfolk Assessment
compared with East of England and national averages
2015
target
2012
target
70%
60%
50%
40%
30%
20%
10%
0%
Transport
Procurement
Facilities Management
Workforce
Community Engagement
Buildings
NHS Norfolk
East of England average
National average

Equality and diversity

Equality and diversity are fundamental to the achievement of our vision. We recognise that this is a huge agenda for the organisation and we are committed to meeting our statutory obligations as a commissioner of healthcare and as an employer.

In preparation for the Equality Act 2010 and the new Public Duties, we have extended our commitment to include age, religion and belief and sexual orientation. We have updated our Single Equality Scheme Action Plan and we are preparing for the NHS Equality Delivery System. Our Single Equality Scheme is evolving into this new system as stated on our website.

We continue to have Black and Minority Ethnic (BME) and Lesbian, Gay, Bisexual and Transgendered staff networks, and have established a network for our staff with disabilities and long-term conditions. This not only aims to promote, support and celebrate diversity in the workplace, but also gives staff a voice on the equalities agenda. To this aim, NHS Norfolk took part in the Stonewall Workplace Index as part of their Diversity Champions Programme and we will be developing a strategy to improve our placing for the next entry. NHS Norfolk is also taking part in the Stonewall Health and Wellbeing Project.

As a member of the Race for Health Programme, NHS Norfolk commissioned a BME Health Needs Survey and we are working on delivering the recommendations from this project. The findings from this report will be incorporated into the Eradicating Racism in Norfolk NHS (ERINN) 2011 report. We are leading on this project (an update of the 2001 ERINN report) which will give a picture of how far the NHS in Norfolk has travelled regarding race equality and whether we still have further to go.

We continue to work in partnership with the Norwich and Norfolk Racial Equality Council (NNREC) to ensure that equality and diversity is embedded in all our work. The NNREC is supporting us to develop and implement the NHS Equality Delivery System and the new public sector equality duty applicable under the Equality Act 2010.

In-line with the NHS Constitution, NHS Norfolk is committed to ensuring that all our staff have the skills, knowledge and support to commission services that are fair and equitable while respecting individual needs regardless of race, disability, age, gender, sexual orientation, or religion or belief.

NHS Norfolk has been a major stakeholder in the INTRAN (Interpretation and Translation for Norfolk) partnership which continues to address the needs of people who cannot speak English, whose first language is not English or who are deaf or hard of hearing.

Commissioning quality improvement

NHS Norfolk leads quality improvement across Norfolk to make sure the care and services that we commission are safe, effective, of high quality and that risks are reduced and patients are treated with respect and dignity.

In 2010/11 several elements were reviewed to strengthen our approach and delivery to quality improvements; for example:

Quality: Quality and safety improvements are essential as we continue to develop our NHS as a health system. The economic pressures facing the NHS will put increasing pressure on services, and measurement will be vital for monitoring safety and quality to improve productivity and efficiency. Within this context we need to recognise that we can only improve what we can measure; to do this we need to consider quality in relation to patient safety, clinical effectiveness and patient experience.

Board reporting: New terms of reference have been developed for the Quality and Patient Safety Committee as a formal subcommittee of the Board. The chair of the committee also reports to the Audit Committee to strengthen governance processes. The Board receives a report on the quality and safety of services commissioned every other month.

Quality monitoring and reporting: Arrangements have been strengthened through provider reporting, announced and unannounced visits and patient experience.

Quality accounts: It is a statutory responsibility for providers of acute, community, mental health, learning disability services and ambulance services to produce and publish a Quality Account. The accounts aim to:

- Increase NHS accountability by making a greater level of information about the quality of healthcare services available to the public.
- Support provider boards and senior managers to focus on quality improvements by assessing and reporting nationally on quality across the range of their services and state where and what improvements they intend to make.

Quality accounts have been developed by our main NHS providers. NHS Norfolk verified and commented on the content of each provider account and ensured all commissioning board members were aware of these.

Patient experience: We monitor the results of national inpatient surveys and NHS Choices to improve services and overall patient experiences within provider organisations. Trends and numbers of complaints and PALS issues are closely monitored and acted upon (see pages 31 – 35).

Quality and Patient Safety Team: The team has two additional posts to support mental health, prisons and acute quality and patient safety. Serious incident reporting and monitoring now sits within the team.

Contracts: The quality schedules within contracts have been strengthened to support provider quality improvement and provider reporting.

Clinicians at the forefront of decision making: There has been a stronger commitment to clinical leadership and engagement.

Privacy and dignity: We are working to eliminate mixed sex accommodation. Clinical members of the quality and patient safety team are involved in provider privacy and dignity meetings, monitor same sex accommodation, provider compliance and make unannounced visits to monitor concerns.

Safeguarding: A Safeguarding Adult Integrated Board has been developed with the local authority and other stakeholders. A deputy designated safeguarding children's nurse was appointed to provide additional support, in particular, to looked after children. This year NHS Norfolk has been working closely with partners to strengthen our approach to supporting victims of sexual assault and domestic violence.

Evidence-based practice: Knowledge Management is a web-based local clinical and management service that supports clinicians to refer people to appropriate services within Norfolk and parts of Suffolk. The site also provides access to all national and local clinical guidance and policy.

Emergency preparedness

When disaster strikes - or when health services are stretched - NHS Norfolk's role is to lead and co-ordinate the health response. Twice during the year we planned and rehearsed for major incidents and three times we were tested for real:

- Swine Flu eased by the beginning of the year although the World Health Organisation did not declare the Pandemic over until 10 August 2010.
- Swine Flu returned as the prominent flu virus this winter, as predicted. NHS Norfolk responded to reports that there were not sufficient supplies of vaccines by establishing actual stock levels and redistributing vaccine to meet demand from all patients in the 'at risk groups'.
- Also this winter, the extremes of cold weather and snow tested health systems to the full. Proactive communication of advance severe weather warnings improved levels of preparedness, enabling health organisations to maintain critical services.
- We took part in two national exercises: Exercise Black Gold tested our response to the implementation of the National Emergency Plan for Fuel, while Exercise Watermark was the largest national exercise ever planned. Watermark was in response to one of the Pitt Review recommendations from recent national flooding experiences and particularly relevant to Norfolk.

The recent Health White Paper setting out the future for Public Health in England gives a clear indication that health emergency preparedness remains a critical function for all organisations. It looks likely that emergency planning will be a function of the newly formed Public Health England with some elements delivered by local authority public health teams.

NHS Norfolk has a statutory responsibility as a Category 1 Responder under the Civil Contingencies Act 2004. Our Major Incident Plan and Action Cards follow the principles for a lead PCT set out within the NHS Emergency Planning Guidance 2005 and can be found at: www.norfolk.nhs.uk/emergency-planning

How we work

About commissioning

NHS Norfolk has been undergoing a period of significant organisational change and has recently restructured the way we commission services to better position the organisation to improve local health and health services and to be better prepared for the changes set out in the Health White Paper.

Over the past year Programme Boards have helped to focus the work of NHSN and have had a number of successes, but the need to move more resources and provide support to GP commissioners necessitated a move to a different way of working as part of this transition. As such, four Delivery Units replaced the Programme Boards from November 2010. These Units are:

1. Out of Hospital Care
2. West Norfolk
3. Central Norfolk
4. Mental Health

In addition, in April 2010, NHS Norfolk and Norfolk County Council entered into an agreement to build on existing joint working, integrating the commissioning of all out of hospital, mental health, learning disability, substance misuse and social care commissioning.

These changes are consistent with the themes of the Health White Paper around putting patients first, improving healthcare outcomes, increasing autonomy, accountability, cutting bureaucracy and improving efficiency.

Improving patient care

Delivering "Bold and Ambitious"

The way that patients in Norfolk receive their healthcare is changing as we begin to innovate new services with our partners in GP consortia and NHS Trusts.

There is an increasing amount of provision in the community setting and ensuring admissions to acute settings are appropriate, as we set out two years ago in 'Bold and Ambitious'. Our aim is to deliver greater productivity in the system and make more effective use of our money. But above all, our emphasis in commissioning health services for the population we serve is on quality of patient care.

There has been a nationwide drive to modernise the NHS through Quality, Innovation, Productivity and Prevention. NHS Norfolk and its partners have collaborated to use this as an opportunity to deliver our long-held strategic objectives.

Below are some of the ways we are changing the NHS together.

Dementia Intensive Support Team

A 7-day-a-week service provided by Norfolk and Waveney Mental Health NHS Foundation Trust. They provide immediate, practical support to dementia patients at home, when crises occur, to help them continue to live well.

Enhanced recovery for patients – Norfolk and Norwich University Hospitals NHS Foundation Trust

Patients are up and walking within hours of a knee or hip replacement and can go home in half the time. Colorectal (colon and the rectum) surgeons are also piloting a similar project.

Tilney Ward

Tilney Ward at the Queen Elizabeth Hospital, King's Lynn, opened as a 20-bed community ward for a three month pilot. It aimed to provide 'in-reach' from community nursing teams, reduce length of stay and provide an alternative to community care.

Front of house GPs

GPs were integrated into the Medical Admissions Unit at the Queen Elizabeth Hospital, King's Lynn and A&E at the Norfolk and Norwich University Hospital in pilot schemes to explore whether there are good alternatives to admission.

To summarise, the rising population - and rising number of older people in our community - means that if the system does nothing and demand continues to rise as projected, the financial pressure on providers and commissioners combined will hit £184 million within the next four years.

Therefore productivity opportunities are being focused on three main workstreams: the area served by the Norfolk and Norwich University Hospital, the area served by the Queen Elizabeth Hospital, King's Lynn and opportunities for the whole health system.

Some of the key innovations to date are described elsewhere in this report; for example, the frail/older people project on page 19 which is instrumental in delivering more care closer to patients' homes.

Referral Management Centres

The first two established in north and south Norfolk, run by GP practices to peer-review referrals into secondary care. They make sure referrals follow best practice and inform further improvements to patient care.

Finding the right care

A study has been launched to find better ways of caring for people who frequently turn up at hospital - when more appropriate care can be found elsewhere.

Integrated care for frail/older people

NHS Norfolk is investing £4m into developing a better way of caring for older and more frail patients, working closely with GP practices, community nursing teams and social care. It is preventing hundreds of avoidable admissions to hospital.

Patients who need closer support to prevent them from having 'episodes' are identified by integrated healthcare teams based at GP surgeries. In Norfolk, we estimate that there are about 2,000 patients who have complex health and social care needs. They might be prone to falls, have heart and lung conditions or frequently fall ill with infections.

They are then allocated a 'Case Manager', a community nurse or matron, who works closely with the GP practice, social care and other health services to keep the patient well and living safely at home where they want to be.

Other clinical staff, including Medicine for the Elderly consultants are also involved to make sure there is a joined-up approach to care.

"It has worked very well for me. I have had a lot of help."
Sheila Leach, from Mundesley, is in her 80s.

Acute community beds

But what happens when the patient really does need a hospital bed? There are in the region of 21 'step-up' or 'acute community care' beds in community hospitals or nursing homes around Norfolk. These allow patients who are too ill to be at home, but not ill enough to need a stay in a large hospital to receive intense care for a few days.

Evidence suggests that patients appreciate care closer to home where family members can visit easily and recovery rates are improved.

This 'acute bed' was pioneered by a team led by Anne Stairs at Thorpewood Medical Group using a bed at Woodside House Care Home in Norwich.

Patient Ken Redgment said after his stay there: "The bed was nearer to my home than the hospital so my wife could visit me more often, so I liked that. And the nice thing about it was that the nurse came across a couple of times a day to see me and make sure I was alright."

Telehealth

A number of patients across Norfolk are being provided with 'assistive technology' which means that health and care staff can monitor patients' conditions from a distance.

The joint project involves NHS Norfolk, Norfolk County Council and Norfolk Community Health and Care NHS Trust (NCH&C). The equipment is used by patients in their own homes to check aspects of their condition, such as their weight and blood pressure, with the results sent electronically to one of NCH&C's specialist clinicians who keep a check on their progress.

Clive Wilkinson uses the technology to record his weight, blood pressure, blood oxygen levels and pulse every day, with one of NCH&C's Community Matrons monitoring changes to Clive's readings from their base in Norwich.

Clive said: "I like knowing that Fiona is keeping up-to-date with my condition without needing to wait for her to come to the house to do tests every day. I have the freedom to do what I want with my day, safe in the knowledge that I'm still being cared for."

Improved access to psychological therapy in Norfolk

A new 'Norfolk Wellbeing Service' aimed at people with mild and moderate depression, anxiety or a phobia was commissioned in mid 2010. The service is being provided by Norfolk and Waveney Mental Health NHS Foundation Trust working in partnership with Mind, the Mancroft Advice Project and Relate.

The forerunner to this service was introduced more than a year ago, under the banner of 'Improving Access to Psychological Therapies' (IAPT).

Patients can self-refer or be referred by their GP and access services, such as counselling or Cognitive Behavioural Therapy.

Since June 2009, 3,097 people have completed their treatment. One of them, Jan, who lives in North Norfolk, said: "I don't know what I would have done without IAPT".

"Things were wrong, I knew I was ill but I was not going to acknowledge it. My doctor told me I would benefit from IAPT and I did. I was having nothing but negative thoughts but IAPT helped me to have positive thoughts."

Partnership working improves treatment for people with eating disorders

> "I have found the Norfolk CEDS team to all be very friendly and approachable to speak to about things, and then in identifying and providing the appropriate form of treatment for me from what they have available." - patient

Cambridgeshire and Peterborough NHS Foundation Trust has provided community eating disorder services for local people since January 2011.

Norfolk Community Eating Disorder Service (Norfolk CEDS) works in partnership with beat (Beating Eating Disorders), a leading UK charity, to provide a service for adults over 18 who have a primary diagnosis of moderate to severe eating disorders.

Eating disorders are complex psychological conditions that can have a huge impact on individuals, families and carers; however, quicker access means that people receive care and treatment before their illness becomes too severe. Norfolk CEDS currently offers an assessment within four days for urgent referrals or within 28 days, depending on individual clinical need.

The beat helpline, internet-based information and support groups, are available to anyone in the NHS Norfolk area who needs advice and support with eating disorders.

Start4Life

In June 2010 the East of England breastfeeding framework was launched in Norfolk, setting out how mums can be supported to breastfeed their babies.

It coincided with the Norfolk launch of 'Start4Life' which aims to promote breastfeeding and the introduction of solid food and physical activity to give babies the best start.

NHS Norfolk has provided small grants to help fund a number of events promoting Start4Life to parents – including sessions organised by Young Fathers for Young Parents at the Mancroft Advice Project in Norwich.

The breastfeeding framework includes actions for Primary Care Trusts and their partners and service providers. The Framework can be found on the NHS Norfolk website at: www.norfolk.nhs.uk/breastfeeding-your-baby.

Equal access to health care

More than 120 people with learning difficulties/disabilities and their carers took part in a Big Health Check Day in Norfolk. There was a chance to have a blood pressure check and find out more about anything from hand hygiene to aromatherapy to mental health.

The Big Heath Check is part of the integrated work in the delivery of the Norfolk Learning Disabilities Health Action Plan. Our goal is to improve access to everyday health services for people who have learning difficulties.

For 2011 the three key aims of the Action Plan are:

1. **Information:** more easy-to-understand information.
2. **Health Books:** make sure everyone with learning difficulties/ disabilities has a Health Book containing their personal health information and needs.
3. **Consent:** people with learning difficulties/disabilities have the right to make choices.

Sophie Tarsey from King's Lynn quit smoking thanks to her NHS Norfolk Health Trainer, James, after years of trying.

Ewa Wilson quit with help from the Health Trainers – and saved £600.

Stubbing out smoking

This year NHS Norfolk has helped 5,033 people quit smoking. That's a record – 13.5% up on last year.

We have put some important initiatives in place including:

- Continuing our partnership with Norfolk Community Health and Care NHS Trust to provide the Smokefree Norfolk service.
- Stop smoking services from META in Thetford for migrant workers.
- Signing up GPs, pharmacists and some dentists to promote and support stop smoking services among patients.

24/7 palliative care

NHS Norfolk commissioned the East Anglian Children's Hospice (EACH) at Quidenham to provide on-call specialist nursing at home for children who are nearing the end of life.

Hospice nurses bring palliative care, management of symptoms and support at home whenever it is required, day or night. It comprises a formal home visiting service, staffed by their own paediatric nurses, with the aim of being on the doorstep within four hours.

The service started in June 2010 and in that time 16 children have been looked after. Feedback from parents using the service has been very positive.

Intermediate care at North Walsham and Aylsham

Building work began at North Walsham to renovate Rebecca House (£1.69 million). We also forged ahead with plans to build a 24-bed ward (£3.7 million) to be open in winter 2011/12, creating an additional six beds and developed plans to make sure the much-loved war memorial stays on the site.

The development at North Walsham and District War Memorial Hospital was one of the milestones required before St Michael's Community Hospital in Aylsham could be closed, in-line with the Intermediate Care Review of 2007.

Aylsham Care Trust has played a pivotal role as our partners in developing the St Michael's site to put in place mitigating measures and improvements to facilities including:

- The commissioning of nine nursing beds in the new St Michael's Court Care Home.
- Developing an NHS physiotherapy suite within St Michael's Court Care Home.
- Building a new health centre and community centre.

Developing stroke care

One of the major priorities for NHS Norfolk – and indeed the Eastern region – has been to improve pathways and care for stroke patients.

Up to this year we made notable strides, such as the opening of a specialist stroke rehabilitation unit at Norwich Community Hospital in January 2010 and the introduction of 24/7 thrombolysis in Norwich in June 2009.

This year we put in place another major piece in the jigsaw, a 24/7 thrombolysis service at the Queen Elizabeth Hospital, King's Lynn. A weekday service was already in place there. Thrombolysis involves giving patients drugs to break up blood clots which have travelled to the brain and are stopping blood from flowing freely. Of course, preventing strokes from occurring is a major priority for us.

55 GP Practices in Norfolk have run Atrial Fibrillation screening for their patients. This involves taking a pulse to detect any irregular rhythms which might identify those people at higher risk of having a stroke.

A total of 50,008 patients were screened. We estimated more than 300 patients would have been diagnosed with atrial fibrillation, leading to further medical care. We have re-commissioned this service for 2011/12.

FAST 'saved me'

When John Alexander, 75, of Norwich, suffered a stroke last year, his wife Maureen remembered the FAST message and dialled 999. Thanks to Maureen and FAST he has made a remarkable recovery:

- Face
- Arm
- Speech
- Time to call 999

For more information about FAST visit: www.norfolk.nhs.uk/stroke

Norfolk Community Health and Care

Looking after you locally

Norfolk Community Health and Care NHS Trust (NCH&C) provides over 70 community-based NHS services to around 850,000 people in Norfolk.

The Trust is part of the NHS and delivers NHS health and care to local people. The organisation achieved independent NHS Trust status on 1 November 2010, marking its formal separation from NHS Norfolk. Prior to this, NCH&C was an arms-length provider organisation of the PCT and part of its many predecessor NHS organisations - meaning NCH&C has a long history of delivering excellent services locally.

NCH&C manages and runs 12 community hospitals, as well as providing 74 different health and care services to the people of Norfolk.

These services include community nursing, health visiting, school nursing, speech and language therapy, stroke rehabilitation, podiatry services, stop smoking services, services for vulnerable people, diabetes services, and specialist palliative care services. NCH&C provides services to patients in community hospitals, outpatient units, GP practices, health centres, and even within patients' own homes.

Following consultation with staff and patients, NCH&C developed the values and behaviours which people said they would most want their community-based NHS Trust to work by, and the values include:

- **Home and community** – NCH&C exists to improve the lives of its patients wherever and whenever they need care.
- **Personalised care** – The Trust is committed to providing safe, excellent care and strives to understand each individual patient's total needs, joining up their health and care across different providers.
- **Enabling our people** – NCH&C values and develops staff expertise and commitment.
- **Pioneering** – The Trust make it easy for creativity and leadership to flourish and is determined to break down all barriers to improved care and value for money.

Looking to the future, NCH&C is aiming to become a Community Foundation Trust during 2012 which will give patients, local communities and staff an even greater say in how it delivers services.

As part of this move to become more locally owned, NCH&C is also recruiting people to become members of the Trust and even to consider standing to be elected onto its Board of Governors. Members and Governors will be able to have a say in the direction of the organisation and ensure the Trust continues to make decisions which will benefit patients locally.

To find out more about NCH&C, its services and its plans for the future, go to:
www.norfolkcommunityhealthandcare.nhs.uk

Involving and listening to you

How we involve patients and carers

NHS Norfolk is committed to involving patients and carers in the decision-making process around the services we commission. The NHS Constitution has underlined the importance of local Patient and Public Involvement and Engagement (PPIE) work in one of its seven principles which says that:

"NHS services must reflect the needs and preferences of patients, their families and their carers. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment."

Local patient and carer views have been gathered through NHS Norfolk's PPIE work and have influenced our overall vision and goals, as well as our day to day business.

Here are a few examples to show how we have listened or responded to local people over the last year.

Listening to local people

Norfolk Citizens Panel and 'Your Voice'

NHS Norfolk continues to be a partner in the Norfolk Citizens Panel. The panel is made up of a group of local people who are surveyed several times a year by organisations wanting to hear their views.

Over 7,000 Norfolk people sit on the Panel, which makes it one of the largest in the country. Nine local organisations work together to run it to help them improve their services, including Norfolk County Council, district councils and Norfolk Constabulary. Over the past twelve months we asked members of the panel questions around stop smoking services and pharmacy services, among others.

NHS Norfolk has continued working with Norfolk County Council's Adult Social Services Department and the Norfolk Local Involvement Network (LINk), in running the joint Involvement Register called 'Your Voice' which is thought to be one of the first schemes like this in the country.

This exciting project gives people who receive their health services from NHS Norfolk and their social care services from Norfolk County Council, the opportunity to sign up to a Register of Involvement and get involved in a wide variety of education, involvement and consultation opportunities.

We are currently working with partners to look at linking the register with the Norfolk Citizens Panel to improve ways of involving patients and public in both health and social care commissioning.

North Walsham Health Campus

The North Walsham Health Campus, approved by the NHS Norfolk Board in July 2008, will see a range of existing and new services under one roof, including an inpatient unit with 24 beds.

To ensure NHS Norfolk involves local people in the development of the new health campus, a Community Involvement Panel (CIP) was set up. The panel is made up of representatives from local voluntary and community organisations, as well as the public sector:

- League of Friends of North Walsham Memorial Cottage Hospital.
- Mundesley Medical Centre Patient Participation Group.
- Norfolk Constabulary.
- North Norfolk District Council.
- Stonham Homestay.
- Norfolk Older People's Forum.
- Voyager Community Group.
- Churches Together, North Walsham.
- North Walsham Town Council.
- North Walsham Area Access Group.

As part of its role to involve the local community, the CIP looked at possible services to be delivered on the site and then asked local people if these proposals were right.

During 2010 the CIP worked on phase two of the involvement process which let local people know what we have done as a result of what they said in phase one. To achieve this, the CIP, with the help of the engagement department, developed publicity materials for a series of exhibitions in North Walsham and District. The exhibitions gave members of the public an opportunity to tell us what they thought about the plans for the refurbishment of the Rebecca House building and the plans for the new 24 bed unit.

Following the events, and working with the CIP, we produced another document to let the public know what we were doing as a result of what they had said. For more information, visit the NHS Norfolk website: www.norfolk.nhs.uk .

The CIP are currently working on the arrangements for the official opening of the site in winter 2011/12.

Local Involvement Networks (LINks)

Members of the Norfolk Local Involvement Network are key members of NHS Norfolk's decision making process, with a member on the main Board, and the new Delivery Units at NHS Norfolk ensuring that the patient voice is heard in all planning and decision making. The LINk is also a partner in the 'Your Voice' involvement register and membership scheme.

Patient Participation Groups

NHS Norfolk has been locally, regionally and nationally recognised for its work to encourage and support the development of Patient Participation Groups (PPGs) in GP surgeries. The NHS Norfolk 'Step By Step Guide to Setting up a Patient Participation Group' is being used as an example of best practice across the NHS. The guide offers practical guidance to staff in general practice and patients who are interested in getting more involved with their local healthcare by setting up a PPG.

PPGs are seen as a way of involving people in local healthcare decision-making, and the guide offers ideas on how to get going. It also gives an overview on how NHS Norfolk supports the development of new PPGs, and helps existing groups breathe new life into the work they do. We are updating the guide to include examples of good practice – coming summer 2011.

To assist with the development of new PPGs and build on strengthening current PPGs, we have produced a DVD showing the benefits to both patients and practices; a copy has been sent to every GP practice and is also available to view at: www.youtube.com/user/norfolknhs.

Aylsham Health Campus

Following extensive public involvement through a telephone survey and questionnaire, NHS Norfolk produced plans to redevelop the Aylsham Hospital site. The plans were published for the development of a health campus fit to deliver health services in the 21st Century with our partners, including Aylsham Care Trust.

More information

Full details of all of the work we have undertaken can be found on our website: www.norfolk.nhs.uk .

Compliments, comments and complaints

Serving our customers

NHS Norfolk reviews its complaints handling policy to make sure that all patients, families and their carers are able to easily feedback their compliments, comments, concerns and complaints to NHS Norfolk. This information helps us to commission healthcare services across Norfolk that meet patients' needs and expectations.

As part of this feedback we take every opportunity to learn from patients' experiences. Most patients want an explanation of what has happened, why it has happened and reassurance that the service is improved, wherever possible, to ensure that others do not have a similar experience.

NHS Norfolk will liaise closely with GP Consortia as they develop to make sure that the handling of patient feedback is effective and continues to be part of commissioning in the future.

Compliments

During the year NHS Norfolk has received 17 compliments as a commissioner of services. These compliments were mainly directed to the Continuing Healthcare Department and the Patient Advice and Liaison Service. We also received four compliments which were passed on to the providers concerned.

Complaints

The commissioning arm of NHS Norfolk received 256 formal complaints and 318 informal queries between 1 April 2010 and 31 March 2011 (167 of which were complaints about independent contractors). We continue to respond to all complaints as quickly as possible, ensure that a full investigation is completed and all concerns are addressed. In those cases where a complex investigation is needed and/or the investigation involves several healthcare organisations, NHS Norfolk takes the lead role as investigator but ensures that the complainant is fully informed about any delays.

During the year we responded to 28 letters from MPs on behalf of their constituents and 73 of the informal queries were from MPs.

NHS Norfolk signposts all complainants to support available from the Independent Complaints Advocacy Service (ICAS) and, in addition, a team of independent conciliators is available to help resolve complaints, where appropriate. During the year ICAS has supported four complainants and the independent conciliators team has helped to resolve one complaint.

The following provides some examples of actions taken during the year:

- A revised appointment service in some GP surgeries.
- An improved referral system in a GP practice.
- A reminder to staff to deal with patients in a sensitive manner.
- Clear information given to patients where there is a new provider of the local GP service.
- Improved communication to patients as a result of their treatment being reviewed by the Prior Approval Scheme.
- GPs to provide written instructions to patients about medication.
- Unannounced visits to acute hospitals as a result of concerns about nursing care.

All complainants are advised that they can contact the Health Service Ombudsman to request a review of the complaint handling once the local resolution stage has been completed. During the year NHS Norfolk is aware that five complainants have contacted the Ombudsman's office, but none of these contacts have resulted in an investigation by the Ombudsman.

Principles for remedy

NHS Norfolk's Complaints Handling Policy incorporates the Parliamentary and Health Service Ombudsman's Principles for Remedy: getting it right, being customer focused, being open and accountable, acting fairly and proportionately, putting things right and seeking continuous improvement. We continue to ensure that these Principles are followed by staff when handling complaints.

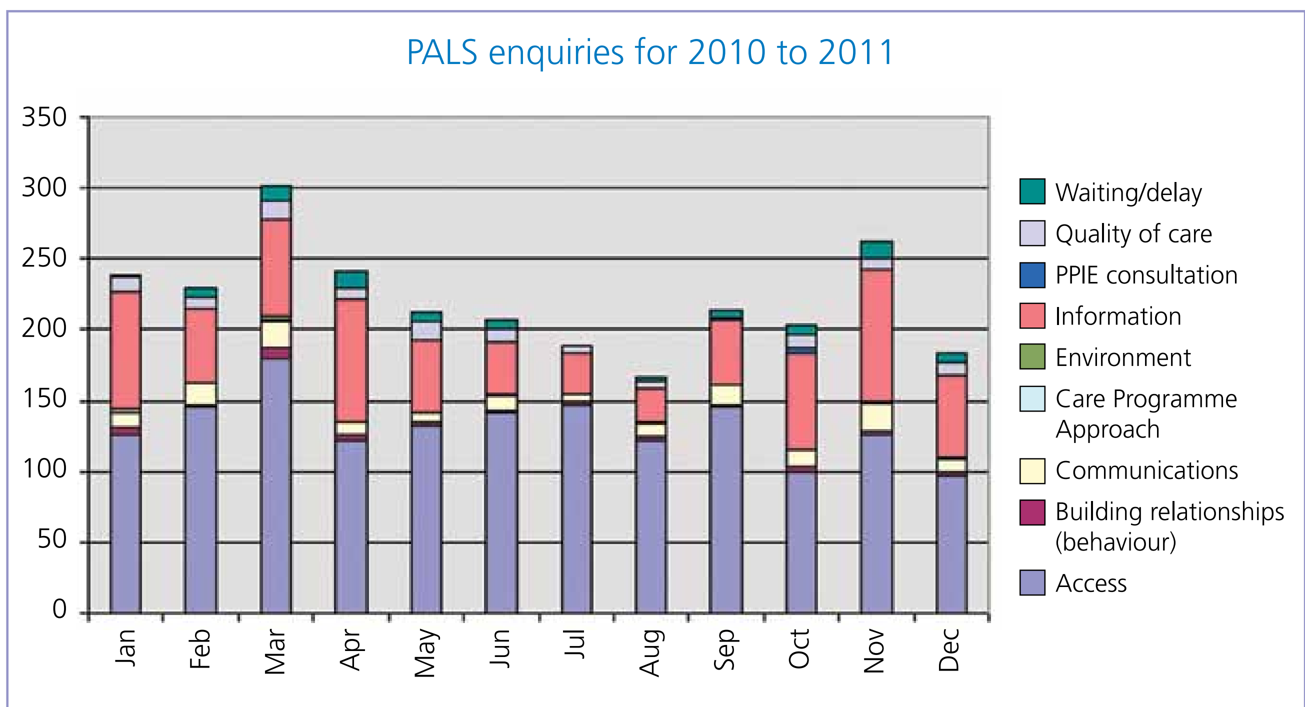
Public spending and reporting

As a public body, NHS Norfolk complies with the Treasury's Guidance on Public Spending and Reporting (Appendix 6.3) with regard to setting charges for information, should this be necessary at any time.

However, NHS Norfolk makes every effort to make sure that as much information as possible is available free of charge to the public via our website (www.norfolk.nhs.uk). This includes information about our activities and services, consultation papers and all responses to requests received under the Freedom of Information Act 2000.

Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service (PALS) provide advice and information for patients, their carers and families about healthcare and NHS services. NHS Norfolk highlights PALS contact details in press releases and patient information, particularly when a new service is introduced.



Between 1 April 2010 and 31 March 2011, PALS handled a total of 2,649 enquiries of which 83% were responded to within one working day.

The promotion of the PALS telephone number as a 'one stop shop' for dental queries continues to be successful and makes sure that NHS Norfolk meets the Strategic Health Authority pledge that NHS primary dental services are available locally to all who need them. A representative from PALS attends NHS Norfolk's Dental Action Group which ensures that any gaps in the provision of NHS Dental Services, as identified through patient contact, is fed back to the dental commissioning/contracting team.

In addition, PALS has provided help and advice to patients as follows:

- How to develop a Personal Health Plan.
- Registering with a GP.
- Patients from overseas needing healthcare and patients returning from abroad seeking a continuation of healthcare.
- How to find a domiciliary dentist and local optician.
- Where to get a chlamydia screening pack.

As part of its work to promote the service PALS officers attended the Royal Norfolk Show, the South Norfolk Show, gave talks to carers' groups and undertook a question and answer session on BBC Radio Norfolk.

We have continued to make sure that all patients can access NHS Norfolk PALS. To help with this we have published an 'Easy Read' leaflet which is available on the NHS Norfolk website:
http://www.norfolk.nhs.uk/resources/pdf/polproc/Complaints-booklet-easy-read.pdf

We also have information on PALS and how to provide feedback on the healthcare services we commission available in a number of different languages.

Our staff

The successful authorisation of Norfolk Community Health and Care (NCH&C) as an NHS Trust on 1 November 2010, resulted in the transfer of approximately 3000 staff to the new Trust. NHS Norfolk employed 349 staff focused on commissioning NHS services from November 2010.

Our commissioning staff in Norfolk

In light of the Government Health White Paper announcing the intention to abolish Primary Care Trusts by March 2013, the NHS Norfolk Workforce team has focused on ensuring that the people of Norfolk do not lose the expertise that has been built up in the commissioning staff and that they are developed to prepare them to support GP-based commissioning in the future, or for their departure from NHS Norfolk. At the same time we will make sure that NHS Norfolk continues to not just meet its legal obligations to its staff but to improve its employment offer.

During the last year NHS Norfolk began a three stage change programme. This has resulted in staff working in new ways and the departure of a number of staff both through a Mutually Agreed Resignation Scheme (MARS) and through compulsory redundancy. Stage three of the change programme will run into 2011/12 and beyond and will focus the organisation on supporting the future GP-led commissioning of healthcare. NHS Norfolk has begun to deliver a plan to develop and support our staff through this process.

Supporting staff through change

Health and wellbeing: NHS Norfolk is committed to the national 'Staying Healthy at Work' programme, making available a range of activities and services for our staff, including stress management workshops.

Occupational health (including counselling): We have developed and expanded our occupational health services to ensure that these aspects of staff health and wellbeing are addressed.

Redeployment: We have developed systems to increase redeployment opportunities that we may be able to arrange internally.

Training and related support: NHS Norfolk is committed to providing its staff with every opportunity for securing future employment within the NHS and has commissioned the following services for staff:

- A support website, with access to online learning and development modules, job search, other specialist advice and presentations.
- Career Support Workshops, including: CV writing and selling yourself, Interview techniques and an introduction to competencies, and Job search techniques and networking.

Norfolk Leadership Academy: Through our membership of the Academy - an initiative which is about supporting and developing current and future leaders in the NHS - we have delivered a range of developments to make sure that line managers can effectively support staff through change.

Pensions clinics: For staff who wish to consider their retirement options.

Information to, and consultation with, staff: A wide range of information channels are used, including regular face-to-face briefings, such as: the weekly Chief Executive briefings, directorate meetings, Staff Management Council, Communications Champions Forum and staff appraisals. There are also electronic briefings, such as: the weekly staff bulletin, intranet and emails. Consultations are carried out via questionnaires and the annual staff survey.

Continuing to develop our 'employment offer' to our staff

Staff appraisals: We are proud to have achieved a 94% coverage rate for appraisal in 2010/11, exceeding our target of 90%.

Talent and leadership development: A number of our managers undertook our 'Transforming Leaders in Commissioning' programme. This programme developed these staff against both NHS Leadership Qualities Framework (LQF) competencies and world class commissioning skills.

Training and development: We have implemented our learning and development policy, with an emphasis on e-learning and our programme of 'learn bites' which are quick and focused learning tools for managers. During 2010/11 we started an apprenticeships programme for staff in Bands 1 to 4 to develop their 'on the job' skills.

Celebrating high levels of performance: We have successfully launched our staff 'Star of the Month' and 'Team of the Quarter' award schemes to recognise staff that go the extra mile in their contribution to the organisation.

Staff survey: Preliminary results of the 2010 Staff Survey gives an important insight into the views of our employees and shows that we have improved our performance this year in a significant number of measures.

This is remarkable, despite two years of steady improvement in our performance we had only reached a slightly below average position when compared to all PCTs by 2009. The early results from the 2010 survey has seen us improve substantially to a point where we are well within the average range when compared with other PCTs. We do not intend to be complacent with these results, but continue to aspire for ever higher performance.

The survey results have driven and focused our transformation plan and work plans in the past and will continue to drive us in the future.

Performance management: As well as celebrating success we also need to be clear with staff as to what acceptable levels of performance look like, and to support staff that suffer from any illness which prevents them from working.

The HR team has given managers employee relations support, regularly evaluating sickness absence records and assisting with appropriate action. We do continue to have some members of our staff who are very seriously ill and absent on a long term basis, but we are pleased that during the 2010 calendar year, which has been very challenging due to the changes in the NHS for many staff in terms of stress and motivation, we maintained our sickness levels at broadly the same low level as in 2009/2010.

Days lost through staff sickness in 2010	
Total staff	353
Total days lost	3,406
Average working days lost	9.65

Staff Management Council and Trade Unions: During the last year we have established our own Staff Side Committee. This has already developed into a valuable partnership between staff and senior management. To underline our commitment to working positively with unions, in partnership, we have encouraged union membership by supporting a series of recruitment days.

Recruitment and retention: We have continued to provide 'learn bites' for recruitment and selection, equality and diversity issues and shortlisting.

NHS staff in Norfolk

As the system leader for the NHS in Norfolk we take responsibility to provide strategic leadership in workforce development across all NHS organisations across the county. We deliver this via our County Workforce Group (CWG).

The CWG leads on the development and improvement of workforce planning, workforce development and design and in the education development and education commissioning for the NHS in Norfolk.

Workforce planning: This year has been key for the CWG as it has supported the development of system workforce plans to support the implementation of 'Bold and Ambitious' across the county.

Workforce development and design: The CWG has invested workforce development monies into initiatives to change the workforce to meet the needs of the future, such as the development of care home staff to be more confident in the management of people who are at the end of their life. We have also invested in trying out new roles to see how they can provide better care for patients.

The County Workforce Group has supported both the Health Innovation and Education Cluster in its work in developing staff and services for people with dementia and the Norfolk Leadership Academy to ensure that NHS leaders are equipped to lead the NHS through one of the biggest changes in the way the NHS works since its creation.

Education development and education commissioning: We continue to work with our universities and colleges to ensure that the people they train on our behalf for careers in the NHS are fit for purpose. We have also overhauled the way we develop our already qualified staff so that they can continue to provide high quality, safe services to our patients.

Who's who

NHS Norfolk is led by a Board which is chaired by Sheila Childerhouse who heads up the non-executive directors, all of whom are recruited from the local community by the NHS Appointments Commission.

The Board also consists of senior officers from NHS Norfolk, led by the Chief Executive, Andrew Morgan and members of NHS Norfolk's Clinical Executive Committee led by the Chair, Dr Ian Mack.

The role of NHS Norfolk's Board is to:

- Provide leadership.
- Make decisions about healthcare services and make sure that staff facilities and finances are managed properly.
- Work together as a team and take responsibility if things go wrong, as well as when they go well.
- Plan for the future so that services can be steadily improved.

The Board concentrates on the overall strategies for NHS Norfolk and makes sure that it meets its statutory, financial and legal responsibilities.

Board members

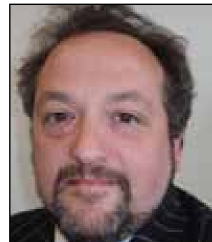
(Non-Executive Directors, Executive Team and representatives from the Clinical Executive)

Non – Executive Directors

Sheila Childerhouse
Chair:
(voting member)

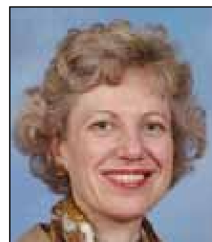
Marion Headicar
(voting member)

Jane Gurney-Read
Vice Chair:
(voting member)



Giles Bushby
(voting member)

Dr Edward Libbey
Audit Committee Chair:
(voting member)



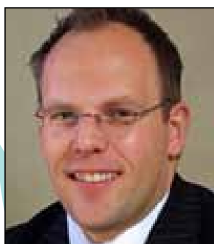
Hilary De Lyon
(voting member)

Executive Team

Andrew Morgan
Chief Executive Officer:
(voting member)

David Stonehouse
Deputy Chief Executive and Director of Finance:
(voting member)

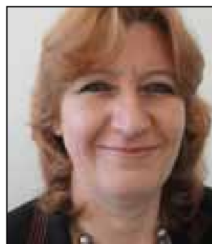
Ian Ayres
Executive Director – Central Norfolk Delivery Unit and Transition:
(voting member)



Paul Cracknell
Executive Director – West Norfolk Delivery Unit and Organisational Services:
(voting member)

Dr Jenny Harries
Joint Director of Public Health, NHS Norfolk and Norfolk County Council:
(non-voting member)

Maureen Carson
Chief Nurse and Director of Quality and Patient Safety:
(non-voting member)



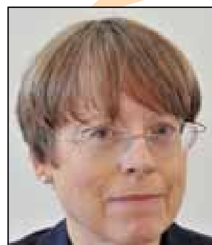
Anne Dray
Director of QIPP and Transformation:
(non-voting member)

Bryan Heap
Medical Director:
(non-voting member)

Jonathan Cook
Director of Corporate Services:
(non-voting member)

Representatives from the Clinical Executive

Dr Ian Mack
Chair of the Clinical Executive:
(voting member)



Dr Victoria Holliday
Joint Vice Chair of the Clinical Executive:
(non-voting member)

Becky Judge
Nurse Representative:
(non-voting member)

Other interests of Board directors (members)

The following declarations of interest are made:

Giles Bushby: Non-Executive Director
Director and Company Secretary of Fossil (UK) Holdings Ltd, Fossil (UK) Ltd, Fossil (UK) Stores Ltd.

Sheila Childerhouse: Chair of NHS Norfolk
Deputy Chair, East of England Development Agency; Trustee, Keysone Development Trust.

Paul Cracknell: Executive Director West Delivery Unit and Organisational Services
Director of charitable company/Trustee of Open Youth Trust.

Hilary De Lyon: Non-Executive Director
Honorary Fellow of the Royal College of General Practitioners; Member of the Labour Party; Chair of Labour Women's Network; Ordinand, Church of England.

Dr Jenny Harries: Joint Director of Public Health
Company Director, Movente Ltd.

Dr Victoria Holliday: Joint Vice-Chair of Clinical Executive
Salaried GP, Holt Medical Practice.

Dr Edward Libbey: Non-Executive Director and Chair of the Audit Committee
Chair, World Energy Solutions (US listed corporation).

Dr Ian Mack: Chair of Clinical Executive
Elected Council Member, King's Lynn and West Norfok Borough Council; GP Partner, Watlington Medical Practice; Director, Watlington Health.

Andrew Morgan: Chief Executive
Non-Executive Director, Health Enterprise East Ltd.

David Stonehouse: Deputy Chief Executive and Director of Finance
Director of Deafblind UK.

Our performance

Performance matters at NHS Norfolk

Performance improved in Norfolk in 2010/11, with significant progress in many key areas such as waiting times, stroke and cancer.

Last year we identified the change in performance in a range of indicators covering health improvement and treatment times.

For consistency, the same set of indicators is tabled below to demonstrate the continued year on year improvement.

Description	2009/10	Target 10/11	Performance 10/11	Change
Providing timely healthcare The percentage of people who were treated within 18 weeks from referral to treatment – admitted patients	90.24%	90%	93%	2.76% ↑
The percentage of people who were treated within 18 weeks from referral to treatment – non-admitted patients	97.9%	95	98.9%	1.00% ↑
The number of patients first seen within two weeks after referral by GP for urgent cancer	93.73	93%	97.7%	4.0% ↑
The number of patients spending 4 hours or less in all types of A&E department	98.5%	95%	98.0%	0.5% ↓

Description	2009/10	Target 10/11	Performance 10/11	Change
Improving Norfolk's health and wellbeing The average mortality rate per 100,000 for men	614.9		600.1	14.8 ↓
The average mortality rate per 100,000 for women	424.4		458.5	34.1 ↑
The actual mortality rate per 100,000 from cancer in people aged over 75	103.9		102.5	1.4 ↓
The actual mortality rate per 100,000 population from heart disease and stroke in people aged under 75	55.9		41.0	14.9 ↓
Percentage of children recorded as obese in reception year	8.8%	8.1%	8.7%	0.1% ↓
Percentage of children recorded as obese in year 6	17.7%	16.4%	16.8%	0.9% ↓
The number of smokers who successfully quit	4,434	5,928	5,033	599 ↑
The number of C. difficile infections from all patients aged 2 and above	331	239	312	19 ↓
The number of MRSA blood stream infections	26	22	27	1 ↑
Other measures Percentage of stroke patients who spend at least 90% of their time on a stroke unit	37.9%	80%	62.9%	25% ↑
Percentage of women aged 53-70 screened for breast cancer in the last three years	81.1%	80%	81.5%	0.4% ↑
The actual number of conceptions to 15 -17 year olds in the calendar year 2009 per 1,000 15 -17 year old population	34.4	26.6	31.1%	1.3% ↓

Performance in 2010/11

NHS Norfolk has improved in 13 of the16 areas highlighted above demonstrating improvement, but highlighting that there is further improvement required in certain areas.

In 2010/11 NHS Norfolk changed the management structure from a Programme Board approach to Delivery Units. These Delivery Units had a geographical and service provider focus which supported clear accountability for service delivery.

The Delivery Units have support from aligned finance, commissioning and information services.

Key performance indicators are managed in detail through the new Delivery Units. NHS Norfolk's Executive Team receives a weekly update on key performance measures and the Board receive a monthly performance report.

Improvements in 2010/11

Significant progress was made in providing timely access to elective care within 18 weeks from initial referral. Since October 2010 the Norfolk and Norwich University Hospital (NNUH) has consistently achieved the NHS target to treat 90% of all patients within this 18 week envelope. The Queen Elizabeth Hospital (QEH) has met this target for every month in 2010/11.

Cancer services have also improved with more people being treated within the national targets.

The opening of the new community stroke unit in Norwich is providing high quality community based rehabilitation services and enabling more patients to be treated on the dedicated stroke ward in the local hospitals.

As part of the overall aim to reduce mortality rates NHS Norfolk has been commissioning 40-74 year old Health Checks in primary care. We have exceeded our planned take up of Health Checks by 50% in 2010/11. In total 29,584 patients have received a Health Check.

We also had another successful year managing winter pressures in the health system. The number of 'Black Alerts', which signify extreme pressure, were very low compared to previous years and the improvements made by health and social care have been nationally recognised.

The locality also performed well in the key patient safety Venous Thromboembolic disease (VTE) check on admission to hospital. Performance at the NNUH and the QEH was 94%. The NNUH has been identified as an exemplar site by the Department of Health.

Improvements in 2011/12

Although NHS Norfolk has improved in a number of key services, some areas of performance have been inconsistent. In particular, we will seek to improve in a number of key public health targets as well as specific areas where performance has been viable, such as infection control.

The organisation will continue to strive for excellence in 2011/12 and seek to bring consistent improvement in a range of areas, particularly the ones highlighted below.

Area	Action for 2011/12
Healthcare Acquired Infections (HCAIs)	Implement a fully integrated Norfolk system plan to reduce the number of infections.
Smoking	Services will be re-commissioning in 2011/12, and stronger links to the Annual Health Checks and lifestyle services. New initiatives focused on smoking in pregnancy and targeting mental health, prisons and young people will also be introduced.
Stroke	The PCT will invest in stroke services at the QEH to improve TIA (mini stroke) and thrombolysis care. An extended 8am – 8pm service will improve stroke indicators. A system event in June 2011 will reinforce the system-wide pathways now in place.
Breastfeeding	The launch of the Action Plan and Joint Hospital and Community Breastfeeding Policy will support improved performance. All three provider trusts will appoint dedicated infant feeding leads and a total of 400 staff will be trained on Breastfeeding Management to UNICEF standards.
Childhood immunisations	Improvements will be made through targeted GP visits by Health Protection Specialists and by increasing the opportunities to have immunisations by Health Visitors and at local centres, such as City Reach.
A&E performance	To maintain 95% performance at each site within NHS Norfolk, we will continue to monitor performance closely and work with individual providers to ensure systems and processes can manage the usual variation in attendances.

Governance

As a public body, it is important that NHS Norfolk has strict governance arrangements in place to ensure financial probity, clinical quality and risk management. During 2010/11, we continued to enhance our arrangements to commission safe, high quality, value for money services to patients and provide assurance to the public. We had in place clear governance arrangements between NHS Norfolk and its provider arm Norfolk Community Health and Care NHS Trust (NCH&C) which became an independent NHS Trust on 1 November 2010. NCH&C have had their application for registration with the Care Quality Commission (CQC) accepted with no conditions.

NHS Norfolk continues to work in partnership with other local public sector bodies to achieve better CQC performance targets and improved commissioning outcomes.

As with all public sector bodies, we have focused on managing risks associated with handling person-sensitive information, working closely with the Information Commissioner, the auditors, and using national guidance, to strengthen our processes and ensuring our providers follow stringent guidance.

No Serious Incidents relating to information losses for NHS Norfolk, NCH&C or GP practice required reporting to the Information Commissioner's Office during 2010/2011.

Operating and financial review

This operating and financial review has been prepared by reference to the requirement of the NHS Manual for Accounts for PCTs. Key indicators of our performance against our principle strategic service objectives for 2010/11 are given in section 7.

NHS Norfolk divested its service provision responsibilities to Norfolk Community Health and Care NHS Trust from 1 November 2010. For our full commissioning year and the part year of our service responsibilities we achieved our breakeven duty with a year end surplus of £959k on an overall budget of £1.2bn.

2010/11 has been a year of consolidating service developments initiated in previous years, e.g. in stroke, psychological therapy services and midwifery, alongside new investments in other areas, such as eating disorder services and older peoples mental health.

Expenditure on hospital activity, continuing care and primary care prescribing has been at higher than planned levels through the course of the year and it has only been through 'one off' underspends in other parts of the budget, e.g. dentistry and the use of contingencies, that we have achieved a breakeven position.

The Quality, Innovation, Productivity and Prevention plans have been developed during 2010/11 and it is vital in the context of low real terms growth going forward that we commission high quality services in a way that is financially sustainable across the health system. In this context investments have been made in the later part of 2010/11 to establish services in the community to give more support to vulnerable elderly patients at risk of being admitted to hospital. Funding has also supported GP commissioners in managing referrals appropriately to secondary care. These quality led developments are key components of the savings programme for 2011/12.

NHS Norfolk has incurred £645k in staff redundancy costs in 2011/12; this supports us meeting our share of national NHS management cost reductions in 2011/12 of just over £2m. NHS Norfolk will work with GP Consortia to ensure commissioning costs are within new running cost targets going forward.

NHS Norfolk managed a capital programme of £5.8m in 2010/11 which has included improvement to facilities at Caroline House and the first phase of redeveloping the North Walsham Community Hospital site. Impairments to asset values have resulted in an overall downward movement to the Estate of £3.9m. There was a £0.9m upward valuation to St Andrews House, the disposal proceeds of which, will support improvements to capital infrastructure in 2011/12. Responsibilities for the PCT's estate will largely transfer to Norfolk Community Health and Care NHS Trust as provider of services within the relevant accommodation from early 2011/12.

NHS Norfolk continues to maintain strong governance arrangements and this year we received an improved rating in the assessment of counter fraud arrangements.

NHS Norfolk's auditors for 2010/11 were the Audit Commission. The cost of the statutory audit was £275k. This fee includes a review of our arrangements for managing 'Payment by Results'.

The directors of NHS Norfolk confirm that, as far as they are aware, there is no relevant audit information of which the organisation's auditors are unaware. They have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors of NHS Norfolk are aware of that information.

For information on how pension liabilities are treated, please cross reference to the accounting policy 1.17 and note 7.5 in the full annual accounts. In respect of senior employees in the PCT, pension entitlements are disclosed in the remuneration report which is section 10 of this Annual Report.

NHS Norfolk has not made any political or charitable donations during the year. Neither have there been any special severance payments.

Details of the compliance with the Better Payments Practice Code are given in section 9 of this report.

NHS Norfolk has signed up to the prompt payments code.

The roles and activities of the Audit Committee

The Audit Committee is an independent committee composed of non-executive directors. The non-executive directors meet at least every quarter to oversee financial, corporate and clinical governance, risk management and internal control. In reviewing the adequacy of our systems of internal control, the committee relies on the work of other committees, such as its subcommittee of the Integrated Governance Committee, whose purpose is to support the Board in specific areas of organisational risk management. The Audit Committee authorises the scope of work conducted by Internal Audit, Counter Fraud, and External Audit, and closely monitors their performance.

Edward Libbey, who has been on the Audit Committee since the establishment of NHS Norfolk (NHSN), was appointed Chair in November 2009 for a period of four years. Stephen Eldred was appointed as a member of the Audit Committee on his appointment to the NHSN Board in July 2009 and resigned in January 2011 as a result of the demands of his other external commitments. His successor, Hilary De Lyon was appointed to the Board in February 2011 and to the Audit Committee simultaneously. Giles Bushby, who was recruited to the NHSN Board from 1 April 2010, joined the Committee but resigned at the end of March 2011 because of his commitments to his external business obligations. A successor to Giles was appointed in April 2011.

Our External Auditors were the Audit Commission and Pricewaterhouse Coopers were our Internal Auditors, and the Committee thank them for their support through the year.

The Audit Committee reviews the Annual Accounts and Statement on Internal Control prior to their approval by the Board. The annual Head of Internal Audit Opinion is consistent with the committee's opinion of NHSN's system of internal control and Statement on Internal Control. The Audit Committee has ensured robust financial processes were in place by monitoring the progress in implementing a substantial number of internal and external audit recommendations. Improvements have contributed towards the attainment of a 'good' rating across all the categories of the Audit Commission's annual Use of Resources assessment in 2009/10. This was a step-change improvement from previous years and the highest rating achieved across all PCTs in the East of England. The Audit Commission congratulated the Committee on its diligence and effectiveness in support of the PCT and the Board. Despite there being no national requirement for a Use of Resources assessment for 2010/11, the Audit Committee has continued to make sure that high performance standards are maintained within the PCT.

The Committee reviewed NHSN's Annual Accounts for 2009/10 prior to recommending their approval by the Board and focused on their compliance with relevant accounting standards and areas of judgement. The Audit Committee has reviewed not only core financial processes but other areas of high risk highlighted within the NHSN Board Assurance Framework. The Committee continues to review the Risk Register and management's mitigation actions and ensures that individual risks are highlighted at the monthly Board meetings, as appropriate. The Committee has also focused on the adequacy of NHSN's information governance arrangements and constructively challenged the self-assessment on compliance with Standards for Better Health.

During the course of the year the Committee considered the consequences of merging the work of the Integrated Governance Committee into that of the Audit Committee rather than as a subcommittee. Following a detailed consideration of the issues, especially in light of the changes anticipated in the structures of the NHS, this change was implemented following approval by the PCT Board and an agreed update to the Terms of Reference of the Audit Committee.

During 2010 it was anticipated that Norfolk Community Health and Care (NCH&C) would be formally separated from the PCT and established as an independent Trust. The Committee made sure that the accounts for both the PCT and NCH&C were constructed to ensure a clear fiscal separation of the activities of both. Separation was finally approved by the Strategic Health Authority/ Department of Health, effective on 1 November 2010. In the interim, the NHSN Audit Committee continued to act as overseer of the NCH&C audit process and act as mentor to the NCH&C Shadow Audit Committee, and its members, until such time as formal separation was confirmed. No significant issues arose during this process.

In 2011/12, the Audit Committee will continue to support the delivery of NHS Norfolk's objectives by ensuring, through the Committee's scrutiny of the system of internal controls, that the organisation continues to build upon recent control improvements. The Committee will seek assurances from the management of principal risks, particularly those relating to the NHSN's longer term commissioning plans at a time of increasing financial constraints at the national level. The Committee will continue, as it has in the past, to work closely with, among others: the Chief Executive and the Executive Team, the Clinical Executive and the Board. The Audit Committee will review the governance arrangements with the formation of a PCT cluster with NHS Great Yarmouth and Waveney and as the move towards GP Consortia develops.

Summary financial statements

Directors' Statements

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Primary Care Trust

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

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

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

Date: 8 June 2011 .... Andrew Morgan
Chief Executive

Statement of directors' responsibilities in respect of the accounts

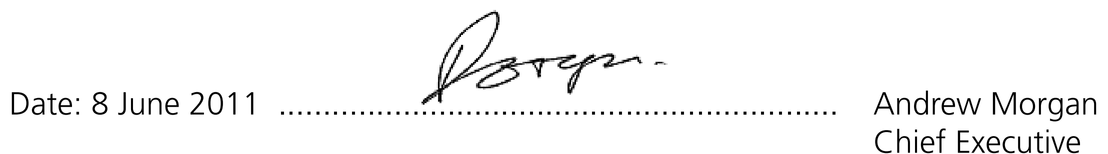
The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the primary care trust and the net operating cost, recognised gains and losses and cash flows for the year. In preparing these accounts, directors are required to:

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

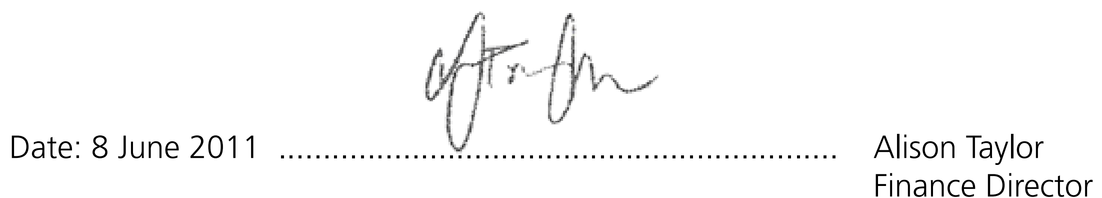
The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the primary care trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of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

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

By order of the Board.



Date: 8 June 2011 .... Andrew Morgan
Chief Executive



Date: 8 June 2011 .... Alison Taylor
Finance Director

Statement on Internal Control 2010/11
NHS Norfolk

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

I have ensured appropriate accountability arrangements through my Executive Team and to the NHS Norfolk (NHSN) Board and am accountable to the East of England Strategic Health Authority, to the Secretary of State for Health and to Parliament. NHS Norfolk works in partnership with a wide variety of other organisations, such as:

- NHS, voluntary and independent sector organisations via service level agreements and contracts to deliver health services to agreed specifications.
- Norfolk social services through legal agreements and pooled fund arrangements and joint commissioning.
- Social care, specialised commissioning, Practice Based Commissioning (PbC) and newly emerging General Practice Consortia, carrying out joint needs assessments, strategic planning and joint commissioning.
- Local partners and formal partnership Boards to promote the objectives of our local health plans and Local Area Agreement.
- Norfolk Local Involvement Network and other agencies for public engagement and involvement.

Strong reporting and accountability with all partnerships is maintained through robust partnership governance arrangements to ensure the delivery of NHS Norfolk's strategic objectives and the shared objectives of the wider health system.

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 organisation's policies, aims and objectives; and
- 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 NHS Norfolk for the year ended 31 March 2011 and up to the date of approval of the Annual Report and accounts.

The autonomous provider arm of NHS Norfolk, Norfolk Community Health and Care (NCH&C), legally separated from NHS Norfolk when it was established as an NHS Trust on 1 November 2010. NCH&C has had its own systems of internal control in place all year, with a Memorandum of Understanding prior to becoming an NHS Trust, detailing how it was accountable to the Board of NHS Norfolk for its governance responsibilities for the seven months ended 31 October 2010. I have reviewed NCH&C's compliance with the Memorandum of Understanding up to 31 October 2010, its 2010/11 Statement on Internal Control and its Head of Internal Audit Opinion to take account, where appropriate, of any issues that need to be reflected in NHS Norfolk's Statement on Internal Control for the year ended 31 March 2011.

3. Capacity to handle risk

As Accountable Officer I ensure that sufficient resources are invested in managing risk at every level of the organisation and I am supported in this task by a governance team. Leadership is given to the risk management process through executive directors and overseen by the Board and Board subcommittees. The Director of Corporate Services works closely with the Director of Finance and the Medical Director and Chief Nurse to ensure that these functions are integrated. Up to date Scheme of Delegation, Standing Financial Instructions and Standing Orders are in place and the Risk Strategy outlines the strategic direction for risk management and appetite for risk.

Staff are trained and equipped to identify and manage risk in a way appropriate to their authority and duties, through a documented system of risk assessment and mandatory, formal and ad hoc staff training. Guidance is available in the Risk Framework and supplemented by the governance team, who provide templates on risk assessments, risk registers and business continuity plans. A positive staff attitude to the control of risk is promoted. Risk management, whether financial, clinical or organisational, is fully embedded in all PCT activities, from monitoring the ongoing risk mitigation of current projects and commissioned services, to identifying risks to Quality, Improvement, Productivity and Prevention initiatives and to the commissioning of new services and pathways, so that risks are mitigated as far as reasonably practicable and managed at the right level of the organisation. Supporting staff to manage risk is particularly important during this period of transition to GP commissioning.

The Integrated Governance Committee (IGC) and Audit Committee scrutinise evidence to gain assurances that risk management is embedded in every activity of the organisation and to share learning experiences across the PCT, revising processes as necessary. These committees merged from January 2011. The Performance Assurance Review (PAR) Group, which I chair, meets monthly and reviews the effectiveness of risk mitigation linked to performance targets and the delivery of corporate objectives. This forum facilitates sharing of good practice across all the Delivery Units of the PCT. The Clinical Quality and Patient Safety Committee reviews and shares the learning from provider adverse events such as complaints and serious incidents to inform contract monitoring and commissioning.

NHS Norfolk participates in a number of county-wide and regional networks and risk management fora from which we apply good practice from elsewhere. The PCT benefits from strong support and guidance from our internal and external auditors who share best practice from other organisations. Our involvement in a number of formal partnerships enables learning from other agencies.

During the seven months ended 31 October 2010, NCH&C assured the PCT of its risk management processes through regular reporting under the Memorandum of Understanding from its Shadow Board and subcommittees and via its Shadow Board Assurance Framework. The report of NCH&C's Managing Director was a standing item at every NHS Norfolk Board meeting. NCH&C's risk management processes have been independently scrutinised by NHS Norfolk's Integrated Governance Committee and Audit Committee and have been independently reviewed by its internal auditors.

In January 2011 the Department of Health published guidance on implementing PCT clusters and NHS Norfolk has been confirmed as a cluster with NHS Great Yarmouth and Waveney. There are associated governance processes that are being closely followed and this will proceed with each organisation maintaining its own chair and non-executive team, but sharing a single executive team. Our boards will work together to identify and agree common issues within the cluster and this will provide greater resilience to both PCTs going forward.

4. The risk and control framework

Risk management in NHS Norfolk involves proactive identification, assessment, evaluation and mitigation as well as reactive response to, and learning from, adverse events such as complaints, and serious incidents. Each Delivery Unit and clinical team identifies and assesses risk to the delivery of their objectives and assigns to a risk owner the responsibility for ensuring that risk is mitigated to an acceptable level as quickly as possible. Risks are recorded onto live risk registers and regularly reviewed. Staff are encouraged to raise risks by a number of routes, including formal whistleblowing, and using a variety of information sources, e.g. incidents, complaints, audits, early warning indicators, tests of business continuity etc. Controls are identified and assurances provided as to the effectiveness of these controls in mitigating the risk. The Executive Team agree risk tolerance and significant, residual risks are escalated, as appropriate, and recorded in the Corporate Risk Register and Board Assurance Framework that provides the Board with assurances as to the effectiveness of the risk management system. NHS Norfolk has been active in reviewing its processes against the recommendations in the Audit Commission's publication 'Taking it on Trust'.

The PCT's major risks, as discussed in the Board Assurance Framework are:

■ Risk of failure to deliver Quality, Improvement, Productivity and Prevention initiatives and associated financial savings

Identified in year in response to funding challenges and the national economic downturn, this risk will continue into next year and is being mitigated by a robust plan, signed up to by all key system stakeholders, closer working with GP commissioners and more detail on the elective care management workstream. The PCT's Performance Management Office is being strengthened to ensure delivery. Each Quality, Improvement, Productivity and Prevention initiative has a list of associated outcomes for quality and value for money.

■ Risk of failure of specialised commissioning

A risk was identified at the start of 2010/11 around lack of sources of assurance relating to the governance and financial reporting processes of the East of England Specialised Commissioning Group (SCG), which is hosted by another PCT and in which NHS Norfolk participates along with a number of other PCT's in the region. This risk has been mitigated by increased Executive Team and Chief Executive focus, requesting more timely financial information from the SCG.

This includes close monitoring of the timelines of the financial information provided by the SCG and of its responses to recommendations made by its internal auditors. NHS Norfolk is also supporting the SCG with Medical Director input. Success of mitigation will be measured by the SCG's ability to provide more timely financial information and to meet its financial targets.

- Failure to deliver national performance targets. Performance has improved this year, but the risk of not achieving certain stretch targets, such as chlamydia, smoking cessation, breastfeeding and accident and emergency waiting times was identified in year. More robust contract management and use of contract levers are the key part of the mitigation strategy.

- Risks to business continuity and loss of corporate memory due to transition to GP Consortia. Identified at the publication of the White Paper 'Equity and Excellence: Liberating the NHS' in July 2010, this risk has been mitigated by a three phase re-organisation of the PCT's structure. This includes the creation of new fit-for-purpose Delivery Units, commencing the alignment of staff to the emerging GP Consortia, as well as clustering with NHS Great Yarmouth and Waveney and a raft of measures of staff support, training, consultation and improved communication. NHS Norfolk's Risk Strategy has been updated to reflect the risks of transition, and the strengthened mechanisms for staff to raise concerns about risk on a day-to-day basis.

- Risks to data security. Risks to data security are monitored by the Information Governance (IG) Committee. Incidents are risk rated according to the risk matrix described in the Department of Health Gateway letter 9571, investigated as per Gateway letter 13177 and reported, as required, to the Information Commissioner. Incident trends are reviewed and lessons learnt widely shared. No Serious Incidents relating to information losses for NHS Norfolk, NCH&C or GP practices required reporting to the Information Commissioner's Office during 2010/2011. The Senior Information Risk Owner (SIRO) oversees the Information Asset Owners (IAOs) who are responsible for their information systems and carry out risk assessments. The PCT has submitted its self-assessment against the IG toolkit, following independent assessment of the PCT's scores for a sample of Toolkit requirements and of the governance arrangements underling the IG framework by the internal auditors. Two areas require increased executive focus to ensure compliance – pseudonymisation and staff training.

- NCH&C. NCH&C operates a Board Assurance Framework (BAF) which identifies their major risks and mitigation plans against the delivery of their business objectives and which has received a moderate internal audit opinion. There has been much improvement in systems and processes following the internal auditor's limited assurance opinion last year, with a review undertaken against 'Taking it on Trust', and a refresh of the BAF and Corporate Risk Register.

  Significant BAF risks include:

  - The risk of growing the business, mitigated by robust tender processes.
  - Risk of achieving financial savings, mitigated by taking forward the Annual Business Plan and monitoring performance by the Executive Team and Board.
  - Risk to quality of prison healthcare; a comprehensive action plan is in place.
  - Risk of loss of patient identifiable information – policies have been reviewed, further staff training provided and a self-assessment against the IG toolkit. No significant data losses have been reported to the Information Commissioner's Office in 2010/11.

NCH&C have a half-yearly Statement on Internal Control review, with recommendations incorporated into the overall risk management action plan. NHS Norfolk monitored the risk of ultra-vires conduct by NCH&C prior to it becoming an independent NHS Trust, with the mitigation action described earlier.

Risk management is embedded in the activity of the organisation, all business cases and Board decisions are risk assessed. This includes equality impact assessments that are published separately on the NHS Norfolk website.

The Board Assurance Framework is a key part of NHS Norfolk's risk management arrangements and is reviewed by the Board at each meeting. The revised BAF for 2010/11 has an improved format and is of more manageable length; some risks have transferred to the Corporate Risk Register, managed by the Executive Team, while clinical risks are recorded on the Part 2 BAF. The internal audit reviews of both the NHS Norfolk Board Assurance Framework and NCH&C BAF gave moderate assurance opinions. Action is being taken to improve our processes, such as improving the description of the sources of controls.

NHS Norfolk consults with public stakeholders on all significant business developments, such as the redeveloped North Walsham and District War Memorial Hospital. It also consults on strategy development and has Local Involvement Network (LINKs) representation on the Board and other key committees, including Delivery Units.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

The PCT has undertaken a climate change risk assessment and developed an Adaptation Plan, to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), and to ensure that this organisation's obligations under the Climate Change Act are met.

The PCT was accountable for NCH&C provider services until 1 November 2010, when NCH&C became an independent NHS Trust. During this time, NCH&C was fully compliant with the Care Quality Commission (CQC) essential standards of quality and safety, except CQC Regulation 9, Outcome 4, in relation to HM Prison Norwich, which management now consider fully compliant. There have been no other significant lapses or insufficient assurance of compliance against any of the remaining regulations.

NCH&C achieved Level 1 compliance for the NHS Litigation Authority (NHSLA) risk management standards at the end of 2009/10. Work is underway to achieve level 2.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. The Head of Internal Audit Opinion for the year ended 31 March 2011 was that 'significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and inconsistent application of controls put the achievement of particular objectives at risk'. There were no limited assurance reports issued to the PCT but two high risk recommendations were received. The first of these related to the Sollis information system support of Practice Based Commissioning. In response, the PCT is monitoring the system for errors and working with the system provider to resolve the issue. The second high risk recommendation related to information governance and accessing training records, this has recently been resolved with the publication on our intranet of records of staff that have undertaken mandatory training, including information governance.

I was also responsible for NCH&C as this was legally part of NHS Norfolk (NHSN) for the first seven months of this year. In preparing this statement for the year I have taken account of NCH&C's 2010/11 Head of Internal Audit Opinion and this also stated that 'significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and inconsistent application of controls put the achievement of particular objectives at risk'. They did, however, have one report of limited assurance for staff appointments, with three high risk recommendations in this area and a further high risk recommendation for both information governance and key financial controls. Action has been taken to mitigate each of these risks that are now the responsibility of NCH&C since it legally separated from NHS Norfolk on 1 November 2010.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives is reviewed on an ongoing basis. My review is also informed by:

- The Information Governance toolkit V8 self-assessment process, which is independently assessed by our internal auditors.
- Our research governance framework.
- The CQC registration process for our community services managed by NCH&C.
- NHSLA membership and risk management assessment for NCH&C.
- My attendance at key governance meetings.
- NCH&C governance reports and assurance reports to Board prior to becoming an independent NHS Trust.

- Contract meetings with providers and the work of the Clinical Quality and Patient Safety team in carrying out unannounced visits, inspections, monitoring provider serious incidents and risks, reviewing governance trend reports and the CQC's Quality and Risk profiles.
- Third party assurance (SAS70) in relation to the financial systems operated on the PCT's behalf by Anglia Support Partnership.
- Specialised Commissioning Group performance and governance reports.
- The external auditors' assessment of the PCT's arrangements for achieving value for money and opinion on financial statements, including related reports.

The major sources of assurance on which reliance has been placed during the year have included the work of our internal and external auditors, the self-assessment against the IG toolkit, reviews of partnership governance, the CQC registration process, the National Sentinel audit of stroke, close working with LINks, the Staff Survey, Counter Fraud Specialist Management Service, the visit from the National Intensive Support team for healthcare acquired infections, root cause analysis of serious incidents and benchmarking. There have been no limited assurance opinions given by our internal auditors for 2010/11.

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 which is collectively responsible for risk management and ensures sound systems of internal control are in place to manage risks and reviews assurances on controls via the BAF. The Board agenda is driven by the significant risks detailed in the BAF.
- The Audit Committee, whose agenda is driven by the Corporate Risk Register, and which reviews the adequacy of the risk management system and Delivery Unit risk registers on a rolling programme. It receives the Clinical Quality and Patient Safety Committee (CQPS) Chair's report at each meeting. In January 2011, the decision was taken to merge the Audit Committee and Integrated Governance Committee in order to reduce duplication and enable a sharper focus on integrated risk management, with reference to national guidance and best practice and advice from our internal auditors. The effectiveness of all Board subcommittees is reviewed annually.
- The Clinical Executive Committee, which gives clinical leadership and direction to the PCT.
- The Executive Team, which supports the delivery of the operational plan and deals with day-to -day operational management of risk. It owns the Corporate Risk Register.
- The Clinical Quality and Patient Safety Committee which, as a subcommittee of the Board, ensures the services commissioned by the PCT are safe, effective, high quality and patient focused. It reviews the clinical risks facing NHS Norfolk and its providers and the effectiveness of risk mitigation. This is summarised in the Part 2 BAF which is reviewed by the Board at each meeting.
- I chair our monthly Performance Assurance Review (PAR) group meeting which calls to account each of my executive director Delivery Unit leads on performance and risk, and escalates risk, as appropriate.
- The Health and Safety Committee, which ensures the health and safety of the PCT workforce, patients and all other persons working or visiting the PCT premises and reviews health and safety risk mitigation.
- The Information Governance Committee, which reviews the risks of data losses, the IG toolkit self-assessment and statutory obligations under the Data Protection Act 1998.

- The work of our internal auditors, who provide an independent and objective opinion to myself as Accountable Officer, to the Board and to the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's objectives.
- The Delivery Units, which regularly review risks and identify emerging risks associated with their commissioning and procurement programmes, maintain live risk registers.
- The PBC Governance Committee, which has provided scrutiny on PBC commissioning plans to the Board.

The NHS Norfolk Board Assurance Framework and self-assessment against CQC regulations has identified the following gaps in control in 2010/11. Plans to address weaknesses and ensure continuous improvement of the system are in place, as summarised in section 4 above.

- Risk of failure to deliver Quality, Improvement, Productivity and Prevention initiatives and associated financial savings.
- Risk of failure of specialised commissioning through lack of sources of assurance.
- Failure to deliver national performance targets.
- Risks to business continuity and loss of corporate memory due to transition to GP Consortia.
- Risks to data security.
- Non-compliance with CQC Regulation 9, Outcome 4, in relation to HM Prison Norwich, which management now consider fully compliant. There have been no other significant lapses or insufficient assurance of compliance against any of the remaining regulations.

Each of these risks has a work plan associated with them and is summarised in the Board Assurance Framework that is considered at each Board meeting.

With the exception of these internal control issues my review confirms that NHS Norfolk has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Date: 8 June 2011 .... Andrew Morgan
Chief Executive

Summary Financial Statements for the year ended 31 March 2011

Full disclosure of Related Party Transactions are set out in Note 31 of NHS Norfolk's Annual Accounts. The Summary Financial Statements contained in this Annual Report might not contain sufficient information for a full understanding of the PCT's financial position and performance. The full annual accounts are published as a separate file on the NHS Norfolk website. Alternatively, to obtain a free copy of the full accounts, please write to the Director of Finance, NHS Norfolk, Lakeside 400, Old Chapel Way, Broadland Business Park, Thorpe St Andrew, Norwich NR7 0WG.

The following information is also available in this report:

- full details of management and administrative costs;
- information on compliance with the Confederation of British Industry (CBI) Better Pay Practice Code.

On 1 November 2010 the provider services of the PCT were legally separated as Norfolk Community Health and Care NHS Trust. Under the requirements of International Accounting Standard 1, which deals with merger accounting, the accounts for the whole of 2010/11 and 2009/10 are restated as though the organisations had always been separated. The restated figures below, therefore, exclude Norfolk Community Health and Care NHS Trust. Further details of this change are disclosed in the full annual accounts.

Statement of comprehensive net expenditure for the period ended 31 March 2011

		Restated
	2010/11	2009/10
	£000	£000
Commissioning		
Employee benefits	**17,117**	16,191
Other costs	**1,226,766**	1,157,994
Income	**(41,614)**	(42,663)
PCT net operating costs before interest	**1,202,269**	1,131,522
Investment income	**(30)**	(24)
Other (gains)/losses	**(123)**	0
Finance costs	**919**	715
Net operating costs for the financial year	**1,203,035**	1,132,213

Other comprehensive net expenditure

	2010/11	2009/10
Net (gain) on revaluation of property, plant and equipment	**(491)**	(2,045)
Impairments and reversals	**0**	2,350
Transfers from donated and government grant reserves	**372**	134
Adjustment for the nominal cost of capital charge	**0**	(817)
Transfers to other bodies within the Resource Account Boundary	**(70)**	0
Net operating costs for the financial year	**1,202,846**	1,131,835

Statement of financial position as at 31 March 2011

	31 March 2011 £000	Restated 31 March 2010 £000	Restated 1 April 2009 £000
Non-current assets			
Property, plant and equipment	**74,336**	83,774	79,346
Intangible assets	**82**	111	150
Other financial assets	**172**	172	139
Total non-current assets	**74,590**	84,057	79,635
Current assets			
Inventories	**9**	8	7
Trade and other receivables	**7,080**	11,958	10,026
Cash and cash equivalents	**3**	2	11
Subtotal	**7,092**	11,968	10,044
Non-current assets held for sale	**6,319**	0	0
Total current assets	**13,411**	11,968	10,044
Total assets	**88,001**	96,025	89,679
Current liabilities			
Trade and other payables	**(59,886)**	(57,831)	(50,439)
Provisions	**(1,541)**	(1,686)	(2,477)
Borrowings	**(50)**	(100)	(49)
Total current liabilities	**(61,477)**	(59,617)	(52,965)
Non-current assets plus/less net current assets/liabilities	**26,524**	36,408	36,714
Non-current liabilities			
Provisions	**(2,140)**	(1,152)	(1,144)
Borrowings	**(11,594)**	(11,657)	(8,987)
Total non-current liabilities	**(13,734)**	(12,809)	(10,131)
Total assets employed	**12,790**	23,599	26,583

	31 March 2011 £000	31 March 2010 £000	1 April 2009 £000
Financed by: Taxpayers' Equity			
General fund	**(5,062)**	5,277	7,816
Revaluation reserve	**15,607**	15,690	16,025
Donated asset reserve	**1,370**	1,704	1,793
Government grant reserve	**875**	928	949
Total Taxpayers' Equity:	**12,790**	23,599	26,583

Statement of changes in Taxpayers' Equity for the year ended 31 March 2010

	General Fund	**Revaluation Reserve**	**Donated Asset Reserve**	**Govt. Grant Reserve**	**Total Reserves**
Changes in Taxpayers' Equity for 2009/10	**£000**	**£000**	**£000**	**£000**	**£000**
Balance at 1 April 2009	**7,816**	**16,025**	**1,793**	**949**	**26,583**
Net operating cost for the year	(1,132,213)	0	0	0	**(1,132,213)**
Net gain on revaluation of property, plant, equipment	0	2,017	0	28	**2,045**
Impairments and reversals	0	(2,346)	(4)	0	**(2,350)**
Release of reserves to SoCNE	0	0	(85)	(49)	**(134)**
Non-cash charges – cost of capital	817	0	0	0	**817**
Transfers between reserves	6	(6)	0	0	**0**
Total recognised income and expense for 2009/10	**(1,131,390)**	**(335)**	**(89)**	**(21)**	**(1,131,835)**
Net Parliamentary funding	1,128,851	0	0	0	**1,128,851**
Balance at 31 March 2010	**5,277**	**15,690**	**1,704**	**928**	**23,599**

Statement of changes in Taxpayers' Equity for the year ended 31 March 2011

	General Fund	Revaluation Reserve	Donated Asset Reserve	Govt. Grant Reserve	Total Reserves
Changes in Taxpayers' Equity for 2010/11	**£000**	**£000**	**£000**	**£000**	**£000**
Balance at 1 April 2010	**5,277**	**15,690**	**1,704**	**928**	**23,599**
Net operating cost for the year	(1,203,035)	0	0	0	**(1,203,035)**
Net gain on revaluation of property, plant, equipment	0	491	0	0	**491**
Release of reserves to SoCNE	0	0	(319)	(53)	**(372)**
Transfers between reserves	589	(574)	(15)	0	**0**
Transfers to other bodies within the resource account boundary	70	0	0	0	**70**
Total recognised income and expense for 2009/10	**(1,202,376)**	**(83)**	**(334)**	**(53)**	**(1,202,846)**
Net Parliamentary funding	1,192,037	0	0	0	**1,192,037**
Balance at 31 March 2010	**(5,062)**	**15,607**	**1,370**	**875**	**12,790**

Statement of cash flows for the year ended 31 March 2011

	2010/11 £000	Restated 2009/10 £000
Cashflow from operating activities		
Net operating cost before interest	**(1,202,269)**	(1,131,522)
Other cash flow adjustments	**8,009**	9,332
Movements in Working Capital	**6,070**	5,459
Provisions utilised	**(1,147)**	(1,678)
Interest paid	**(890)**	(689)
Net cash outflow from operating activities	**(1,190,227)**	(1,119,098)
Cash flows from investing activities		
Payments to purchase property, plant and equipment	**(5,173)**	(10,524)
Payments to purchase intangible assets	**3,179**	820
Proceeds of disposal PPE and intangible assets	**3,179**	820
Loans made in respect of LIFT	**0**	(33)
Interest received	**30**	24
Net cash inflow/(outflow) from investing activities	**(1,964)**	(9,713)
Net cash inflow/(outflow) before financing	**(1,192,191)**	(1,128,811)
Cash flows from financing activities		
Net Parliamentary funding	**1,192,037**	1,128,851
Capital grants received	**198**	0
Capital element of payments in respect of finance leases, on-SoFP PFI and LIFT	**(113)**	(49)
Cash transfers from other NHS bodies	**70**	0
Net cash inflow/(outflow) from financing	**1,192,192**	1,128,802
Net increase/(decrease) in cash and cash equivalents	**1**	(9)
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	**2**	11
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	**3**	2

PCT management costs

	2010/11	2009/10
Management costs (£000s)	**11,124**	12,746
Weighted population (number in units)	**737,096**	728,442
Management cost per weighted head of population (£ per head)	**15.09**	17.50

PCT running costs

	2010/11	2010/11
Running costs separately identified for the first time in 2010/11	**Commissioning services**	**Public Health**
Running costs (£000s)	**31,029**	1,933
Weighted population (number in units)	**737,096**	737,096
Management cost per weighted head of population (£ per head)	**42.10**	2.62

Better Payment Practice Code

Measure of compliance	**2010/11 Number**	**2010/11 £000**	**Restated 2009/10 Number**	**Restated 2009/10 £000**
Non-NHS Payables				
Total Non-NHS trade invoices paid in the year	**21,408**	**156,304**	20,190	80,015
Total Non-NHS trade invoices paid within target	**18,396**	**140,571**	16,186	66,259
Percentage of Non-NHS trade invoices paid within target	**85.93%**	**89.93%**	80.17%	82.81%
NHS Payables				
Total NHS trade invoices paid in the year	**3,471**	**782,545**	2,554	609,765
Total NHS trade invoices paid within target	**2,799**	**758,645**	1,276	582,799
Percentage of NHS trade invoices paid within target	**80.64%**	**96.95%**	49.96%	95.58%
The Better Payment Practice Code requires the PCT to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.				

Independent Auditor's report to the Board of Directors of Norfolk Primary Care Trust

I have examined the Summary Financial Statement for the year ended 31 March 2011 and which comprises the Directors' Statements, Statement of Internal Control, Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows, Management Costs, Running Costs and Better Payment Practice Code.

This report is made solely to the Board of Directors of Norfolk Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statement.

I conducted my work in accordance with Bulletin 2008/03 'The auditor's statement on the summary financial statement in the United Kingdom' issued by the Auditing Practices Board. My report on the statutory financial statements describes the basis of my opinion on those financial statements.

Opinion

In my opinion the Summary Financial Statement is consistent with the statutory financial statements of the Norfolk Primary Care Trust for the year ended 31 March 2011. I have not considered the effects of any events between the date on which I signed my report on the statutory financial statements (9 June 2011) and the date of this statement.

Neil Harris
Officer of the Audit Commission

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

27 June 2011

Remuneration Report

This report gives details of the NHS Norfolk's Remuneration and Terms of Service Committee and the PCT's policies in relation to the remuneration of its senior managers which the Board has defined as executive and non-executive directors and members of the Clinical Executive Committee.

Details of remuneration payable to the senior managers of NHS Norfolk in respect of their services during the year ended 31 March 2011 are given in the tables at the end of this report.

The Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is a subcommittee of the Board. The Committee is chaired by Jane Gurney-Read (Non-Executive Director) and its other member is Sheila Childerhouse (Chair of the Board). During 2010/11 Andrew Egerton-Smith and Giles Bushby (Non-Executive Directors) were also members of the committee. Meetings are attended by Ian Tegerdine (Director of Workforce) and Andrew Morgan (Chief Executive), who advises on matters relating to the other executive directors. The Chief Executive does not attend when his own remuneration is being considered.

Until 31 October 2010 to recognise the arms length provider relationship with Norfolk Community Health and Care, the meeting was split with one part of the meeting including additional members from the shadow board of NCH&C: Lisa Gamble and Vivien Clifford-Jackson (Non-Executive Committee members), Sheila Adams O'Shea (Managing Director) and Barbara Wilson (Director of Human Resources).

Executive Directors: remuneration policy

The salaries for the Chief Executive and directors of the PCT are determined through national terms and conditions, and the NHS 'Pay Framework for Very Senior Managers in Strategic Health Authorities, Special Health Authorities, Primary Care Trusts and Ambulance Trusts' which came into effect on 1 October 2006.

The Remuneration and Terms of Service Committee is responsible, under its Terms of Reference, for confirming the salaries of the Chief Executive and directors and considering any of the flexibilities available within these terms and conditions. Under the terms of the national pay and conditions, the Remuneration and Terms of Service Committee has responsibility for determining whether national pay uplifts and any non-consolidated bonus payments should be paid to the Chief Executive and the directors. Only VSMs in organisations that meet their agreed financial control totals are eligible for pay awards. This applies to both the basic uplift and performance bonuses.

Performance bonus payments are non-consolidated, non-pensionable and, in addition to the consolidated annual uplift, are payable in organisations that have achieved their financial control targets.

The number of awards in each organisation is a matter for the relevant remuneration committee in consultation with the Chief Executive Officer, but is subject to affordability and an absolute ceiling that the total cost of bonuses must not exceed 5% of the reckonable pay bill for all VSMs within the relevant bonus pool.

The nationally determined nil cost of living uplift for 2010/11 was adopted by the Remuneration Committee for all staff employed on the VSM Pay Framework. Furthermore, recognising the principle of restraint in the pay of senior staff, the Remuneration and Terms of Service Committee determined that no non-consolidated bonus payments would be made for the year ended 31 March 2010 to the Chief Executive and eligible directors. The senior staff on Agenda for Change Terms and Conditions received the cost of living increase in accordance with national agreements.

The policy for determining the length of contract and the notice periods for the Chief Executive and the directors is laid down within the national terms and conditions. The notice period required for the termination of a chief executive is six months by either party and for executive directors is six months notice from the PCT and three months notice from the employee. Terms and Conditions for liability in the event of early termination are under the standard terms of the VSM pay scale. The PCT may exercise discretion regarding payment in lieu of part or all of the notice period. All of the PCT's directors have been issued with and signed a contract of employment based on the national template.

Executive directors and members of the Clinical Executive Committee are eligible to participate in the NHS Pension Scheme which provides salary-related pension benefits on a defined benefit basis.

Most executive directors have rolling service contracts; Ian Ayres and Anne Dray have fixed term contracts. The table below discloses contract start dates and, where applicable, leave dates. Note David Stonehouse's contract was transferred from a predecessor organisation: West Norfolk PCT.

Executive Director in post at 31st March 2011	Role	Contract date	Leave date for fixed term contracts
Andrew Morgan	Chief Executive	1 September 2010	
David Stonehouse	Deputy CEO and Director of Finance	1 October 2000	
Ian Ayres	Executive Director, Central Delivery Unit and Transition	1 March 2010	31 March 2013
Paul Cracknell	Executive Director, West Delivery Unit and Organisational Services	1 May 2010	
Bryan Heap	Medical Director	1 August 2007	
Maureen Carson	Chief Nurse and Director of Quality and Patient Safety	1 November 2007	
Anne Dray	Director of QIPP and Transformation	1 September 2010	31 August 2012
Dr Jenny Harries	Joint Director of Public Health	10 January 2011	
Jonathan Cook	Director of Corporate Services	1 January 2010	
Ian Tegerdine	Director of Workforce and Corporate Development	1 June 2008	
Patricia Turner	Director of Communications and Engagement	21 July 2009	

Non-Executive Directors: remuneration policy

Non-executive directors are appointed by the NHS Appointments Commission for a fixed term. Their remuneration consists of fees determined by the NHS Appointments Commission. No increase in pay was applied in 2010/11. Non-executive directors are reimbursed for out-of-pocket expenses incurred on the PCT's business. Non-executive directors are not eligible to participate in the NHS Pension Scheme.

The Non Executive appointments became effective on the following dates:

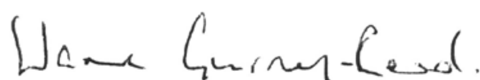
Non-executive director	Role	Contract date	Leave date
Sheila Childerhouse	Chair	1 October 2006	30 September 2014
Dr Edward Libbey	Non-Executive Director	1 October 2006	30 September 2013
Jane Gurney-Read	Non-Executive Director	1 July 2009	30 June 2013
Marion Headicar	Non-Executive Director	1 July 2009	30 June 2013
Giles Bushby	Non-Executive Director	1 April 2010	Resigned 31 March 2011
Hilary De Lyon	Non-Executive Director	1 February 2011	31 January 2015

Board appointments during 2010-11

- Paul Cracknell was appointed to the post of Executive Director, West Delivery Unit and Organisational Services (1 May 2010).
- Julie Garbutt resigned from the post of Chief Executive (28 May 2010).
- David Stonehouse was appointed as Interim Chief Executive (1 May 2010 to 31 August 2010), returning to the post of Deputy Chief Executive and Director of Finance (1 September 2010).
- Andrew Morgan was appointed as Chief Executive of NHS Norfolk from 1 September 2010. Following the formation of a PCT cluster with NHS Great Yarmouth and Waveney on 16 February 2011, Mr. Morgan was appointed as Chief Executive of both organisations. Part of his remuneration costs were recharged to NHS Great Yarmouth and Waveney, but for clarity this report includes the full annual remuneration paid.
- Stephen Wells was appointed to the post of Interim Director of Finance (29 April 2010 to 1 October 2010).
- Anne Dray was appointed as the Director of QIPP and Transformation from 1 September 2010.
- Dr Jenny Harries was appointed as the Director of Public Health from 10 January 2011.
- Dr Tim Crayford resigned as Interim Director of Public Health (31 December 2010).
- Two new non-executive directors (NEDs) were appointed to the Board of NHS Norfolk during 2010-11: Giles Bushby (1 April 2010) and Hilary De Lyon (1 February 2011).
- Three non-executive directors left during 2010-11: Andrew Egerton-Smith retired (30 September 2010), Stephen Eldred resigned (31 January 2011) and Giles Bushby resigned (31 March 2011).
- Ian Mack resigned as Chair of the Clinical Executive Committee (31 March 2011).

Senior managers' remuneration for the year ended 31 March 2011

Details of remuneration payable to the senior managers of Norfolk PCT in respect of their services during the year ended 31 March 2011 are given in tables 1 to 2 overleaf.



Jane Gurney-Read
Chair Remuneration Committee

Date: 8 June 2011

Table 1: Salaries and Allowances

Name and Title	2010-11			2009-10		
	Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000	Benefits in kind (rounded to the nearest £100) £000	Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000	Benefits in kind (rounded to the nearest £100) £000
Norfolk PCT Board Members						
Sheila Childerhouse (Chair)	40-45	0	0	35-40	0	0
Andrew Egerton-Smith (NED) until 30 September 2010	0-5	0	0	5-10	0	0
Dr Edward Libbey (NED)	10-15	0	0	5-10	0	0
Jane Gurney-Read (NED)	5-10	0	0	5-10	0	0
Marion Headicar (NED)	5-10	0	0	5-10	0	0
Stephen Eldred (NED) until 31 January 2011	5-10	0	0	5-10	0	0
Giles Bushby (NED) 1 April 2010 to 31 March 2011	5-10	0	0	0	0	0
Hilary De Lyon (NED) from 1 February 2011	0-5	0	0	0	0	0
Caroline Rivett (NED) until 31 October 2009	0	0	0	5-10	0	0
Martin Stephenson (NED) until 31 May 2009	0	0	0	0-5	0	0
Luc D'Iorio (NED) until 31 December 2009	0	0	0	5-10	0	0
Julie Garbutt (CEO) until 28 May 2010	25-30	0	0.4	170-175	10-15	6.3
Andrew Morgan (CEO) from 1 September 2010	80-85	0	0.8	0	0	0
David Stonehouse (Deputy CEO and Director of Finance). (Interim Chief Executive 1 May to 31 August 2010)	125-130	0	3.1	120-125	0	0.8
Stephen Wells (Interim Director of Finance) 29 April to 1 October 2010	145-150	0	0	0	0	0

Ian Ayres (Executive Director, Central Norfolk Delivery Unit and Transition)	125-130	0	0	180-185	0	0
Paul Cracknell (Executive Director, West Norfolk Delivery Unit and Organisational Services) from 1 May 2010	105-110	0	0.5	0	0	0
Bryan Heap (Medical Director)	100-105	0	0	105-110	0	0
Maureen Carson (Chief Nurse and Director of Quality and Patient Safety)	100-105	0	0	105-110	0	0
Anne Dray (Director of QIPP and Transformation) from 1 September 2010	60-65	0	0	0	0	0
Dr Jenny Harries (Joint Director of Public Health) from 10 January 2011	25-30	0	0	0	0	0
Dr Tim Crayford (Interim Director of Public Health) until 31 December 2010	175-180	0	0	5-10	0	0
Jonathan Cook (Director of Corporate Services)	85-90	0	0	75-80	0	0
Ian Tegerdine (Director of Workforce and Corporate Development)	80-85	0	1.6	75-80	0	0.9
Patricia Turner (Director of Communications and Engagement)	80-85	0	0	75-80	0	0
Steve Davis (Interim Chief Operating Officer) until 31 March 2010	0	0	0	230-235	0	0
Dr John Battersby (Joint Director of Public Health) until 18 October 2009	0	0	0	65-70	0	1.3
Anna Bennett (Director of Performance, Planning and Procurement) until 1 June 2009	0	0	0	15-20	0	0
Sheila Adams O'Shea - Managing Director Provider arm. 2010-11 remuneration disclosed in Norfolk Community Health and Care NHST Annual Report.	N/A	N/A	N/A	120-125	0	0

Non-Executive Committee Members (Shadow Board) 2010-11 remuneration disclosed in Norfolk Community Health and Care NHST Annual Report						
Geoffrey Chilton	N/A	N/A	N/A	5-10	0	0
Vivienne Clifford-Jackson	N/A	N/A	N/A	0-5	0	0
Lisa Gamble	N/A	N/A	N/A	0-5	0	0
James Ross	N/A	N/A	N/A	0-5	0	0
Alistair Roy	N/A	N/A	N/A	0-5	0	0
Clinical Executive Committee (ClEX)						
Ian Mack (Chair until 31 March 2011)	90-95	0	0	55-60	0	0
Chris Francis	40-45	0	0	35-40	0	0
Cath Robinson	40-45	0	0	35-40	0	0
Becky Judge	40-45	0	0	35-40	0	0
Cathal Daly	40-45	0	0	35-40	0	0
Victoria Holliday	40-45	0	0	35-40	0	0
Gerie Hadman left (10 February 2010)	0	0	0	20-25	0	0
Andy Furniss left (10 February 2010)	0	0	0	25-30	0	0
John Sampson left (1 December 2009)	0	0	0	50-55	0	0

The provider services of NHS Norfolk separated to form the Norfolk Community Health and Care NHS Trust on 1 November 2010. Under the principles of merger accounting the finances of the PCT and the Trust are reported separately for the whole of 2010-11. This remuneration report does not, therefore, include any details for executive or non-executive directors of the Trust. Full disclosure of their details may be found in the Annual Report of Norfolk Community Health and Care NHS Trust.

The figures noted above relate to payments within the financial year, rather than annual salary costs. Figures for staff leaving or appointed part way through the year are for that part year only.

Hilary De Lyon, Stephen Wells and Dr Tim Crayford were engaged under self-employed or agency arrangements and the salary figures in the table above relate to the total charge invoiced to the PCT in the year. In 2009/10 Ian Ayres was engaged under self-employed arrangements until 28 February 2010.

Table 2: Pension Benefits 2010/11

Name and Title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2010 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Real increase in Cash Equivalent Transfer Value £000
Norfolk PCT Board Members							
Andrew Morgan	0-2.5	2.5-5	45-50	140-145	758	783	(26)
David Stonehouse	0-2.5	2.5-5	35-40	100-105	444	488	(48)
Ian Ayres	0-2.5	2.5-5	15-20	55-60	423	485	(61)
Paul Cracknell	2.5-5	7.5-10	5-10	25-30	79	63	9
Anne Dray	0-2.5	2.5-5	35-40	115-120	660	675	(20)
Jenny Harries	0-2.5	0-2.5	15-20	55-60	352	321	3
Bryan Heap	0-2.5	0-2.5	20-25	65-70	N/A	540	0
Maureen Carson	(0-2.5)	(0-2.5)	35-40	110-115	690	730	(54)
Jonathan Cook	2.5-5	12.5-15	30-35	95-100	576	529	14
Ian Tegerdine	0-2.5	2.5-5	20-25	60-65	284	290	(14)
Patricia Turner	0-2.5	2.5-5	10-15	30-35	163	154	1

Cash Equivalent Transfer Values

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

Real Increase in CETV

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

Norfolk PCT does not make any contributions to stakeholder pensions.

Details are not required of non-executive directors, non-pensionable managers and independent GPs who are on the Clinical Executive Committee of the PCT since pension disclosures are not required for these groups.

In his budget of 22 June 2010 the Chancellor announced that the uprating (annual increase) of public sector pensions would change from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI) with the change expected from April 2011. As a result, the value of the CETVs for some members has fallen since 31/03/2010.

No CETV values are disclosed for staff over the normal NHS retirement age.

Table 2: Pension Benefits 2009/10

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2010 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2009	Real increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Norfolk PCT Board Members							
Julie Garbutt	0-(2.5)	(2.5)-(5)	55-60	175-180	1132	1040	27
David Stonehouse	0-2.5	0-2.5	30-35	95-100	488	437	20
Jonathan Cook	0-2.5	0-2.5	25-30	80-85	529	479	19
John Battersby	0-2.5	0-2.5	15-20	55-60	315	277	10
Patricia Turner	0-2.5	5-7.5	5-10	25-30	154	99	28
Bryan Heap	2.5-5	9.5-10	20-25	60-65	540	417	70
Maureen Carson	2.5-5	12.5-15	35-40	105-110	730	577	87
Sheila Adams O'Shea	0-2.5	5-7.5	45-50	135-140	923	804	55
Ian Tegerdine	0-2.5	0-2.5	15-20	55-60	290	255	15
Ian Ayres	n/a	n/a	15-20	50-55	485	n/a	n/a

If you would like this Annual Report in large print, audio, Braille, alternative format or in a different language, please contact NHS Norfolk on 01603 257006 and we will do our best to help.

NHS Norfolk
Lakeside 400
Old Chapel Way
Broadland Business Park
Norwich
Norfolk NR7 0WG

Tel: 01603 257000
Web: www.norfolk.nhs.uk

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