NHS

70 YEARS OF THE NHS 1948 - 2018

The Queen Elizabeth Hospital King's Lynn

NHS Foundation Trust

Annual Report 2017/18


12 MAY
NURSES'

Performance Report

2017/18

Contents

Overview

The overview gives readers a short summary that provides them with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Statement from the Chief Executive

This annual report marks the completion of my first year as Chief Executive of the Queen Elizabeth Hospital King's Lynn. It has been a year marked by both achievement and challenge during which I have been struck by both the dedication and commitment of hospital staff and the high esteem in which the local population holds this hospital.

We started this year by introducing a new strap line into the hospital's lexicon, "Staff, Patients, Community". This was a personal commitment to put staff at the forefront of all we do. With our current CQC inspection underway at time of writing, we are far from complacent and we know there is a great deal of work still to do but this statement clearly shows our intent and direction of travel.

We are working to create an approach to care which places the patient and not the organisation at its centre. To do this we must maintain a dedicated and motivated workforce by putting the needs of our staff first and must work consistently and constructively with our partners in the local healthcare system and the community we serve.

Throughout the past year the Trust has worked hard to sustain its service delivery and financial performance while at the same time maintaining the provision of safe care to patients. This has been against a backdrop of one of the most challenging winters on record in the NHS. The Board's corporate objectives are:

1. To deliver care that is safe, effective and provides patients with the most positive experience possible
2. To develop and sustain a well-led, effective, motivated and productive workforce
3. To secure financial sustainability
4. To develop, maintain and maximise the potential of the Trust's infrastructure and assets
5. To engage effectively in system-wide transformation planning / re-design and plan implementation, for the benefit of our patients and the community we serve

After a third inspection by the Care Quality Commission (CQC) in June 2015, and the subsequent decision by Monitor (now NHS Improvement) to take the Trust out of special measures in August of that year, the organisation's focus has been firmly on work to address its current rating of 'requires improvement'.

To this end the Trust has developed and implemented a range of internal programmes to improve quality and ensure financial and clinical sustainability. In the past year these have included:

- The embedding of a 100 day challenge methodology to engender behavioural change among staff and deliver service improvements.
- The introduction of the 'Red 2 Green' scheme aimed at reducing the number of days patients spend in the hospital with no positive action being taken in relation to their ongoing care needs.
- The roll out of the 'End PJ Paralysis' campaign internally and playing a key role in its national roll out.
- The implementation of a challenging CIP programme under the banner of the Trust's financial prudence and value for money campaign, Back to Black.
- The continuation of the Trust's recruitment drive, which has seen the implementation of a more streamlined recruitment system and several successful recruitment events for Alied Health Professionals (AHPs) and nurses.
- An outline business case to reroof the hospital approved by NHSI.

Externally the Trust has continued its close collaboration with its partners in the local health economy and the wider region, as part of its approach to integrate more closely. This has included the executive team's collaboration with partners to:

- Continue with the close collaboration with West Norfolk CCG which developed from recommendations arising from the regulator's Contingency Planning process looking at the health economy of West Norfolk.
- Develop and implement the Norfolk and Waveney Sustainability and Transformation Partnership (STP) work
- Continue the collaboration between the three acute hospitals in Norfolk which began with the Norfolk Provider Partnership agreement in 2016.
- Maintain and improve the local A&E Delivery Board with the Trust CEO as its chair so that it brings partners together and enables solutions to mutually shared problems.

The Trust is not complacent about the challenges it faces and the risks to the organisation. These challenges and the steps to address them are set out in the Annual Governance Statement. However, our key challenges remain:

- Financial sustainability
- The emergency pathway
- Nurse and medical staff recruitment
- Embedding and sustaining quality improvements.

It has been a notable disappointment that for the second year in a row the Trust has failed to achieve its budgetary commitments. This year the Trust did not meet the deficit target it initially agreed or, following capacity issues in winter which saw the cancellation of much of the elective programme for several months, its revised deficit target. I am, however, pleased to report that we delivered our Cost Improvement Programme of £8.2m in full. This is the first time we have achieved our full target for some years. Our new Director of Resources has spent the past year putting fiscal control systems in place which now give us confidence that we are able to remain in control of the financial elements of our business in the future to deliver on our promises and value for money services.

This has been a difficult year to work in the NHS and I am incredibly proud of all staff at The QEH. They remain dedicated and committed to providing the best possible treatment to every patient who comes through our doors.

I would also like to thank our League of Friends and other charitable donors without whose fundraising efforts our patients' experience would be much diminished. Their generosity is a clear demonstration of the importance that our local community places on the services provided by our hospital. This is yet another reason why all at The Queen Elizabeth Hospital King's Lynn are committed to ensuring it has a bright and sustainable future.

In addition, I would like to thank our very dedicated and committed governors who support us daily.

With the continued help and dedication of our staff, and the support of our partners and the wider community, I have every confidence we can continue to ensure a bright future for this hospital and deliver the best care possible for every patient who comes here for treatment.

Jon Green – Chief Executive
Date: 22/5/2018

Purpose and activities of the foundation trust

The Queen Elizabeth Hospital provides acute services to the populations of King's Lynn and West Norfolk, and parts of Cambridgeshire, Lincolnshire, North Norfolk and Breckland.

In view of its geographic position on the borders of Norfolk, Cambridgeshire and Lincolnshire, the Trust is commissioned by clinical commissioning groups from the three counties, to provide acute hospital services. The lead commissioner is West Norfolk Clinical Commissioning Group.

The QEH provides acute services at district general hospital level for the following specialist areas:

- Accident and Emergency
- Day Surgery
- Breast Surgery
- Cardiology
- Specialist Care of the Elderly
- Clinical Health Psychology
- Cytopathology
- Ear, Nose and Throat
- Maxillo Facial Surgery
- Microbiology
- Neurophysiology
- Oncology and a specialist Macmillan unit
- Neurology
- Obstetrics and Gynaecology
- Orthodontics
- Paediatrics
- Radiology
- Respiratory
- Rheumatology
- Urology
- Critical Care
- Haematology
- Dermatology
- Fertility
- Neurology
- Pathology
- Ophthalmology
- Orthopaedics

1980. People queue to look inside the newly-built Queen Elizabeth Hospital on Gayton Road, King's Lynn.

In addition the hospital has a renal dialysis unit, which is an outreach unit of the nephrology service in Cambridge. Our oncology service is supplemented by additional facilities in Cambridge and thoracic and plastic surgery services are provided by the Norfolk and Norwich University Hospital.

A brief history of the foundation trust

The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust was authorised as a Foundation Trust in 2011.

The Trust was placed in 'special measures' in October 2013 after a CQC inspection in May and a Rapid Response Review (RRR) in August of that year. The Trust was found to be non-compliant with 12 of 16 CQC outcomes and the RRR made recommendations to improve patient care. Four formal warning notices were also served on the Trust by the CQC.

A re-inspection by the CQC in July 2014 found that improvements had been made in consent to care and treatment, care and welfare of patients, nutrition and hydration, incident reporting, respecting and involving service users, dealing with complaints, keeping records, and co-operating with other providers. However, our

services remained non-compliant with the regulations on staffing, support for workers, safeguarding and medicines management and so the Trust remained in 'special measures'.

A third inspection took place in June 2015. In its resulting report the CQC recognised the Trust's work and progress on its improvement journey. While continuing to rate the organisation as 'requires improvement', the CQC acknowledged that the Trust had made significant improvements, notably in the 'well led' domain, and the inspectorate recommended to Monitor that the Trust be taken out of special measures. The following assessment was made across five domains:

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well Led	Good

Monitor, which has since become NHS Improvement, subsequently removed the Trust from 'special measures' in August 2015. At time of writing the Trust is currently undergoing its most recent inspection by the CQC.

Key issues and risks in delivering the Trust's objectives

The Board has agreed its Corporate Objectives as:

1. To deliver care that is safe, effective and provides patients with the most positive experience possible
2. To develop and sustain a well-led, effective, motivated and productive workforce
3. To secure financial sustainability
4. To develop, maintain and maximise the potential of the Trust's infrastructure and assets
5. To engage effectively in system-wide transformation planning / re-design and plan implementation for the benefit of our patients and the community we serve

The Board also agreed its Principal Risks to the delivery of these objectives.

At the January 2018 review, the articulation of the Principal Risks was reviewed and in some cases revised, to account for the developing strategic environment in which the Trust operates.

Principal Risks, as revised in January 2018 are:

- There is a risk that patients do not receive quality care because clinical effectiveness, safety, and/or experience do not meet accepted standards
- There is a risk that the Trust will not deliver its short or longer-term financial plans.
- There is a risk that the Trust will not exert effective influence in the STP forum and other partnerships to secure appropriate transformation
- There is a risk that the Trust does not establish appropriate workforce engagement, leadership, capacity and capability to support the delivery of its objectives
- There is a risk that the Trust's physical infrastructure, including IT and Estate will not be maintained / improved and be fit for the future needs of the Trust

The Board has monitored its position in respect of these principal risks at each public Board meeting throughout 2017/18, and has continued to identify its key risks as being financial sustainability, workforce and estate.

Going concern

The concept of going concern is a basic assumption within accounting practice, where it is assumed that an entity will be able to continue to operate for a period of time sufficient to enable it to fulfil its commitments, obligations and objectives. In other words, the entity will not be forced to cease its business in the foreseeable future.

There is no presumption of going concern status for NHS foundation trusts and Directors must decide each year whether it is appropriate to prepare the Trust's accounts on the going concern basis.

In making this assessment the Board has taken into account best estimates of future activity and cash flows and has been mindful of the Government Financial Reporting Manual which states that "the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient as evidence of going concern."

The Board considered its 'Going Concern' position at its meeting in April 2018 and after consideration of risks and uncertainties agreed that:

'The use of the going concern basis is appropriate but there are material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a going concern, in which case these should be disclosed.'

Nevertheless after making enquiries, and considering the reality of the uncertainty materialising, the Directors have a reasonable expectation that the Trust will have access to adequate cash resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts.

Performance analysis

Financial Performance

In 2017/18 the Trust set a deficit budget of £16.3m. The delivery of this deficit budget was a significant challenge for the Trust particularly against the backdrop of increased activity and the difficulties of recruiting and retaining key members of clinical staff.

In December the Trust presented a 'bottom line' recovery trajectory of £18.2m deficit to the regulator. The bottom line deficit of £20.013m is £1.813m adverse to the recovery trajectory driven by the reasons;

- clinical income not achieving forecast levels £2.8m, and £0.5m relating to a number of factors including CQUIN income shortfall & penalties adverse to forecast.
- all other operating income and expenditure being net £0.1m off trajectory, primarily associated with additional non recurrent non-pay costs off-set by the Learning & Development Agreement (LDA) income being higher than planned.

At the end of the financial year the Trust has recorded a control total loss of £20.013m, which is £3.713m adverse to plan. As noted above, the main drivers of the adverse variance are under delivery of clinical income and additional expenditure on substantive and agency staff associated with managing the pressure of winter demand.

The Trust's core business of acute services is funded by the standard 'payment by results' model of payment, with contracts for services agreed annually with local Commissioners at prices agreed by the Department of Health. The year on year income changes are illustrated in the table below:

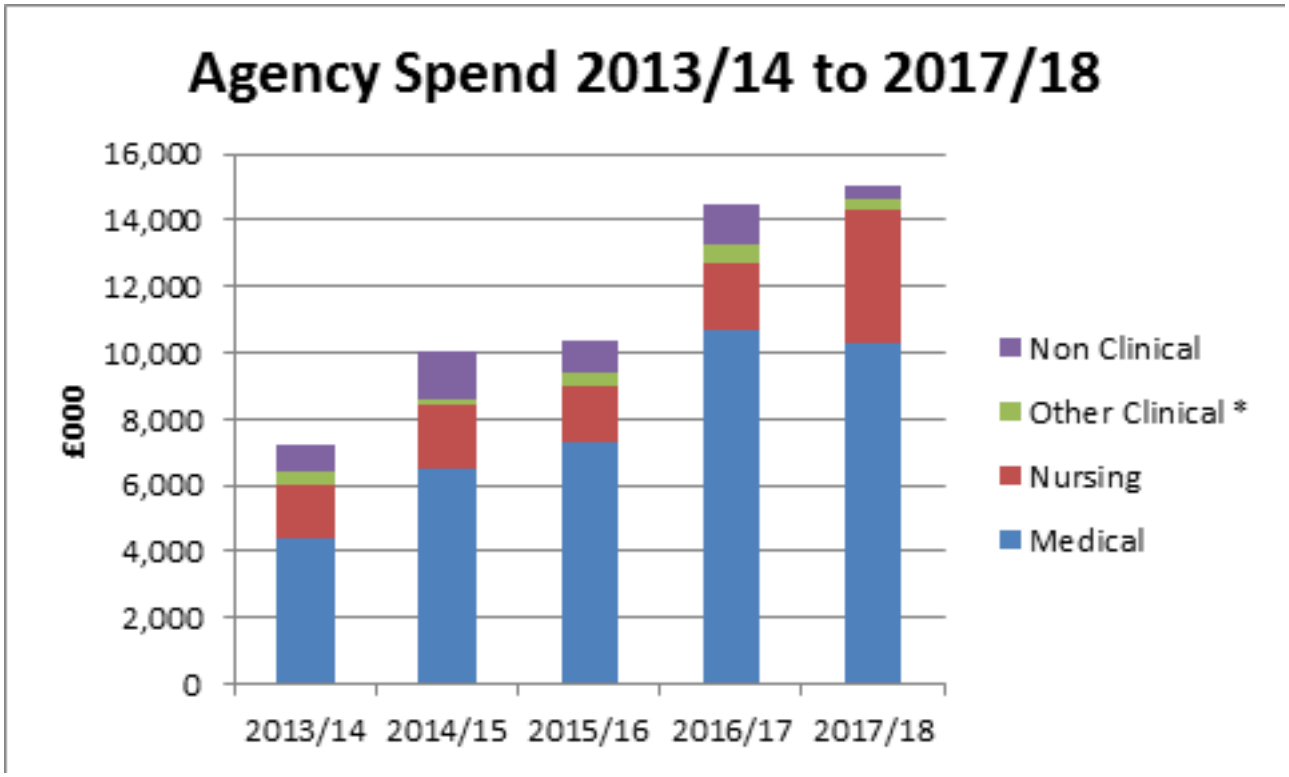
NHS Clinical Revenue	2017/18		2016/17		Activity Variance		Revenue Variance	
	Activity	Revenue	Activity	Revenue				
	No.	£000	No.	£000	No.	%	£000	%
A&E	65,010	8,646	62,319	7,469	2,691	4.3%	1,177	15.8%
Elective Inpatients	5,060	11,240	5,548	12,013	(488)	(8.8%)	(773)	(6.4)%
Elective Excess Bed Days	599	151	697	155	(98)	(14.1)%	(4)	(2.6)%
Daycases	32,361	16,908	32,605	17,835	(244)	(0.7)%	(927)	(5.2)%
Non-elective Inpatients	37,978	62,946	35,926	57,979	2,052	5.7%	4,967	8.6%
Non-elective Excess Bed Days	9,842	2,348	11,434	2,438	(1,592)	(13.9)%	(90)	(3.7%)
Emergency Threshold Cap		(3,795)		(2,810)			(985)	35.1%
Outpatients	**272,599**	29,063	**291,297**	32,311	**(18,698)**	(6.4)%	**(3,248)**	(10.1)%
Other Clinical Income		39,850		37,308			**2,542**	6.8%
Total NHS Clinical Revenue		**167,357**		**164,698**			**2,659**	**1.6%**
Private Patient Income		72		780			**(708)**	(90.8)%
Other Clinical Income		591		433			**158**	36.5%
Total Income from activities		**168,020**		**165,911**			**2,109**	**1.3%**

Clinical income at the end of March is £2.387m adverse to plan (including sustainability funding received of £1.405m). Winter pressures' being more severe than expected is the main driver of the deterioration in the performance. Planned care performance (elective in-patients, day-cases and outpatients) is £5.127m below the plan for the year. Unplanned care (non-elective inpatients and A&E) is £1.517m above plan. All other items of clinical income combine to be £1.223m above plan which includes a winter pressures funding allocation and other non- recurrent items of income.

Under-achievement of the Trust's income plan was compounded by an overspend on expenditure which is chiefly driven by additional costs to support additional activity e.g. staffing costs for additional escalation beds.

The cost of agency staffing remains a significant challenge to the Trust, with expenditure in 2017/18 totalling £15.0m. This is an increase of £0.6m on 2016/17 and £5.0m above the £10m expectation set by the Regulator.

As can be seen from the graph below, the cost of agency staff remains the consistent area of increasing cost as the Trust has a number of vacancies in difficult to recruit to areas. Whilst agency medical staff cost show a slight decrease from £10.7m to £10.3m, agency nursing has risen from £1.9m to £4.0m (a rise of 107%). These are also the areas experiencing the year on year increase in demand. The Trust continues to try and minimise expenditure through implementation of Department of Health led cost control measures but a workforce strategy and plans to address recruitment and retention to specific posts remain a priority for clinical and financial sustainability.



The Trust delivered £8.2m of efficiency savings (including £2.8m associated with the Financial Recovery Plan) which is circa 4% of turnover. The Trust received £18.8m of cash support from the Department of Health.

For 2017/18 the Trust has spent £4.1m on capital expenditure with the main areas being:

- Medical Equipment - £820k
- Backlog Maintenance - £744k
- CT Scanners - £719k
- Pharmacy Robot - £592k
- End of Life IT Hardware - £355k
- GP Streaming Development - £319k gross (£159k of control funding received)
- L1 Fire Alarm - £297k
- Various Other - £137k
- Donated Assets - £92k

Work on the installation of the L1 Fire Alarm commenced in December 2017. The Pharmacy ADS 'Robot', was successfully commissioned and went live in March 2018.

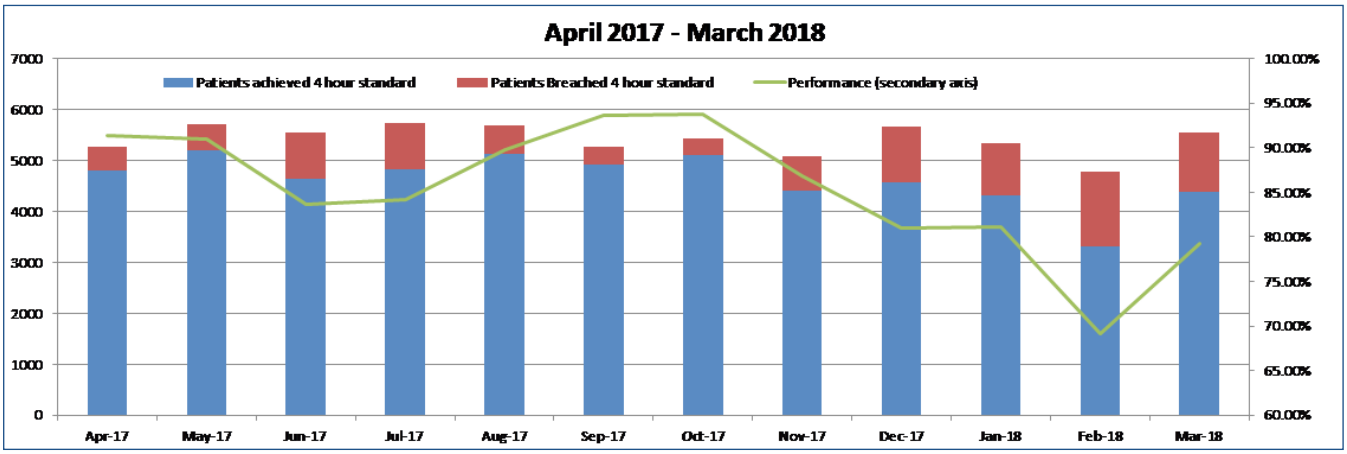
As at the 31st March 2018 the Trust has received over £82m of Department of Health loans. The Trust remains in a financially unsustainable position and continues to work with partner organisations, developing long term strategies and service transformation plans that can return the overall health economy to a clinical and financially sustainable position.

Operational Performance

This section outlines the Trust's performance in several of the key performance indicators. Performance is reported to NHS England, the Department of Health and NHS Improvement on a regular basis.

Accident and Emergency 4 hour access target

The Trust has had another year of unprecedented A&E demand. Across the year the Trust saw a 4.1% growth in A&E attendances in 2017/18 compared to 2016/17. Against this challenging backdrop the Trust has seen some dips in performance against the four hour target. Significant work is being done across the system, led by the QEH Catchment A&E Delivery Board to seek to streamline patient flow across emergency pathways of care. This work is being led by the QEH CEO and AO of WNCCG. The Trust is striving to minimise internal delays, supported by the introduction of a number of initiatives (Point Prevalence / Red2Green / Fit2Sit etc.) The Trust continues to work with its system partners to both minimise delays in discharging patients to appropriate care settings and to help inform demand management schemes that may help to control demand. This work is being focused by the planned implementation of Discharge to Assess in 2018/19.



Month	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17
Patients achieved 4 hour standard	4812	5187	4632	4817	5117	4919	5102
Patients breached 4 hour standard	458	512	906	908	581	338	336
% achievement of standard	91.31%	91.02%	83.64%	84.14%	89.90%	93.57%	93.82%

Month	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	17/18
Patients achieved 4 hour standard	4417	4579	4321	3302	4390	55595
Patients breached 4 hour standard	666	1076	1007	1472	1149	9409
% achievement of standard	86.90%	80.97%	81.10%	69.17%	79.26%	85.53%

Ambulance Handover

Intrinsically linked to the Trust's 95% access target is the ability of the Trust to receive patients from ambulances. This target, known as the handover waiting time, shows the amount of time the ambulance and crew have had to wait with the patient before A&E were able to accept the patient. The standard expected is that a patient is handed over within 15 minutes.

	0-15 Minutes	15-30 Minutes	30 - 1 Hour	1 Hour +	Grand Total
April - EEAST	450	988	176	83	1697
May - EEAST	439	1032	112	77	1660
June - EEAST	411	962	174	120	1667
July - EEAST	393	887	173	86	1539
August - EEAST	330	1069	134	55	1588
September - EEAST	399	1096	128	33	1656
October - EEAST	382	1109	76	23	1590
November - EEAST	395	1021	168	105	1689
December - EEAST	386	1020	142	76	1624
January - EEAST	324	1050	365	282	2021
February - EEAST	176	1066	314	248	1804
March - EEAST	439	1012	415	193	2059

The Trust has implemented a range of initiatives in partnership with EEAST and supported by ECIP to seek to reduce the length and number of Ambulance Handover delays and has successfully implemented the Ambulance Handover protocol. The Trust remains committed to improving this position and delivering a better patient experience. This will require similar actions to those highlighted under the 4 hour access target, with some of the most challenging actions supporting flow through the whole health and social care system.

Cancer access targets

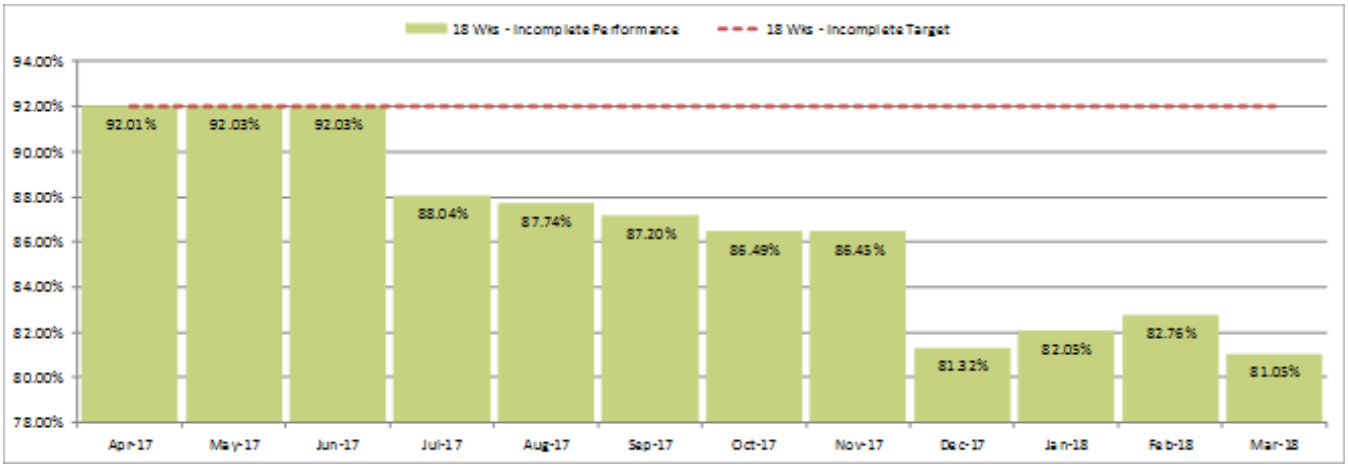
While the Trust has consistently met the 14 day and 31 day standards, there have been dips in performance against the 62 day standard in quarters one and four. This has been due to a range of reasons which have been recognised by the Trust and several significant pieces of work have been undertaken to seek to ensure that we are delivering timely care for our patients.

Cancer Services have continued to focus on 62 day backlog reduction and embedding escalation processes within operational teams to minimise breaches and rollovers from one month to the next, and ensure that the 85% standard is achieved consistently going forward. All issues with each pathway have been captured in an overarching Remedial Action Plan. This will ensure our recovery is both rapid and sustainable.

	Target	Q1	Q2	Q3	Q4
2 week wait	93.00%	97.44%	96.21%	95.97%	97.19%
31 days	96.00%	98.39%	98.52%	99.38%	98.28%
62 days	85.00%	79.37%	87.44%	85.06%	80.29%

Eighteen Week Referral to Treatment Time

The Trust has seen a significant deterioration in performance against the 18 week RTT target in 2017/18.



This dip in performance has been as a result of a number of factors, including the impact of increased non-elective demand upon the elective bed base. A detailed action plan is in place for each specialty with clear forecast trajectories which have been developed by the operational teams and are being supported by the CCG to ensure that we recover performance in 2018/19.

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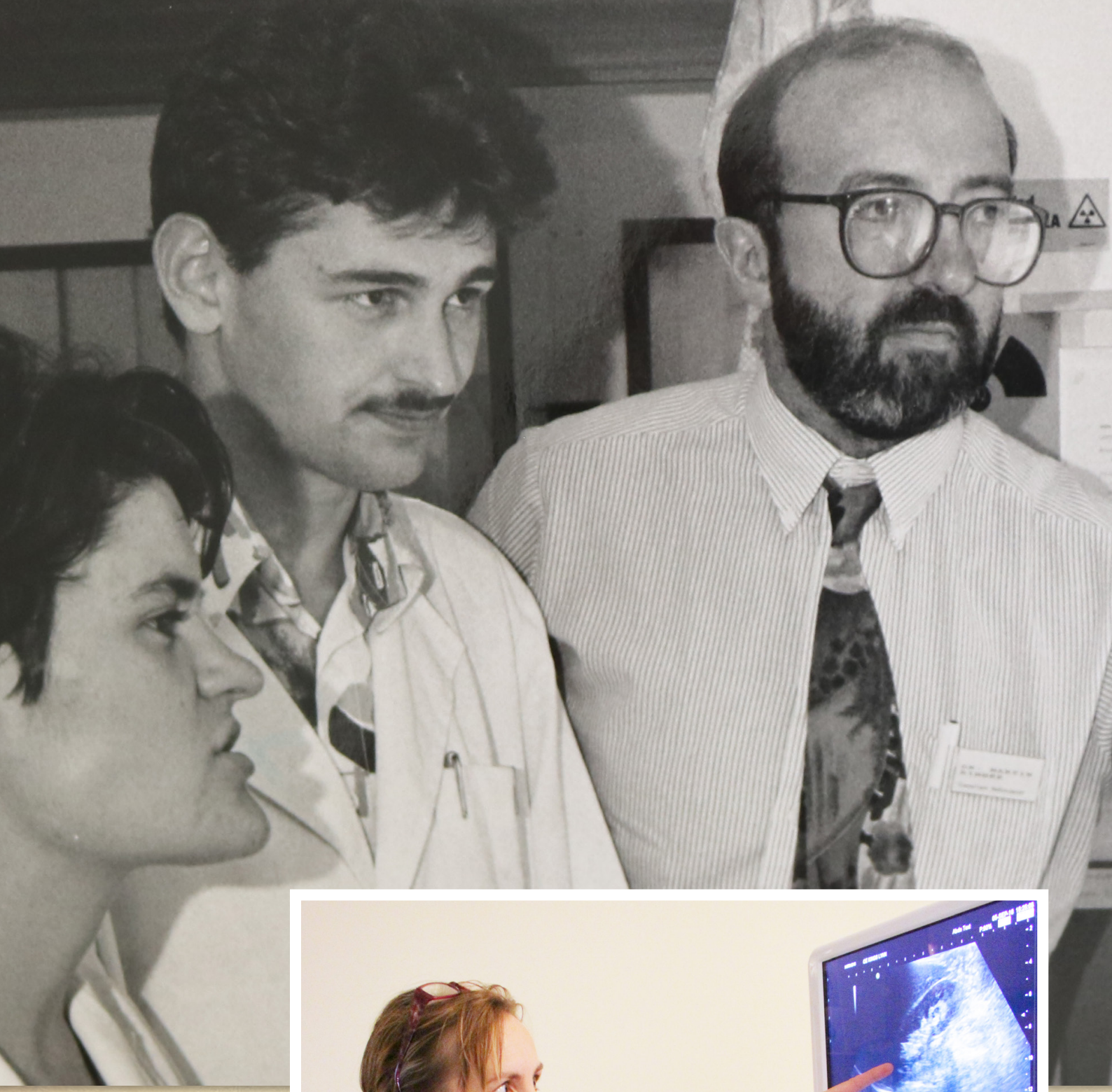
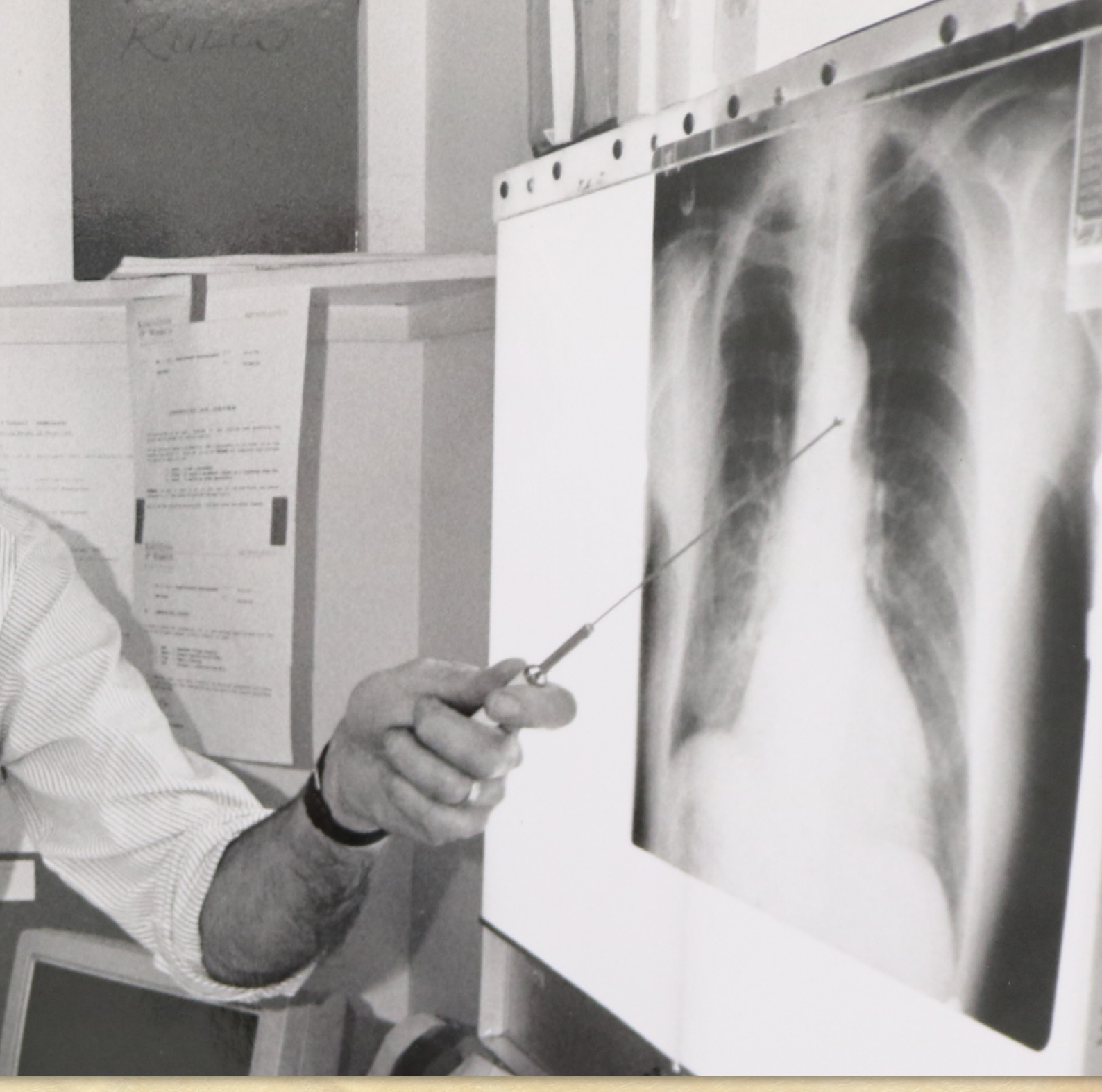




Accountability Report

2017/18

Contents

I am pleased to present the Trust's Accountability Report.

Jon Green – Chief Executive
Date: 22/5/2018

Directors' report

How our hospital is governed

What is a Foundation Trust?

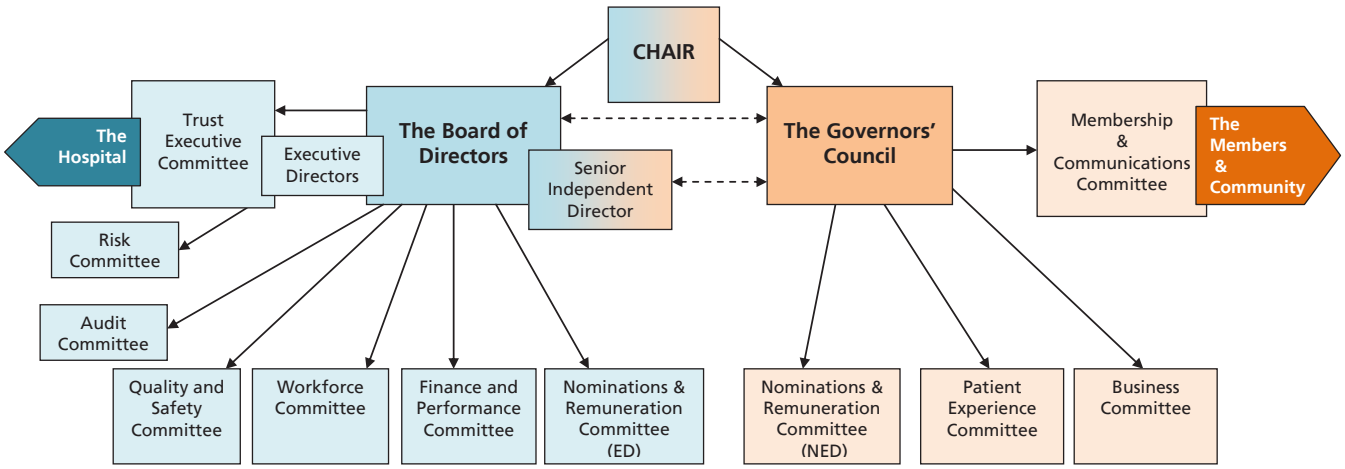
A Foundation Trust is a Public Benefit Corporation. This means that:

- The Trust is accountable to the communities we serve through the Governors' Council and Foundation Trust members
- Members of the Foundation Trust elect both public and staff representatives from the membership to serve on a Governors' Council
- The Trust is independent and accountable direct to Parliament
- The Trust remains part of the NHS
- Our key regulators are NHS Improvement (referred to here as 'the Regulator') and the Care Quality Commission.

A Foundation Trust has both a Board of Directors and a body to represent the interests of the Foundation Trust membership and the community served by the Trust. At The Queen Elizabeth Hospital, this body is called the Governors' Council. The Governors' Council has a range of statutory, strategic and locally determined functions.

The Trust operates within a framework of corporate governance, which can be defined as 'the systems, processes and behaviours by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety and quality of service as they relate to patients and carers, the wider community and partner organisations'. Department of Health - Integrated Governance Handbook.

The Queen Elizabeth Hospital, King's Lynn Governance Structure



Key
ED = Executive Director
NED = Non-Executive Director

Edward Libbey – Chair

Edward became a Non-Executive Director of NHS Norfolk in October 2006. He subsequently joined the NHS Norfolk and Waveney Cluster Board where he was also Chair of its Audit Committee. In July 2012 he was appointed to the Cluster Board of NHS Cambridgeshire & Peterborough and as its Audit Committee Chair, until its transfer of responsibilities to the CCG and other organisations on 31 March 2013. Edward joined The Queen Elizabeth Hospital, King's Lynn as Chair in July 2014.

David Thomason – Vice Chair

David recently retired from the post of Deputy Chief Executive, Executive Director for Resources, at the Borough Council of King's Lynn and West Norfolk. He is a qualified accountant and was a member of the Chartered Institute of Public Finance and Accountancy (CIPFA). David joined the Board of The Queen Elizabeth Hospital, King's Lynn in August 2015. As well as his role as Vice Chair, David chairs the Finance and Performance Committee and is the Senior Independent Director (SID).

Ian Pinches

Ian is a Fellow of the Association of Chartered Certified Accountants (FCCA) and is also a Fellow of the Royal Society for the encouragement of Arts, Manufactures and Commerce (FRSA). He owns his own business and his interests outside work include charitable housing. Ian chairs the Audit Committee. Ian has been a member of the Board since November 2012.

Mandy Ashton

Professor Ashton has worked in healthcare for 31 years in various roles, including nursing and policy making. She has worked in community and acute settings but has helped to develop education and training programmes for nurses in Uganda and Labrador. In 2008, Prof Ashton became a Professor of Clinical Leadership with De Montfort University in Leicester. Two years later she was awarded an OBE for services to nursing and healthcare. Mandy joined the Board in August 2017.

Ian Harvey

Professor Harvey is a doctor and professor of Epidemiology. He qualified from Cambridge and Cardiff and, after working in hospital medicine and general practice, has spent most of his career working in universities. Since 1998 Ian has been based at the University of East Anglia where until recently he was Dean of the Faculty of Medicine and Health Sciences. He was a Non-executive Director of Norfolk Community Health and Care from January 2013 until January 2016, when he joined the Board of The Queen Elizabeth Hospital, King's Lynn.

Jon Green – Chief Executive

Jon was an officer in the Royal Navy for 20 years before joining the NHS in 2005 as part of the Gateway to Leadership programme. He has a wealth of experience in healthcare management after working at The Whittington Hospital in London, Kettering District General Hospital and West Suffolk NHS Foundation Trust. He took over the helm of the Hospital in May 2017.

Roy Jackson - Director of Finance and Resources

Roy joined the Trust in spring 2017. He has been an NHS director of finance for 17 years and has also served a period as an Acting Chief Executive Officer. Roy has very broad experience of the NHS, working right across the healthcare system in commissioning, mental health services, community services and acute services. His role encompasses finance, estates and facilities, procurement and, from April 2018, contracting.

Nick Lyons – Medical Director

Nick started his career in the armed forces as an RAF Medical Officer and became a junior doctor in 1989 after graduating from Manchester University. He has worked in General Practice and in the Department of Health and has experience in service redesign and quality innovation. Nick has held the posts of Medical Director in the Channel Islands and Weston Area Health Trust before joining the team in King's Lynn during April 2017.

Emma Hardwick – Chief Nurse

Emma is dual qualified as a nurse and midwife. She brings a wealth of nursing, midwifery and managerial experience in the East of England and London. Emma completed her Master's degree in 2008 and is a Nye Bevan graduate. She joined the Trust in January 2017 from The Ipswich Hospitals NHS Trust, where she was Associate Director of Nursing and Midwifery for three years.

Jon Wade – Chief Operating Officer

Jon has been working in the NHS for 15 years after starting his career at NHS Blood and Transplant. He moved to the Trust in 2011 where he has held the positions of Head of Information and Contracts, Financial Recovery Lead and Deputy Director of Contracting and Information. Jon, who holds a Master's Degree, took on the role of Director of Strategy and IT in November 2016 and became Chief Operating Officer in April 2018.

Ciara Moore – Chief Transformation Officer

Ciara has been working in healthcare for several years and completed a Master's degree at Anglia Ruskin University Cambridge in 2014. She has held a variety of positions at Cambridge University Hospitals Trust, including Operations Manager for Medicine, Deputy Associate Director of Operations for Medicine and Deputy Director for Recovery. Ciara joined the hospital in March 2017 as Chief Operating Officer. She was made Chief Transformation Officer in April 2018.

Karen Charman – Interim Director of HR and OD

Karen began work with the Trust as Director of Human Resources in the late spring of 2017. She is a qualified nurse who has developed a national senior leadership profile across a range of disciplines, including Human Resources, workforce design, productivity transformational change, communications, business development and integrated performance management.

For names of those who at some point during the financial year were directors of the Trust but who no longer hold the position, please see the relevant table in the remuneration report.

All directors are required to complete, and keep up to date, their declarations of Interest. These are recorded in the Register of Directors' Interests. A copy of the register is presented periodically at the Board's public meetings and is available by contacting the Trust Secretary on 01553 613614.

Statutory statements

As part of the Directors' Report the Trust is required to make the following statutory statements:

- So far as the directors are aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware
- The directors 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 NHS foundation trust's auditor is aware of that information
- The Trust can confirm that it has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance
- The Trust has made no political donations to any individual, body or organisation in the 2017/18 financial year
- Our Trust is committed to working with all of our supplier partners fairly and professionally. One way that we do this is by working to the Better Payment Practice Code. We aim to pay at least 95% of invoices within the agreed terms, unless there is a dispute or for other reasons. For most of our partners, this would be within 30 days of the date of invoice or receipt of goods & services. However, in some cases this may not be the case due to lack of adequate supplier information.

The Trust's performance for 2017/18 is shown in the following table:

	Number	£m
NHS Suppliers		
Total invoices paid to target	66	£4.4
Total invoices paid in year	1,120	£12.9
% paid within target	6%	34%
Non NHS Suppliers		
Total invoices paid to target	5,691	£9.8
Total invoices paid in year	50,033	£66.0
% paid within target	11%	15%
Combined		
Total invoices paid to target	5,757	£13.8
Total invoices paid in year	51,153	£78.9
% paid within target	11%	17%

The poor performance in 2017/18 is driven by the timing of receipts and the requirement for loan funding.

- Income received from the provision of goods and services for the purposes of healthcare services is greater than income received for any other purposes. Income received for services other than healthcare

services, is used for the benefit of the hospital and its patients.

'Well-Led Framework'

The regulatory definition of a 'well-led' organisation is one where the leadership, management and governance of the organisation ensure the delivery of sustainable high quality person-centred care, support learning and innovation, and promote an open and fair culture.

The Board submitted its self-assessment against the Well-Led framework to NHSi in December 2017. Since then, the Trust has been addressing identified areas for improvement and has in place a comprehensive Board Development Programme.

The Trust is anticipating a CQC Well-Led assessment in June 2018, as part of the inspection that began in April 2018. More information can be found in the Annual Governance Statement.

The Trust has had regard to NHS Improvement's 'well-led' framework in arriving at its overall evaluation of the organisation's performance, internal control, board assurance framework and quality improvement plans.

The Board believes that there are currently no material inconsistencies between:

- the annual governance statement
- the corporate governance statement, the quality report, and annual report and
- reports arising from Care Quality Commission planned and responsive reviews of the NHS foundation trust and any consequent action plans developed by the NHS foundation trust. (CQC Report pending, following inspection in May/June 2018)

Remuneration report

Foundation Trust Remuneration Report

The remuneration report has been audited.

Annual Statement on Remuneration

In accordance with the Regulator's Code of Governance, The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust has two Nomination and Remuneration Committees, dealing with the remuneration of the non-executive directors (NEDs) and executive directors (EDs) respectively. Director membership and meeting attendance in respect of the Nomination and Remuneration Committee is set out in the governance section 'Board of Directors' 2017/18 table'.

The Nomination and Remuneration Committee (NED appointments) is a governor committee, making recommendations in respect of non-executive director remuneration to the Governors' Council (the Governors' Council is not permitted to delegate any of its powers to a committee). The committee is chaired by the Trust Chair (unless the committee is considering the remuneration of the Trust Chair). Non-executive director remuneration is benchmarked using NHS Providers' annual survey analysis, and, as a reflection of spending restraint in the NHS and the very low pay awards made to staff subject to Agenda for Change in the organisation in recent years, there have been no changes to the remuneration of the non-executive directors or the Trust Chair in 2017/18.

The Nomination and Remuneration Committee (ED appointments) is a committee of the Board, with delegated authority to approve the terms and conditions, including the remuneration of the executive directors. The members of the committee are the non-executive directors and the CEO (unless the committee is considering the remuneration of the CEO), chaired by the Trust Chair. Executive remuneration is benchmarked using NHS Providers' annual survey analysis, on appointment and annually. As a reflection of spending restraint in the NHS, and, the very low pay awards made to staff subject to Agenda for Change in the organisation in recent years, the Nomination and Remuneration Committee (ED appointments) have made no changes to executive director remuneration in 2017/18.

The terms of reference of The Nomination and Remuneration Committee include provisions to secure oversight in the matter of compliance with Department of Health, Her Majesty's Treasury and regulatory guidance in respect of remuneration arrangements for Very Senior Managers.

Edward Libbey - Trust Chair and Chair of the Remuneration Committee
Date: 22/5/2018

Senior Managers' Remuneration Policy

The Trust has an Executive Director Pay Policy in place.

The Chief Executive undertakes the appraisals of the executive directors and the Chair undertakes the Chief Executive's appraisal, making an assessment of overall performance against annually agreed objectives.
The Trust had no 'Performance–Related Pay' incentives in place in 2017/18 for executive directors or other very senior managers.

The Trust had two executive directors earning more than £150,000, in post in 2017/18. Both directors were appointed and remuneration agreed after seeking the views of ministers via NHS Improvement as required by the June 2015 guidance from Department of Health before making executive/ VSM appointments with

a higher salary than the Prime Minister (£150,000), with justification. All executive salaries are within the benchmarked range for foundation trusts.

The checklist used by the Nomination and Remuneration Committee (ED appointments) facilitates the committee's consideration of, and compliance with, guidance issued since 2015 by the DoH, Her Majesty's Treasury and the regulator in respect of the terms and conditions for executive directors, other very senior managers, interim appointments and consultants. The checklist assimilates guidance relating to:

- Proposed Very Senior Manager (VSM) remuneration of more than £150,000
- Board members, including interims should be 'on-payroll', except in exceptional, short-term cases
- Where there are exceptional, short term cases - interim daily rates paid should not normally exceed what would be paid to substantive appointees
- 'Retire and Return' – VSMs, particularly those leading organisations receiving additional tax payer support, should not be better off by taking their pension and returning almost immediately, to work for the NHS
- The new redundancy terms for NHS staff in England (within section 16 of Agenda for Change) should apply to all newly appointed VSMs (unless they are on statutory redundancy terms)
- Senior staff should not be leaving on significantly better compensation packages than more junior colleagues The approval process for management consultancy costs
- 'Fit and Proper Person' test – All Board level appointments to be subject to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19 – 'Fit and Proper Person' test
- Revised tax guidance responsibilities from April 2017
- Employment or engagement following NHS Redundancy

Very Senior Managers (VSM)

The Trust's definition of Very Senior Managers (VSM) comprises of executive and non-executive directors operating at board level.

Non-executive and governor expenses

Expenses are reimbursed to both directors and governors in accordance with the Trust's policies. Aggregate non-executive director expenses for 2017/18 were £8,314. Aggregate governor expenses were £6,102.

Service Contract Obligations

The Trust has historically engaged a number of contractors who have all signed an agreement to a notice period, usually of one month. There are no additional or specific obligations on the Trust should there be a need for early termination of any such contracts.

Remuneration Committee

Details of the membership and attendance at the Nomination and Remuneration Committees (EDs) can be found in the Governance Section of the Annual Report table, 'The Board of Directors and Supporting Executive Portfolio Holders - in 2017/18'.

Remuneration Received

The remuneration of the Board of Directors appointed or leaving during the year is included for their period of membership only.

Details of remuneration and audited information

Details of Directors' remuneration for the period ended 31 March 2018 is set out in the Remuneration tables.

The median remuneration of the reporting entity's staff is based on annualised, full-time equivalent

remuneration of all staff (including temporary and agency staff) as at the reporting date.

The calculation uses the basic salary of each employee, part time staff have had their salary grossed up to their full time equivalent salary. The banded remuneration of the highest paid director, calculated for comparison purposes on a full time basis at The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust in the financial year 2017/18 was £160,000 -£165,000 (2016/17 - £300,000-£305,000); this was 7.16 (2016/17 – 13.83) times the median remuneration of the workforce, which was £22,683. In 2017/18, no members of the workforce received remuneration in excess of the highest paid director. Remuneration ranged from £1,733 to £160,000.

This information is presented in this way to:

- ensure transparency in executive remuneration;
- provide the trust with an opportunity to monitor their own remuneration and note any adverse or anomalous trends.

Fair Pay multiple		
	2017/18	**2016/17**
	£	**£**
Midpoint of banded remuneration of highest paid* director - full year effect	163,000	303,000
Median total remuneration	22,683	21,909
Ratio	7.16	13.83

Total remuneration includes salary, non-consolidated performance related bonuses, benefits in kind as well as severance payments. It does not include employer pension contributions, the cash equivalent transfer value of pensions, overtime or shift allowances.

The median and lowest salary cost for the Trust is low compared to some other trusts. This is as a result of the Trust not having outsourced non-clinical services, for example domestic and catering staff remain the employees of the Trust.

The highest paid director of the Trust in 2017/18 was the Medical Director whilst in 2016/17 it was the Interim Medical Director.

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Foundation Trust Directors Remuneration Report					
		1st April 2017 to 31st March 2018			
Salaries and allowances		**(a) Salary**	**(b) Expenses payments (taxable)**	**(c) Performance pay and bonuses**	**(d) Long term performance pay and bonuses**
		Bands of £5,000	**To nearest £100**	**Bands of £5,000**	**Bands of £5,000**
Edward Libbey	Chairman	50-55	1000		
Ian Pinches	Non-executive	10-15			
John Rees (to 30/09/2017)	Non-executive	5-10	100		
Maureen Carson (to 21/12/2017)	Non-executive	5-10	300		
David Thomason	Non-executive	10-15			
Ian Harvey	Non-executive	10-15	100		
Mandy Ashton (from 21/08/2017)	Non-executive	5-10	100		
Jon Green (from 01/05/17)	Chief Executive	145-150			
Karen Croker (from 01/04/2017 to 05/05/2017)	Chief Executive	0-5			
Dorothy Hosein (to 31/03/17)	Chief Executive	-			
Nick Lyons (from 01/04/17)	Medical Director	160-165	2100		
Timothy Petterson (from 11/07/2016 to 31/03/2017)	Medical Director	-			
Beverly Watson (to 16/09/2016)	Medical Director	-			
Emma Hardwick (from 16/01/2017)	Director of Nursing	145-150			
Catherine Morgan (to 20/01/2017)	Director of Nursing	-			
Roy Jackson (from 02/05/17)	Director of Resources	125-130			
David Stonehouse (to 02/08/17)	Finance Director	40-45			
Jon Wade (from 21/11/2016)	Director of Strategy and IT	105-110			
Karen Charman (from 03/07/17)	Director of Human Resources	90-95			
Ciara Moore (from 13/03/2017)	Chief Operating Officer	125-130			
Karen Croker (to 31/03/2017)	Chief Operating Officer	20-25	2000		
Sandy Spencer (from 06/06/2016 to 06/09/2016)	Chief Operating Officer	-			
Patricia Dunmore (from 23/07/2015 to 27/05/2016)	Chief Operating Officer	-			

1st April 2017 to 31st March 2018		1st April 2016 to 31st March 2017					
(e) All pension-related benefits	(f) TOTAL (a to e)	(a) Salary	(b) Expense payments (taxable)	(c) Performance pay and bonuses	(d) Long term performance pay and bonuses	(e) All pension-related benefits	(f) TOTAL (a to e)
Bands of £2,500	Bands of £5,000	Bands of £5,000	To nearest £100	Bands of £5,000	Bands of £5,000	Bands of £2,500	Bands of £5,000
	55-60	50-55					50-55
	10-15	10-15					10-15
	5-10	10-15					10-15
	5-10	10-15					10-15
	10-15	10-15					10-15
	10-15	10-15					10-15
140-142.5	285-290						
	0-5						
	-	180-185				0-2.5	180-185
	160-165						
	-	300-305					300-305
	-	75-80				0	75-80
		25-30					25-30
	-	95-100				42.5-45	135-140
60-62.5	185-190						
72.5-75	115-120	125-130	8,100			27.5-30	160-165
82.5-85	195-200	35-40				115-117.5	150-155
225-227.5	350-355	5-10				25-27.5	30-35
	25-30	140-145					140-145
		80-85					80-85
		40-45					40-45

Off-payroll	Left in year
Prior year only	Secondment

Foundation Trust Directors Remuneration Report			
Pension Benefits		**(a) Real increase in pension at pension age**	**(b) Real increase in pension lump sum at pension age**
		Bands of £2,500	**Bands of £2,500**
Jon Green (from 01/05/17)	Chief Executive	5-7.5	10-12.5
Emma Hardwick (from 16/01/2017)	Director of Nursing	35-37.5	110-112.5
Ciara Moore (from 13/03/2017)	Chief Operating Officer	10-12.5	20-22.5
Roy Jackson (from 02/05/17)	Director of Resources	2.5-5	10-12.5
David Stonehouse (to 02/08/17)	Finance Director	2.5-5	0-2.5
Jon Wade (from 05/12/2016)	Director of Strategy and IT	2.5-5	7.5-10
Karen Charman (from 03/07/17)	Director of Human Resources	20-22.5	62.5-65

(c) Total accrued pension at pension age as at 31 March 2018	**(d) Lump sum at pension age related to accrued pension at 31 March 2018**	**(e) Cash equivalent transfer value at 1 April 2017**	**(f) Real increase in Cash Equivalent Transfer Value**	**(g) Cash Equivalent Transfer Value at 31 March 2018**	**(h) Employer's contribution to stakeholder pension**
Bands of £5,000	**Bands of £5,000**	**£000**	**£000**	**£000**	**£000**
75-80	50-55	238	119	403	23
145-150	110-115	-	727	727	17
80-85	55-60	229	164	394	17
230-235	170-175	1185	122	1318	18
175-180	125-130	768	34	868	6
60-65	40-45	158	59	217	14
85-90	60-65	-	326	440	14

Left in year

Staff report

Our Staff

The Trust is one of the largest employers in the West Norfolk area, employing 3246 staff as at 31 March 2018. The Trust aims to be the 'employer of choice', with a range of benefits and incentives and also by offering new and existing staff support to develop through an investment in 'growing-your-own' workforce strategies as an important part of the Trust's plans to ensure a sustainable future workforce.

An analysis of average staff numbers (whole time equivalent)

	31 March 2018			31 March 2017		
	Permanent	Other (Agency & Bank)	Total	Permanent	Other (Agency & Bank)	Total
	wte	wte	wte	wte	wte	wte
Medical and dental	307	53	360	305	51	356
Ambulance staff	3	0	3	2	0	2
Administration and estates	563	13	576	555	21	576
Healthcare assistants and other support staff	276	25	301	270	20	290
Nursing, midwifery and health visiting staff	1254	179	1433	1241	134	1375
Nursing, midwifery and health visiting learners	3	0	3	3	0	3
Scientific, therapeutic and technical staff	316	8	324	309	9	318
Healthcare science staff	55	4	59	58	2	60
Social care staff	0	0	0	0	0	0
Total average numbers	**2777**	**282**	**3059**	**2743**	**237**	**2980**

Staff Gender

A breakdown of staff by gender as at 31 March 2018 is included in the table below: of the number of male and female:

As at 31st March 2018 Staff breakdown by gender			
Category	Female	Male	Total
Exec	3	4	7
Non Execs	1	4	5
Senior Manager	35	29	64
Other	2470	700	3170
Grand Total	2509	737	3246

Staff Costs

It is recognised that staff costs is the largest area of Trust spend and that costs have increased over the last year to ensure high quality safe patient care. There will be a focus during 2018/19 on developing workforce and recruitment strategies to ensure a sustainable affordable workforce with the aim of reducing the reliance on agency workers with a focus on enhanced consistency of care and reducing costs.

	31 March 2018			31 March 2017		
	Permanent	**Other**	**Total**	**Permanent**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Salaries and wages	102,440	3,063	**105,503**	99,873	0	**99,873**
Social security costs	8,044	1,836	**9,880**	8,973	346	**9,319**
Employer's contributions to NHS pensions	11,091	548	**11,639**	10,677	411	**11,088**
Termination benefits	0	0	**0**	41	0	**41**
Apprenticeship levy	483	22	**505**	0	0	**0**
Agency/contract staff	0	15,032	**15,032**	0	14,438	**14,438**
Total Staff Costs	**122,058**	**20,501**	**142,559**	**119,564**	**15,195**	**134,759**

Staff Engagement

The Trust recognises that by developing an engaged, enabled and empowered workforce, which is well-led and supported, the Trust can ensure its staff are getting the best possible experience, and in turn patients are getting the best care. The aim is to improve staff engagement further by introducing new methods to engage with staff for example a weekly Team Brief, staff listening sessions, team meetings.

The Trust encourages open and honest communication throughout the organisation and Executive Team members have an 'Open door' policy. The Executive Team members have also been assigned 'buddy' areas which they visit and engage with staff.

Trust Values

The Trust values are embedded into processes for example values based recruitment. In addition, we have also continued with monthly values-in-action awards where staff can be nominated for a particular value, providing details of how the staff member has put the Trust values into action within their role. These values in action awards are presented by the Trust Chief Executive and details of the award winners are communicated throughout the Trust.

Values in Action Awards

Between April 2017 and March 2018, 153 members of staff have received values awards. The breakdown of the values awards is as follows:

45 Compassion
21 Courage
4 Curiosity
53 Pride
51 Responsibility

Long Service Awards

The Trust recognises staff long service and the following numbers of staff received an award presented by the Chief Executive and Trust Chair for reaching 40, 30, 20 or 10 years' long service from 1 January 2017 to 31 December 2017.

40 years : 1 staff
30 years : 4 staff
20 years : 11 staff
10 years : 17 staff

Leadership Development

Accelerating challenges in healthcare have made it imperative that front line clinicians, particularly nurses and midwives, have the leadership capability to drive radical service redesign and improvement. The ability to influence and lead change at the front line is now central to delivering this agenda at all levels within the hospital. The Trust has a responsibility to both identify our leaders of the future and support all staff in the role they do today.

Given this context, the Trust continued to support a number of leadership and development programmes to enable staff at all levels achieve their roles in delivering excellent quality patient care and support service functions to ensure high performing teams.

The Trust participated in a new Systems Leadership programme sponsored by Health Education England from May 2017 to March 2018, aimed at developing leadership skills in working across boundaries. The programme was delivered through five cohorts across each participating locality (West Norfolk, Central Norfolk, Great Yarmouth & Waveney, East Suffolk & North East Essex and West Suffolk). Delegates will work collaboratively on an integration related project to improve their systems leadership competencies across four domains; individual effectiveness, relationships and connectivity, innovation and improvement and learning capability building.

Talent Management

During 2017/18 the Trust has been developing its Strategy and Framework for Talent Management across the Employee life cycle. This will be consulted on during the Spring of 2018 and through the launch of a new Behaviours Framework which when finalised will be embedded in all key HR processes. Our recruitment and appraisal process will be the first to be modelled around the agreed framework, which has been designed as a direct result of feedback from Staff.

Our delivery programme will be a balance of proven success at other local organisations and bespoke delivery for the Trust where the need requires. A partner Trust has been recognised nationally for their approach to implementing Talent Management and have agreed to share their materials and learning, which QEH will use. Regional funding is supporting this roll-out via an external agency so there will be no direct cost to the Trust.

Lifelong Learning

Lifelong Learning is a partnership programme between the Trust and our recognised trade unions; it aims to give staff learning opportunities to help with confidence and encourage access to personal development. The opportunities do not necessarily relate to work, with classes including wellbeing activities such as Pilates, yoga, dancing and sewing, as well as continuing support for dementia awareness sessions. The approach to partnership working in setting up Lifelong Learning and the development of a dedicated centre (The Inspire Centre) resulted in the Trust being recognised at the national HPMA awards ceremony in June 2017.

Staff sickness absence

Average FTE 2017	FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence	Average Sickness % 2017
2,778	31,050	11.2	1,014,033	50,371	4.98

From 1st April 2017 to 30th September 2017 the Trust continued to use Firstcare who provided a 24/7 absence reporting line, giving staff access to immediate and on-going advice from a registered nurse. This also supported improvement in sickness absence reporting, with managers receiving real time notifications and alerts.

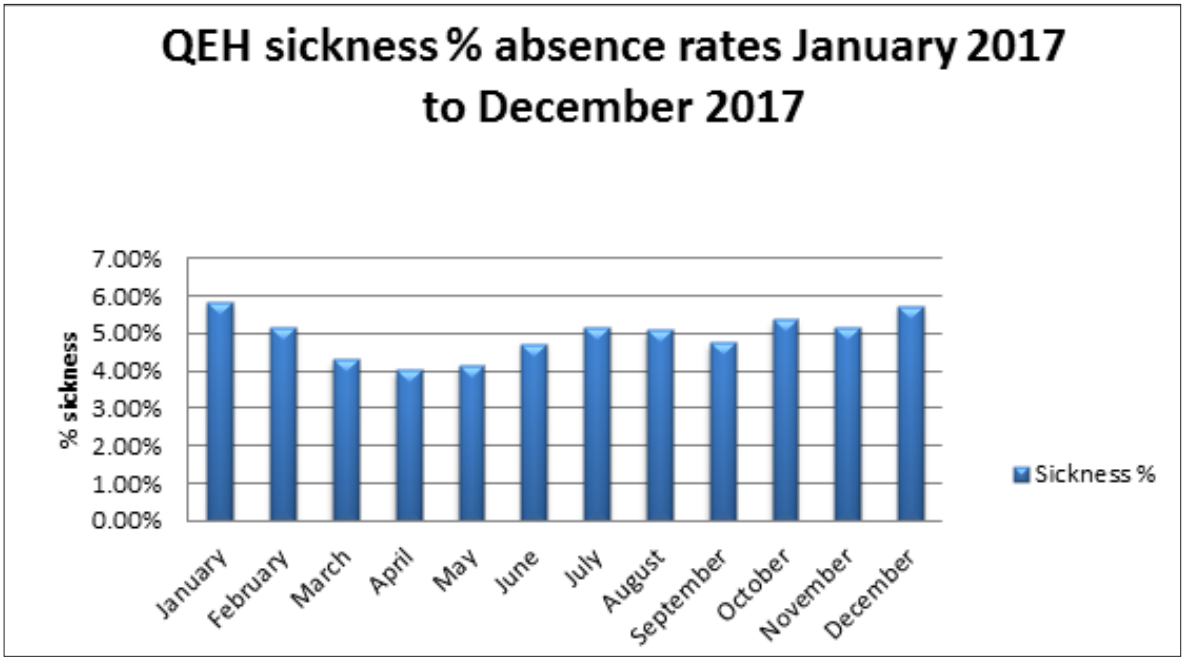
In October 2017 the contract with Firstcare ended and managing absence including reporting mechanisms became the responsibility of Line Managers across all areas. This is considered to have improved challenge to staff absence and offers flexibility in absence management.

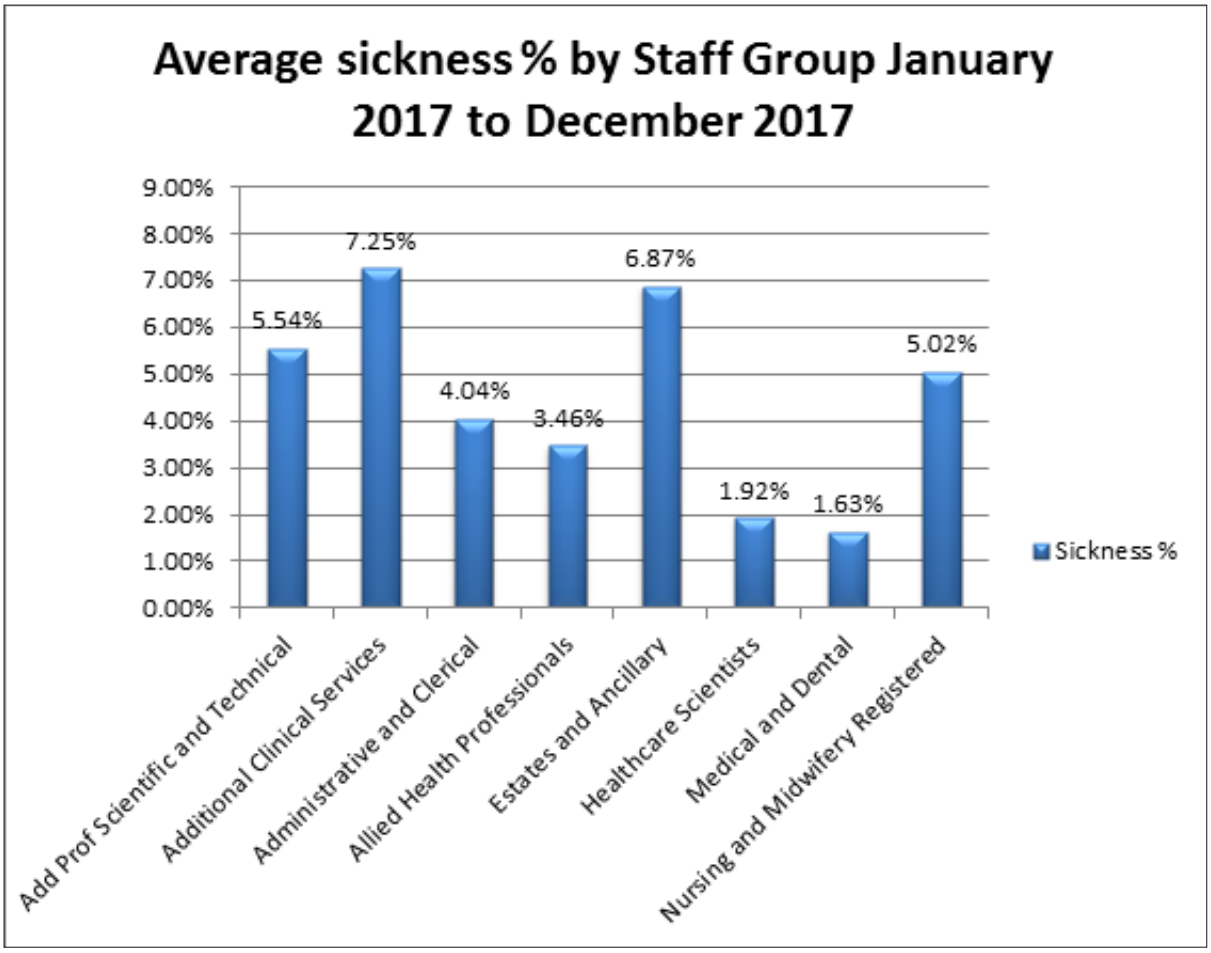
However sickness absence remains a concern for the Trust. In 2017/18 the Trust's average percentage was 5.2, with, despite over 80% vaccination, a significant impact from influenza in January and February 2018. Sickness absence rates are monitored and reviewed within Speciality, Divisional and Performance Review meetings.

'Supporting You to Support Your Staff' sessions continued during 2017/18. These sessions are designed to support newly appointed managers with all aspects of line management including the practical application of the Managing Attendance Policy. These sessions are also attended by Occupational Health and union representatives.

A new sickness absence policy, which focuses on knowing your staff and avoiding absence, has been agreed and will be rolled out across the Trust by the end of May with workshops and one-to-one sessions with line managers. Additional training will also be provided to line managers to support them with difficult conversations.

The following tables show the Trust's monthly sickness absence and how this was spread over the eight staff groups.





Staff Policies

Staff policies and actions applied during the financial year:

Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities.

The Recruitment and Selection Policy has been updated over the last year. The policy states that the Trust will always seek to select and appoint the best possible candidate for each role, matching the candidates to

the relevant and up to date Job Description and Person Specification.

The Trust will adhere to all current Employment and Equality Legislation, and will ensure that there is no discrimination against candidates on the grounds of any protected characteristic, currently;

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation.

In line with the Diversity and Equality of Opportunity Policy, the Trust bases its decisions relating to all aspects of recruitment and employment on knowledge, understanding, competence, ability, skill and relevant experience.

Equal opportunities information is recorded for all applications and successful applicants.

Equal opportunities training is provided for all employees and this is covered in the corporate induction programme.

All successful candidates are subject to an Occupatio `nal Health (OH) clearance and OH will make recommendations prior to commencement of employment.

All policies are assessed for equality prior to being implemented.

The Trust also achieved Diversity and Inclusion Partner Status and was presented with an award.

The Diversity and Inclusion Partners Programme supports participating trusts to progress and develop their equality performance and to build capacity in this area. At the same time, the programme provides an opportunity for partners to offer advice, guidance and demonstrations of good practice in equality and diversity management to the wider NHS. Partners are supported to achieve this in a number of ways.

Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period.

The Trust Managing Attendance Policy provides information on the Trust commitment and processes with the aim, as far as possible, to remove or reduce any disadvantage faced by the employee which would not be faced by a non-disabled person. In accordance with the Managing Attendance Policy, where an employee becomes permanently incapable of undertaking their normal contractual duties, the Trust will consider making reasonable adjustments to the duties of their job, subject to the needs of the service, or to find suitable alternative employment elsewhere within the Trust.

Should an individual be redeployed, appropriate training is provided for the individual to be able to undertake the role. In addition, individuals are offered a four week trial period.

The Trust also has a Diversity and Equality of Opportunity Policy which states that the Trust will ensure that all people are treated fairly, with dignity and respect, irrespective of their gender, race, age, disability, sexual orientation, marital status, religion, belief, ethnic or national origin.

A discussion is held with all staff during the appraisal/performance development review (PDR) process to enquire whether any adjustments need to be made to their roles to enable them to continue to work, along with any support that may help with their career development.

Policies applied during the financial year for the training, career development and promotion of disabled employees.

The Recruitment and Selection Policy for the Trust states that if a disabled individual meets the essential criteria for a post they are guaranteed an interview. On attending interviews, reasonable adjustments are made to ensure that individuals can attend and have resources and facilities that meet their needs.

The Diversity and Equality of Opportunity Policy states that the Trust is flexible in accommodating special requirements by making reasonable adjustments to the training and development environment, design and use of training materials.

A discussion is held with all staff during the appraisal/PDR process to enquire whether any adjustments need to be made to their roles to enable them to continue to work; it includes an enquiry about any support that may help with their career development.

Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees.

The Trust has continued to focus on staff engagement through a range of activities such as monthly Chief Executive briefing sessions. These sessions are open to all staff and provide an opportunity to share information and for staff to ask questions and provide feedback. Other successfully implemented communication methods include 'Friday Round-Up', which is an email of all key messages sent to all staff every week, and 'The Knowledge', a Trust weekly publication for all staff. More recently a Trust Executive weekly Team Brief face to face meeting with Senior Managers has been introduced with Senior Managers cascading the Team Brief to their teams. Members of the Executive Team have been assigned 'buddy' areas which they visit and encourage the involvement of employees in the Trust performance under the Quality Matters programme.

Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests.

Where an organisational/service change is proposed, in line with the Organisational Change Policy, a consultation takes place. This includes individual consultation meetings and group consultation meetings. In all consultations, staff are asked for their views as part of the process.

Monthly Joint Staff Consultative Committee (JSCC) meetings take place and consultations are a standing agenda item as well as all areas which may affect staff but are not necessarily subject to consultation for example Health and Well Being, Financial management support.

Staff group-based meetings take place monthly to discuss proposed changes.

The Chief Executive highlights areas of change within the organisation through regular briefing sessions.

The annual staff survey and staff Friends and Family Tests invite the views of staff. In addition staff are requested to provide their views when leaving the Trust via an Exit Interview or completion of an exit interview questionnaire, providing feedback on their experience of working at the Trust and whether they would recommend the Trust to others.

Actions taken in the financial year to encourage the involvement of employees in the NHS foundation trust's performance.

Members of the Executive Team have been assigned 'buddy' areas, which they visit and encourage the involvement of employees in the Trust performance.

The Chief Executive provides a weekly communication to all staff and this is cascaded throughout the organisation and feedback and ideas are encouraged.

Staff are encouraged to become involved in the Trust performance and to generate and share ideas for

improvement. A 'Team QEH' email was set up and communicated to staff as a mechanism to submit ideas and every suggestion is considered and responded to.

The 'Friday Round Up' email and 'The Knowledge' publication outline Trust performance in key areas and is distributed to staff.

Monthly performance meetings take place with the divisional management teams and Executive Directors.

Information on health and safety performance and occupational health

Health and Safety

The organisation has continued its work in this financial year to improve and sustain the governance of health and safety across the Trust; this has included closer working with Clinical areas, Estates, Facilities, Infection Prevention and Control (IP&C) and Occupational Health services. The Health & Safety Committee (now a sub-committee of the Risk Committee) continues to receive comprehensive reports from topic specialists that include staff incident trends and analysis. Where deficits are identified, remedial action plans are put in place.

There were a total of 18 RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reports made during the period 1 April 2017 to 31 March 2018.

Quality Improvement Programmes this year have included:

- Containing development of the Trust's electronic web-based system for the safe management of Control of Substances Hazardous to Health (COSHH). The Trust database of assessments continues to develop and expand.
- Continuing the development of the network of health and safety confident and competent staff across the Trust and at all levels from senior managers to local risk champions. This includes the introduction of training sessions as part of the risk champions' meetings and additional IOSH health and safety training in January 2018.
- Continued Involvement in groups such as falls and bariatric steering groups, and closer working with the patient safety team.
- Review of H&S and risk management training to streamline the content and develop a workbook
- Project underway to upgrade the fire alarm system to L1 standard.
- On-going monitoring of health and safety folders in all departments via scheduled H&S audits. This provides assurance that the folders are being used, and generic risk assessments are completed to support safe working practice.
- In January 2018 the H&S Officer and Fire Safety Officer became part of the Estates team.

Occupational Health

There were 432 manager referrals received from April 2017 to March 2018, this is an increase of 3 from the previous year. The largest numbers of referrals received are from managers for staff that need support. Support includes return to work, flexible working, long-term sickness support, physical injuries sustained out of work, redeployment, staff undergoing an investigation, multiple health issues, staff undergoing a disciplinary and return to work, following surgery.

There were 98 self-referrals received from April 2017 to March 2018, this is an increase of 26 from the previous year.

The Occupational Health Physiotherapist received 382 referrals, the majority being self-referrals from staff. There were 433 referrals last year; this is a decrease of 51.

Manual Handling Training

Numbers of staff undertaking mandatory Manual Handling training (Core Induction and Updates) was 893 for patient handling and 454 for non-patient handling. An increase of 219 for patient handling, and a decrease of 231 for non-patient handling occurred between April 2017 and 31 March 2018.

Non manual-training /support was provided for bariatric care, for volunteers using wheelchairs, for doctors and for using specialist equipment.

Information on policies and procedures with respect to countering fraud and corruption.

In conjunction with the Local Counter Fraud Specialist, policies are reviewed and audits undertaken as appropriate. A local counter fraud risk assessment was also undertaken and subsequent action plan developed to ensure this was incorporated into relevant policies and procedures. These included the following actions:

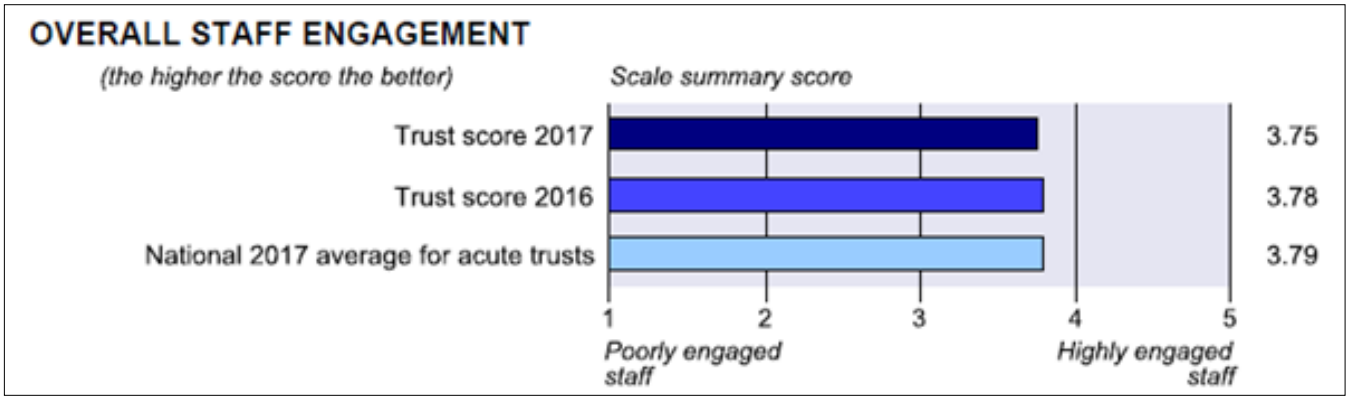
- Anti-Fraud and Anti Bribery policy in place.
- Staff at Band 8d and above are required to make a declaration of interests
- Audit of HR files to ensure correct documentation is held
- Interview packs and Recruitment Policy updated for panel members to declare any personal relationships with candidates
- Reference made to appropriate policies to include reference to the Anti-Fraud and Anti-Bribery Act
- Implementation of e-Rostering which monitors annual leave.

Staff Survey 2017

The Trust Staff Survey 2017 was provided to 3136 staff to complete, 1434 surveys were completed providing a response rate of 46%, an improvement of 1% from the previous year. There was not a significant change between the Trust Staff Survey Results for 2016 and 2017.

Staff Survey 2017 – Results

The figure below shows how The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.75 was below (worse than) average when compared with trusts of a similar type.



The table below shows how The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2016 survey.

	Change since 2016 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	No change	Below (worse than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment	No change	Below (worse than) average
KF4. Staff motivation at work	No change	Above (better than) average
KF7. Staff ability to contribute towards improvements at work	No change	Average

Staff Survey table - Response rate, Top 5 ranking scores and Bottom 5 ranking scores

Overall	2017		2016		
	Trust	National Average	Trust	National Average	% Increase / decrease
Response Rate	46%	44%	45%	44%	1% increase
Top 5 ranking scores					
KF24. Percentage of staff / colleagues reporting most recent experience of violence	74%	66%	73%	67%	1% increase
KF3. Percentage of staff agreeing that their role makes a difference to patients/service users	91%	90%	91%	90%	No Change
KF2. Staff satisfaction with the quality of work and care they are able to deliver (Sliding scale 1 -5)	3.96	3.91	4.01	3.96	0.05 decrease
KF8. Staff satisfaction with the level of responsibility and involvement	3.94	3.91	3.95	3.92	0.01 decrease
KF4. Staff motivation at work	3.94	3.92	3.97	3.94	0.03 decrease
Bottom 5 ranking scores					
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	21%	15%	21%	15%	No change
KF23. Percentage of staff experiencing physical violence from staff in the last 12 months	3%	2%	3%	2%	No change
KF9. Effective team working	3.64	3.72	3.73	3.75	0.09 decrease
KF20. Percentage of staff experiencing discrimination at work in the last 12 months	17%	12%	14%	11%	3% increase
KF12. Quality of appraisals (Sliding scale 1 -5)	2.96	3.11	2.94	3.11	0.02 increase

Development of Staff Survey Action Plans

The Trust Executive Team has implemented new ways to communicate the results of the staff survey to staff throughout the Trust including walking copies of the results to the management 'buddy' areas.

The sub group of the Leadership and Organisational Development Committee that reports to the Workforce Committee led the plan of resulting actions and feedback.

As a result of this the HR Director has been commissioned to use the results from the Staff Friends and Family Test, Behaviour workshops and this survey to draft a new behaviours framework for the organisation.

The results of the Staff Survey have also been filtered by division and the HR Business Partner team are

working with managers and staff to understand and plan local change that would also make a difference to staff.

Staff Friends and Family Test

The Trust is committed to improving the engagement of staff with the Staff Friends and Family Test during 2018/19. Further analysis of staff feedback and development of action plans will continue to take place with a renewed emphasis on providing responses to staff on positive actions and changes made due to feedback received.

Each quarter, staff are asked to rate their Trust against two key questions:

Question 1
Would you recommend your Trust to friends and family as a place to come for treatment?

Question 2
Would you recommend your Trust to friends and family as a place to work?

Respondents are asked to respond to these questions on a scale ranging from "extremely likely" to "don't know".

The number of responses to the Staff Friends and Family Test has improved over the last year 2017/18.

Staff Response Rate

Quarter	1	2	3	4
No of responses received 2015/16	372	291	undertaken as part of the annual staff survey	365
No of responses received 2016/17	338	266	undertaken as part of the annual staff survey	245
No of responses received 2017/18	411	459	undertaken as part of the annual staff survey	450

Expenditure on Consultancy

The Trust has spent £282k on consultancy in 2017/18, all with PricewaterhouseCoopers. The objective of the consultancy work was to provide advice on how the Trust could improve both short and medium term financial performance.

Exit Packages

The exit packages within this disclosure were made under local arrangements.

Freedom to Speak Up Guardian and Whistleblowing

The Trust has in place a comprehensive whistleblowing policy. This policy, along with the Whistleblowing Lead, helps guide staff through both the internal and external whistleblowing process. A Whistleblowing line is provided to facilitate easy contact with the Whistleblowing Lead. All whistleblowing reports are document and reported to Board on a monthly basis.

The Trust also has a Freedom to Speak Up Guardian in place. The name and contact details of for this person are widely publicised across the Trust and the Guardian provides regular reports to Board.

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Departures where special payments have been made
<£10,000	0	4	4	0
£10,001 - £25,000	0	0	0	
£25,001 - 50,000	0	1	1	
£50,001 - £100,000	0	0	0	
£100,001 - £150,000	0	0	0	
£150,001 - £200,000	0	0	0	
>£200,000	0	0	0	
Total number of exit packages by type	**0**	**5**	**5**	**0**
Total Resource cost (£)	**£0**	**£58,000**	**£58,000**	**£0**

Exit Packages: other (non-compulsory) departure payments	2017/18		2016/17	
	Payments Agreed	Total Value	Payments Agreed	Total Value
	Number	**£000**	**Number**	**£000**
Mutually agreed resignations (MARS) contractual costs	1	25		
Contractual payments in lieu of notice	4	33	3	19
Non--contractual payments requiring HMT approval			11	50
Total	**5**	**58**	**14**	**69**

Reporting high paid off-payroll arrangements	
All off-payroll engagements as of 31 March 2018, for more than £220 per day and that last for longer than six months	**2017/18 Number of engagements**
	Number
No. of existing engagements as of 31 March 2018	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0
Confirmation:	
The Trust can confirm that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	

For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2017 and 31 Mar 2018, for more than £220 per day and that last for longer than six months	2017/18 Number of engagements
	Number
Number of new engagements, or those that reached six months in duration between 01 Apr 2017 and 31 Mar 2018	1
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	1
Number for whom assurance has been requested	1
Of which:	
Number for whom assurance has been received	1
Number for whom assurance has not been received *	0
Number that have been terminated as a result of assurance not being received	0

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 Apr 2017 and 31 Mar 2018	2017/18 Number of engagements
	Number
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	1
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	1

Disclosures set out in the NHS Foundation Trust Code of Governance

Compliance with the NHS Foundation Trust Code of Governance

The Regulator has in place a Code of Governance, which sets out expectations concerning the Trust's corporate governance arrangements. Schedule A to the Code, sets out the detail of required corporate governance disclosures, including those that are reported in this annual report:

- Schedule A1 – Statutory Requirements
- Schedule A2 – Provisions requiring a supporting explanation (see table below)
- Schedule A3 – Supporting information to be made publicly available (see table below)
- Schedule A4 – Supporting Information to be made available to Governors
- Schedule A5 – Supporting information to be made available to Members
- Schedule A6 – Provisions requiring a compliance statement or explanation where the Trust has departed from the Code.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Trust is required to report against the provisions of The Code in a variety of ways, as set out below.

At 31 March 2018, the Board of Directors declares compliance with the provisions of **The Code of Governance, Schedule A1 (Statutory Requirements)**.

The Trust's compliance status in respect of **The Code of Governance, Schedule A2 (Provisions requiring a supporting explanation)** is set out in the table below:

Provision	Provision Summary	Supporting Explanation
A.1.1	This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	The Trust has in place an Engagement Policy, which describes how Governors may engage with the Board of Directors when they have concerns about the performance of the Board of Directors, compliance with the Licence Conditions or the welfare of the Trust. The Trust also has in place a 'Dispute Resolution Procedure', to deal with disputes relating to the Trust's constitution. Summary statements outlining how the Board and Governors' Council operate, including a summary of the types of decisions taken, are set out in the Annual Report, in 'The role of the Board of Directors' and 'The role of the Governors' Council' respectively.
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	See table – 'The Board of Directors in 2017/18'.

A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	See table - 'The Governors' Council composition in 2017/18'.
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	In respect of the criteria set out in The Code of Governance, all non-executive directors are judged to be independent in character and judgement. No relationships or circumstances have been identified that are likely to affect, or could appear to affect, directors' judgement.
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	See Board of Directors' Biographies. The Board is substantively appointed as at 31 March 2018. The skills and experience reflected in the Board membership, mean that the Board is balanced and appropriate to the requirements of the Trust.
B. 1. 10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	See 'Committees of the Governors' Council - The Nomination and Remuneration Committee (Non-Executive Director appointments).
B. 3. 1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	The Trust Chair has no commitments likely to impact on his work with the Trust.
B. 5. 6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Governors canvass the opinion of the Trust's members and the public in a variety of ways, including through engagement with Healthwatch Norfolk and the Patient Participation Groups of the GP surgeries within the Trust's catchment area. The Trust's appointed Governors represent the views of a range of local strategic partners.
B. 6. 1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Board and Director performance evaluation methodologies employed include: • Self-assessment (after each Board meeting) • ED appraisal • NED appraisal (involving the Governors) In 2017/18, the Board self-certified compliance with general condition 6 of the NHS provider licence and made its corporate governance statement, AHSCs and training of governors. See also 'Evaluating the Board's Performance'. The Trust undertook a self-assessment against the 'Well-Led Framework for Governance, submitted to the Regulator in December 2017 and is expecting a CQC 'Well-Led' assessment in June 2018.

B. 6. 2	Where an external facilitator is used for reviews of governance, they should be identified and a statement made as to whether they have any other connection with the trust.	No external reviews of governance have been undertaken in 2017/18, other than those governance-related reviews undertaken as part of the Trust's Internal Audit programme.
C. 1. 1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	See sections on: • 'The Directors' Report' • 'The Audit Committee and External Audit' • 'The Annual Governance Statement'
C. 2. 1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	See: 'The Annual Governance Statement'.
C. 2. 2	A trust should disclose in the annual report: a. if it has an internal audit function, how the function is structured and what role it performs; or b. if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	See 'The Audit Committee and External Audit'.
C. 3. 5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Not applicable in 2017/18
C. 3. 9	A separate section of the annual report should describe the work of the committee in discharging its responsibilities. The report should include: • The significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed • An explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted, and • If the external auditor provides non- audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	See 'The Audit Committee and External Audit'; and 'The Independent Auditor's Report to the Governors' Council'.

D. 1. 3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable
E. 1. 5	The Board of Directors should state in the annual report the steps they have taken to ensure that the members of the Board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS Foundation Trust, for example through attendance at meetings of the Council of Governors, direct face-to- face contact, surveys of members' opinions and consultations.	See 'The Role of the Board of Directors'.
E. 1. 6	The Board of Directors should monitor how representative the NHS foundation trust's membership is, and the level and effectiveness of member engagement and report on this in the annual report.	See 'The Membership Strategy' and 'Current Foundation Trust Public Membership'.

In respect of **The Code of Governance, Schedule A3**, the following information is available as indicated:

Provision	Provision Summary	Supporting Explanation
A. 1. 3	The board of directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.	Annual Report and on website.
B. 1. 4	A description of each director's expertise and experience, with a clear statement about the board of director's balance, completeness and appropriateness.	Annual Report and on website.
B. 2. 10	The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.	On request and in Annual Report – 'Committees of the Governors' Council'.
B. 3. 2	The terms and conditions of appointment of non- executive directors.	On request and in Annual Report.
C. 3. 2	The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference.	On request and in Annual Report – 'The Audit Committee and External Audit'.
D. 2. 1	The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board of directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the NHS foundation trust.	On request and in the Annual Report – 'Committees of the Governors' Council'. No remuneration consultants have been appointed during 2016/17.
E. 1. 1	The board of directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.	On request.

E. 1. 4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website.	Website and Annual Report – 'Contacting the Governors'.

In respect of **The Code of Governance, A4 (Supporting Information to be made available to Governors) and A5 (Supporting information to be made available to Members)**, the Board of Directors confirms that the following information is made available:

	Provision	Information
A4	B. 7. 1	In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that after formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. **Trust Chair's reappointment** - *The Senior Independent Director made assurances that after formal performance evaluation, the performance of the individual proposed for re-appointment continued to be effective and to demonstrate commitment to the role to the Governors' Council, on the reappointment of the Trust Chair from July 2017 for a further term.*
A5	B. 7. 2	The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information. *No Governor elections were undertaken in 2017/18.*

In respect of **The Code of Governance, Schedule A6 (Provisions requiring a compliance statement or explanation where the Trust has departed from the Code)**, the Board declares compliance with all provisions as at 31 March 2017, except provision B1.2 requiring at least half the board of directors, excluding the chairperson, to be non-executive directors, determined by the board to be independent. This situation arose as a result of a non-executive director resignation and lasted for four months. The Trust will once again be compliant with this provision from May 2018, following successful recruitment to the non-executive director vacancy.

The Board of Directors

The Board of Directors has, during 2017/18, met in public on six occasions. The Board has also met in private where its debate has considered commercially sensitive and/or involved confidential issues. The Board meets in less formal workshop settings to undertake strategic planning and development activities.

As at 31 March 2018, the Board of Directors was made up of the Chair, four non-executive directors and five voting executive directors. The five voting executive board positions at 31 March were: the Chief Executive; the Director of Finance and Resources; the Medical Director, the Chief Nurse and the Chief Operating Officer. The resignation of a non-executive Director and subsequent recruitment and selection activities has meant that for a period of approximately four months, the Trust has not been compliant with the Code of Governance provision B.1.2., requiring at least half the board of directors, excluding the chairperson, to be non-executive directors, determined by the board to be independent. This position will be rectified in May 2018, following successful recruitment to the non-executive director vacancy. The meetings of the Board of Directors have been supported by other executive portfolio holders.

During 2017/18, the Trust welcomed an aspiring NHS non-executive director to work with the Board, as part of NHSi's NExT Director Scheme, designed to promote and support Board diversity.

The Role of the Board of Directors

The Board of Directors has a dual role: leadership and control. It has collective responsibility for setting the strategic direction of the organisation and for overseeing and ensuring the delivery of its strategy and the performance of the organisation.

Some of the responsibilities of the Board of Directors

- To ensure that the Trust meets its statutory duties and complies with its terms of authorisation and its constitution
- To ensure that the organisation's policy framework is developed in accordance with the rights, pledges and responsibilities contained in the NHS Constitution
- To provide leadership for the organisation in respect of agreed organisational values and standards of conduct, in accordance with accepted standards of behaviour in public life, which include the principles of selflessness, integrity, objectivity, openness, honesty and leadership (Nolan)
- To establish a robust performance management framework and support the Executive Team in meeting the organisation's performance targets; monitoring the performance of the Trust and ensuring that the Executive Directors manage the Trust within the resources available, in such a way as to:
  - ensure the quality and safety of healthcare services
  - plan for continuous improvement
  - protect the health and safety of Trust employees and all others to whom the Trust owes a duty of care
  - use Trust resources efficiently and effectively
  - promote the prevention and control of Healthcare Associated Infection
  - comply with all relevant regulatory, legal and code of conduct requirements
  - maintain high standards of ethical behaviour, corporate governance and personal conduct in the business of the Trust
  - maintain the high reputation of the Trust both with reference to local stakeholders and the wider community

- To engage, as appropriate, with the Governors' Council, in accordance with the statutory and regulatory framework.

The Board of Directors and in particular the non-executive directors, have developed an understanding of the views of governors and members about the NHS Foundation Trust, for example through:

- attendance at meetings of the Governors' Council
- Governor attendance at Board of Director meetings

- Governor representation at some key committee meetings and working groups
- Board/Governor development workshops
- Governors' one-to-one and Governors' Council Committee Chairs' meetings with the Trust Chair.

The Chair, the Vice Chair and the Senior Independent Officer

In a Foundation Trust, the Trust Chair chairs both the Board of Directors and the Governors' Council. The Queen Elizabeth Hospital's constitution makes provision for the Board's appointment of a Senior Independent Director, who has particular duties regarding working with the Governors' Council and the Board of Directors to address any issues where it is inappropriate for the Chair to do so. The Trust's Senior Independent Director was appointed by the Board in 2016. The appointment was supported by the Governors' Council. The Governors' Council appointed the Trust's Vice Chair in February 2016.

In 2017/18, the Trust Chair has had no other significant commitments that have had an adverse impact on his role as Chair of the Foundation Trust.

Register of Directors' Interests

All directors are required to complete and keep up to date their declarations of interest, which are recorded in the Register of Directors' Interests. A copy of the register (Board member extract) is presented periodically at the Board's public meetings and is available by contacting the Trust Secretary on 01553 613614.

Delegation and the Committees of the Board of Directors

The Board of Directors' Terms of Reference and Scheme of Delegation set out those matters reserved for the Board. The Board delegates powers to formally constituted committees, in accordance with its scheme of reservation and delegation.

Committees reporting and accountable to the Board of Directors at 31 March 2018:

- The Trust Executive Committee – through which the strategic direction of the Board is communicated to all functional areas of the organisation and through which the Board's strategic direction is translated into tactical and operational planning and service delivery / performance monitoring
- The Quality and Patient Safety Committee
- The Finance and Performance Committee
- The Workforce Committee
- The Nomination and Remuneration Committee (Executive Director Appointments)
- The Audit Committee.

The Audit Committee and External Audit

The Audit Committee met five times during 2017/18. Its purpose is to maintain oversight of the adequacy of the control environment of the Trust, including those controls related to financial reporting procedures and quality. This work involves the monitoring of the effectiveness of internal controls and risk management processes. The Audit Committee approves strategies and plans for countering fraud and receives reports from the Trust's Local Counter Fraud Specialist at each meeting. The Chair of the Audit Committee is a qualified accountant.

The Audit Committee approves the Internal Audit work programme and monitors the effectiveness of the Internal Audit function. The committee also receives and considers reports and opinion from both internal and external auditors. RSM provided the Trust's Internal Audit function in 2017/18. The Internal Auditors audit a range of both financial and quality controls at the Trust and provide levels of assurance accordingly.

The work of the Audit Committee supports the completion of the Annual Governance Statement by the Accounting Officer.

The Trust's external auditor for the period covered by this Annual Report was KPMG. KPMG was re-appointed

in 2016/17 as the Trust's external auditors by the Governors' Council after a transparent process, overseen by a group of governors, appointed by the full Council.

KPMG has provided no additional non-audit services in 2017/18.

The Audit Committee is satisfied concerning the ongoing independence of the External Audit function.

Evaluating the Board's Performance

The Board of Directors uses a number of methods to evaluate the performance of the Board and its committees. In 2017/18, performance evaluation methodologies employed include:

- Board Self-assessment (after each Board meeting)
- Executive Director appraisal
- Non-Executive Director appraisal
- Performance evaluation of the Audit Committee – using the model criteria of the NHS Audit Committee Handbook.

In 2017/18, the Board self-certified its compliance with General Condition 6 of the NHS Provider Licence. In 2017/18 the Board also made its Corporate Governance Statement and declarations concerning AHSCs and the training of governors.

The Trust undertook a self-assessment against the 'Well-Led Framework for Governance, submitted to the Regulator in December 2017 and is expecting a CQC 'Well-Led' assessment in June 2018.

The Constitution

The Trust's constitution sets out the governance arrangements for the organisation. It is published on the Trust's website in the Corporate Governance section. The Trust's Constitution Working Group reviews the provisions of the Constitution periodically. Proposed changes are approved by the Board of Directors, the Governors' Council and the Members (at the Annual Members' Meeting) where the proposed revisions pertain to the powers or duties of the Governors.

Director 1st April 2016 - 31st March 2018	Date of end of current NED terms of office	Audit Committee 5 meetings		Nomination and Remuneration Committee (ED Appointments) 3 meetings		Meetings attended out of 12 Governors' Council Meetings inc. March 2018
Edward Libbey Non-Executive Director (NED) Trust Chair From 1 July 2014	July 2020			Chair	3/3	12/12
Ian Pinches – NED Chair of Audit Committee and Charitable Funds Committee – From 12 November 2012	Dec 2018	Chair	5/5		3/3	10/12
David Thomason – NED Chair of Finance & Performance Committee From 3 August 2015	Sept 2018	✓	5/5		3/3	9/12
Ian Harvey – NED From 4 January 2016	Jan 2019				2/3	11/12
Amanda Ashton - NED Chair of Workforce Committee (from December 2017) From 21st August 2017	Sept 2020	✓	1/2		2/2	4/7
Jon Green Chief Executive Officer (CEO) From 1st May 2017					3/3	11/11
Jon Wade Director of Sustainability and I.T. From 21st November 2016						11/12 (1 sub)
Emma Hardwick Chief Nurse From 16th January 2017						12/12 (1 sub)
Ciara Moore Chief Operating Officer From 13th March 2017						11/12 (2 subs)
Nicholas Lyons Medical Director From 13th March 2017						12/12
Roy Jackson Director of Finance & Resources From 2nd May 2017 (Interim) From 1st February 2018 (Substantive)						11/11
Karen Charman Director of HR & OD From 3rd July 2017						8/9
David Stonehouse Director of Finance, Deputy CEO To 2nd August 2017						4/4 (4 subs)

Karen Croker Interim Chief Executive Officer (CEO) From 1st April - 5th May 2017						1/1
John Rees – NED Chair of Quality Committee From 8th September 2014 To 30th September 2017		✓	3/3			5/6
Maureen Carson – NED Chair of Workforce Committee From 7th September 2015 To 21st December 2017						6/9
Key: ✓= Committee member		No longer serving on the Board of Directors				

The Role of the Governors' Council

The Governors' Council:

- appoints the Chair and non-executive directors to the Board of Directors
- sets the remuneration of the Chair and non-executive directors
- approves the appointment of the Chief Executive Officer
- appoints the auditor
- influences decisions about developing services.

Statutory duties for governors:

- to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors
- to represent the interests of Foundation Trust members as a whole and the interest of the public.

Governors:

- have the right to receive board agendas and minutes
- can require directors to attend a meeting to obtain information about Foundation Trust performance or director performance
- vote to approve:
  - constitutional changes
  - a merger, acquisition, dissolution or separation
  - an increase by more than 5% of the Foundation Trust's non-NHS income.

Advice and training for governors:

- Foundation Trusts are required to ensure their governors have the skills and knowledge needed to carry out their roles
- The Regulator has established a panel to give advice to governors – more than half of the governors would need to approve a referral to the panel.

The Governors' Council is not responsible for the day-to-day running of the Trust.

At 31 March 2018, there were 30 governor seats on The Governors' Council of The Queen Elizabeth Hospital. The Governors' Council is made up as follows:

Sixteen Elected Public Governors

- 9 from West Norfolk
- 2 from Breckland, North Norfolk (and the Rest of England)

- 3 from Northern Cambridgeshire
- 2 from South-East Lincolnshire.

Six Elected Staff Governors

- 3 Clinical
- 3 Non-Clinical.

Eight Appointed Governors

- Norfolk County Council (statutory)
- Borough Council of King's Lynn and West Norfolk
- Breckland District Council
- West Norfolk Clinical Commissioning Group
- The University of East Anglia
- The College of West Anglia
- West Norfolk Carers
- Freebridge Community Housing.

2017/18 Election report

There were no elections held during 2017/18.

Meetings of the Governors' Council

The Governors' Council has met formally in public, 7 times during 2017/18 (excluding the Annual Members' Meeting) and met at one extraordinary Non-Executive Appointment meeting.

The dates and venues for the Governors' Council meetings in 2018 can be found on the QEH website in the Governors' Council section. Alternatively, members can contact the Foundation Trust Office on 01553 613142 or email FT.Membership@qehkl.nhs.uk for details. In response to concerns raised about the effectiveness of the sequencing of the Board and GC meetings and following a review, from November 2017 both of these meetings, on a trial basis, are held on the last Tuesday of every month.

The Lead Governor, reappointed by the Governors in February 2017, has a particular role as point of contact with NHS Improvement on behalf of the Governors' Council (GC), should this prove necessary. She also works with the Chair in drafting the forward plan and agendas for the meetings of the GC.

Committees of the Governors' Council

The Governors' Council may not delegate its powers. However, it has set up five committees to assist in the delivery of some of its statutory functions. Four of these committees have met regularly throughout the year and have developed challenging work programmes:

The Membership and Communications Committee – worked on the delivery of the Membership Strategy to support engagement and communication with the members and wider public.

Membership recruitment - In 2017/18, the Committee continued to work to increase the public membership and to address some areas of underrepresentation in the public membership profile, through targeted recruitment. Once again successful collaboration with the College of West Anglia has enabled wider representation from younger people. Regular membership recruitment took place within the Trust's Outpatient Department.

Communication / engagement - To assist in communicating with members and the wider public, the Committee has nominated members to participate on the editorial panel of the Trust's newsletter and has developed an engagement strategy, which includes a programme of healthcare events for members. In 2017 two healthcare events were held at the Trust; a Cardiology Event in May and a COPD (Chronic Obstructive

Pulmonary Disease) Event in September.

The Nomination and Remuneration Committee – (Non-Executive Director appointments) – to make recommendations to the Governors' Council regarding the appointment and remuneration of non-executive directors. The Terms of Reference for this committee have been drawn up in alignment with the Code of Governance and Monitor's 'Your Statutory Duties – A Reference Guide for NHS FT Governors'. The committee making recommendations to the Governors' Council in respect of NED appointments is made up of governors and the Trust Chair. The governors commenced the process of recruiting two new Non-Executive Directors to the Trust in January 2018 and expect to approve the Nomination and Remuneration Committee's recommendations early in 2018/19.

The Patient Experience Committee – Undertakes work and makes recommendations through the Governors' Council to help ensure that the patient perspective is understood and considered when the Trust's services are being planned and reviewed.

The Patient Experience Committee has undertaken a wide range of activities throughout 2017/18:

- Nursing Interview panel work;
- Involvement with listening events;
- Involvement in mock CQC Inspections;
- Engagement with Norfolk Healthwatch;
- Liaison with Matrons and Leads across all specialties / wards;
- Review of Patient Experience information drawn from a variety of sources;
- Involvement with the Catering Department / Hospital Catering Association Event;
- Attended a NHS Providers East Yorkshire/East of England Governors' Regional Workshop

Governors have also been involved as the representatives of the patient and the public in a variety of areas of the Trust's work, including:

- Relationships and formal liaison with West Norfolk Patient Partnership and affiliated GP Patient Participation Groups;
- Involvement in PLACE (Patient-Led Assessments of the Environment) Inspection and additional ward and department inspections;
- Development of relationships with South East Lincolnshire Patient Participation Groups;
- Sustainability and Transformation Partnership and Consultation Meeting(s);
- West Norfolk Association Meetings;
- Governors' Council Meetings;
- Healthcare Events; and
- Surveys

The Business Committee – Discusses with executive and non-executive directors, the QEH's engagement with the Trust's Regulator and undertakes detailed work in respect of finance, strategic planning and business decisions requiring Governors' Council approval. The Business Committee will make recommendations to the Governors' Council as appropriate.

Constitution Working Group – This Committee undertakes work and makes recommendations, as necessary, regarding proposed amendments to the Trust's Constitution.

Contacting the Governors – Members and the public can contact the governors at FTGovernor@qehkl.nhs.uk or by post at the following address:

The Foundation Trust Office, The Queen Elizabeth Hospital King's Lynn NHS FT, Gayton Road, King's Lynn, Norfolk. PE30 4ET

Constituency	Name	Current Term / Period remaining - Years	Governors' Council Meetings Attendance	Nomination and Remuneration Committee Member	Membership & Communications Committee Member	Patient Experience Committee Member	Business Committee Member
West Norfolk (9)	Robin Broke (re-elected Feb 2016) 3rd term	3/1	7/8	✓			
	Steve Clark (re-elected Feb 2017) 2nd term	3/2	6/8	✓			Chair
	Simon Clarke (elected Feb 2016) 1st term	3/1	6/8				✓
	Esmé Corner OBE (re-elected Feb 2017) (Lead Governor) 3rd term	3/2	7/8	✓	✓	Chair	✓
	Jonathan Dossetor (re-elected Feb 2017) 3rd term	3/2	7/8	✓	Chair	✓	
	Penny Hipkin (re-elected Feb 2017) 3rd term	3/2	6/8	✓	✓	✓	
	Robert Outred (elected Feb 2016) 1st term	3/1	7/8		✓	✓	
	Peter Tasker (elected Feb 2016) 1st term	3/1	8/8			✓	
	Barrie Taylor (re-elected Feb 2017) 3rd term	3/2	8/8			✓	
Cambridgeshire (3)	Jenny Brodie (Feb 2016) 2nd term -	3/1	7/8			✓	✓
	Malcolm Bruce (Feb 2017) 1st term	3/2	6/8		✓	✓	
	Betty Lewis (Feb 2017) 3rd term	3/2	8/8		✓	✓	
Breckland, North Norfolk & Rest of England (2)	Clive Monk (Feb 2017) 2nd term	3/2	8/8			✓	✓
	Patricia Tickner (Feb 2017) 1st term	2/1	5/7		✓	✓	
SE Lincolnshire (2)	June Chadwick (2017) 1st term	3/2	5/8			✓	
	Aimee Hicks (February 2016) 1st term	3/1	3/8			✓	
Staff Clinical (3)	Mark Abbott (February 2016) 1st term	3/1	1/8				
	Julie Calton (re-elected Feb 2017) 2nd term	3/2	6/8	✓		✓	
	Nigel Tarratt (Feb 2016) 2nd term	3/1	7/8		✓	✓	✓
Staff Non Clinical (3)	Darren Barber (elected Feb 2016) 1st term	3/1	3/8		✓		
	Sophia Buckingham (elected Feb 2016) 1st term	3/1	5/8				✓
	Dave Coe (re-elected Feb 2017) 3rd term	3/2	7/8	✓			✓
8 Appointed Governors							
Borough Council King's Lynn & West Norfolk	Paul Kunes - from June 2015	3/1	3/8				✓
Breckland	Ian Sherwood – from May 2016	3/2	4/8				
College of West Anglia	Ann Compton – From Feb 2017	3/2	5/8			✓	

Freebridge Community Housing	Andy Walder – from March 2017	3/2	4/4				
Freebridge Community Housing	Ray Johnson – from February 2014	3/0	4/4				Chair
Norfolk County Council	Sandra Squire – from July 2017	3/3	1/6				
Norfolk County Council	Jim Perkins – from June 2015	3/2	1/2	✓			
West Norfolk CCG	Hilary De Lyon – from February 2014	3/0	3/8	✓			
West Norfolk Carers	Jane Evans – from February 2015	3/0	6/8		✓	✓	
UEA	Paul Dansie – from April 2016	3/1	3/8				
Key:	**Governors no longer serving on the Governors' Council as at 31-3-2018**						

Meetings' attendance includes the Annual Members' Meeting and excludes the extraordinary Governors' Council meeting.

All governors have made declarations of interest and have signed copies of the Trust's Code of Conduct for Governors. The Register of Governors' Interests can be accessed by contacting the Trust Secretary on 01553 613614.

Who can become a Member?

Membership of the Foundation Trust is free and is open to patients, the public and NHS staff. Becoming a Foundation Trust member shows that you are interested in the hospital and its future.

Membership is open to most people over the age of 16 living or working within the Trust's catchment area, which is:

- West Norfolk
- part of Breckland & North Norfolk
- part of northern Cambridgeshire, and
- part of south-east Lincolnshire

Membership is also open to people who live outside the area, but who have an interest in the Trust.

Members of Staff

Because the Trust appreciates and values its staff, they are automatically members of the Foundation Trust and do not need to apply for membership. Members of staff who do not wish to be a member can choose to opt out.

How do I apply to become a member?

There are a number of ways to apply for Foundation Trust membership.

- The easiest way is to apply on-line by visiting the Trust's website, where you will find an on-line application form in the Foundation Trust section.
- E-mail: FT.membership@qehkl.nhs.uk and we'll send out an application form in the post
- Write to:

The Foundation Trust Office
The Queen Elizabeth Hospital King's Lynn NHS FT
Gayton Road

King's Lynn
Norfolk
PE30 4ET

You can also call the Foundation Trust Office on 01553 613142 for information about Foundation Trust Membership.

The Membership Strategy

We achieved a public membership of 7,668 by the end of 2017/18.

The QEH Public Constituency	Members 31 March 2017	Members 31 March 2018
Gender		
Male	2960	2997
Female	4498	4671
Total	**7458**	**7668**
Constituency		
Breckland, North Norfolk & Rest of England	1317	1344
Cambridgeshire	665	688
SE Lincs	594	582
West Norfolk	4882	5054
Total	**7458**	**7668**
Age		
16-21	981	932
22-29	477	686
30-39	503	538
40-49	644	632
50-59	812	798
60-74	1911	1874
75+	1514	1605
Not stated	616	603
Total	**7458**	**7668**
Ethnicity		
White	6974	7241
Mixed	31	34
Asian or Asian British	73	78
Black or Black British	30	32
Other	19	19
Not stated	331	264
Total	**7458**	**7668**

Statement of the Chief Executive's responsibilities as the accounting officer of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require The Queen Elizabeth Hospital King's Lynn NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Queen Elizabeth Hospital King's Lynn NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the NHS foundation trust, and to enable the officer to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the 69 NHS foundation trusts and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Jon Green – Chief Executive
Date: 22/5/2018

Annual Governance Statement

1 Scope of responsibility

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

2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3 Capacity to handle risk

Risk Management

The Medical Director has executive responsibility for the Trust's Risk Management function, with line management responsibility for a Risk and Governance Team which oversees and supports the maintenance of the Trust's Risk Register at all levels of the organisation, and which undertakes Risk training at appropriate levels throughout the Trust for Risk Managers and Handlers. The Risk and Governance Lead (The Deputy Director of Patient Safety) also oversees the Trust's Clinical Audit function, the Trust's compliance with the Duty of Candour and the management and reporting of Serious Incidents and Never Events

Internal Audit undertook a review of the risk management system in 2017/18 and provided an assurance level of 'amber/red' (partial assurance) that the controls upon which the organisation relies to manage this area are suitably designed and consistently applied. All recommendations are being addressed by the Trust and the new in post Deputy Director of Patient Safety is already making significant improvements to the Trust's Risk Management methodologies, including the development of a comprehensive Risk Management Framework to support Trust decision-making.

An executive Risk Committee, chaired by the Chief Nurse, meets monthly and reports to the Trust Executive Committee. The Risk Committee reviews the corporate risk register high risks every month and scrutinises all divisional and departmental risk registers on a programmed rolling basis, providing assurance to the Board, via the Trust Executive Committee and escalating concerns as appropriate.

The Board Assurance Framework and Board oversight of the Corporate Risk Register

The Board of Directors agrees and monitors the Board Assurance Framework and all high scoring risks on the Corporate Risk Register. The Board Assurance Framework sets out the principal risks to the delivery of the Trust's strategic objectives. Each risk has a lead Executive Director and key monitoring committee assigned to it and details of the controls in place to mitigate against the risk. Any gaps in controls are highlighted through this process, allowing management action to be taken. The Board agrees target risk ratings for all strategic risks and assesses residual risk against its key strategic aims once assurance is received that effective internal controls and mitigations are in place. The Board has also articulated its risk appetite for all principal risks monitored through the Board Assurance Framework.

The Internal Audit review of the Board Assurance Framework, undertaken in 2017/18, gave a 'green' assurance rating, providing substantial assurance that the controls upon which the organisation relies to manage the identified risk(s) are suitably designed, consistently applied and operating effectively.

4 The risk and control framework

The Board completed its Corporate Governance Statement in accordance with Licence Condition 4 in 2017 and confirmed statements in relation to:

- the effectiveness of governance structures
- the responsibilities of directors and subcommittees
- reporting lines and accountabilities between the board, its subcommittees and the executive team
- the submission of timely and accurate information to assess risks to compliance with the trust's licence; and
- the degree and rigour of oversight the board has over the trust's performance.

Risks identified include:

- Risk of inconsistent compliance with Trust Policy. Systems have been developed to monitor and encourage compliance
- Consistency of committee effectiveness at divisional level – revised governance arrangements in place from April 2018
- Financial stability – regular monitoring of recovery and planning activities with Board and Regulator
- New executive team (May 2017) - the Trust's executive team is now substantive with high calibre appointments.
- International nurse recruitment pipeline (esp. in Europe). Trust continues to recruit locally, nationally and internationally – developing 'grow your own' arrangements and optimising relationships with universities re. student nurse training and retention
- Junior Doctor rota gaps expected from August 2017 due to revised rules for selecting rotation locations. Trust has developed successful and innovative recruitment offerings, in place to attract junior doctors and mitigate the risk

In March 2017, The Board set out its revised Corporate Objectives for 2017/18 as:

- To deliver care that is safe, effective and provides patients with the most positive experience possible
- To develop and sustain a well-led, effective, motivated and productive workforce
- To secure financial sustainability
- To develop, maintain and maximise the potential of the Trust's infrastructure and assets
- To engage effectively in system-wide transformation planning / re-design and plan implementation, for the benefit of our patients and the community we serve

The objectives align well with the elements of the Corporate Governance Statement and the Board is able to utilise its mechanisms for monitoring risk and appropriate mitigations in order to contribute to its agreement on its annual Corporate Governance Statement.

The Board has reviewed and re-articulated its key risks in 2017/18 through the Board Assurance Framework:

- There is a risk that patients do not receive quality care because clinical effectiveness, safety, and/or experience do not meet accepted standards
- There is a risk that the Trust will not deliver its short or longer-term financial plans.
- There is a risk that the Trust will not exert effective influence in the STP forum and other partnerships to secure appropriate transformation
- There is a risk that the Trust does not establish appropriate workforce engagement, leadership, capacity and capability to support the delivery of its objectives
- There is a risk that the Trust's physical infrastructure, including IT and Estate will not be maintained / improved and fit for the future needs of the Trust

The Board has in 2017/18, also confirmed its top strategic risks as being:

- Financial Sustainability
- Workforce
- Estate

The Board has monitored its position and mitigations in respect of these principal risks throughout 2017/18. In addition, the Board considers all medium to high corporate risks with a residual risk score of between 15 and 25 and their associated mitigations.

The Board had six committees reporting to it during 2017/18, namely:

- The Quality and Patient Safety Committee
- The Finance & Performance Committee
- The Trust Executive Committee
- The Nomination and Remuneration Committee (Executive Director Appointments)
- The Audit Committee
- The Workforce Committee.

The Board is alerted to risks identified at the committees via a Chair's Key Issues reporting methodology. Committees reporting to the Board are required to produce an annual report, summarising their activities in the reporting year and compliance with their terms of reference. In this way, the Board can secure assurance of the effectiveness of its committees.

Each division and department has a risk register, which is reviewed and updated regularly and presented to the Risk Committee on a rotational basis. All high scoring risks are included on the Trust's Corporate Risk Register for presentation to the Board at each meeting. Risks are scored in accordance with Trust's policy, requiring the application of a National Patient Safety Agency approved matrix system, which takes account of the likelihood and impact of the risk, if it were to be realised.

Risk management training is provided to relevant staff and policies and related templates are available on the Trust's intranet site. The 2017/18 Risk Management Internal Audit identified issues concerning Risk Management Training. Audit recommendations are being addressed by the newly appointed Deputy Director of Patient Safety. Additional 'Risk Appetite' development has been undertaken for the Board in 2017 and the Board has articulated its risk appetite in respect of the principal risks monitored through the Board Assurance Framework.

The Trust Executive Committee is chaired by the CEO and the membership in 2017/18 comprised the Executive Director Team and the Trust's senior medical, nursing and operational leaders and senior managers. The Committee is responsible for the delivery of the Trust's business plans. The Trust Executive Committee develops, implements and reviews tactical plans, approves and recommends associated policy and monitors the performance of the organisation against its plans and key performance indicators.

The Trust Executive Committee is the key forum for holding teams and colleagues to account for the delivery of plans and operational performance. There are also regular performance review meetings with each key team, with executive oversight of quality, financial, operational and workforce performance and with key issues escalated as appropriate.

The Quality and Patient Safety Committee monitors the delivery of the Trust's Quality objectives as reflected in its Quality Strategy and reviews key quality information to provide the Board with assurance that the Trust is delivering effective, safe services and a positive patient experience. The Quality and Patient Safety Committee also undertakes detailed 'Quality Enquiries', where concerns have been raised relating to the delivery of quality services in a particular area.

The Finance & Performance Committee monitors and reviews the adequacy of the Trust's financial risk assessments, assumptions, sensitivities, mitigation plans and contingencies. It monitors the Trust's on-going financial position against the Board approved plans, including cost improvement plans and any action plans

in place to recover the financial position. The Committee monitors the Trust's performance in delivering services in accordance with key access standards. It also considers and reviews the alignment of capacity and activity volumes to financial plans and service line contributions.

The Workforce Committee oversees and monitors the Trust's workforce issues and risks including those relating to recruitment, retention, sickness absence management, education, training and staff satisfaction / engagement. The Workforce Committee also oversees the delivery of the Trust's Workforce Strategy and Workforce Race Equality Standard Action Plan and the development of the Trust's Behavioural Framework and Organisational Development Strategy.

The Nomination and Remuneration Committee (ED appointments), oversees the recruitment of the executive directors and approves executive appointments.

The Audit Committee is responsible for overseeing the effectiveness of the Trust's control environment; it is chaired by an independent non-executive director. The Committee receives reports from Internal Audit, including from the Local Counter Fraud Specialist.

Internal Audit agrees an annual plan with the Audit Committee, which includes both financial and quality control audits and is also driven by the Trusts strategic risks. The work includes identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal Auditing Standards. Reports of the internal audit reviews and associated recommendations are reported to the Audit Committee. The Audit Committee monitors the Trust's delivery of the recommendations and agreed actions through its regular review of the Internal Audit Recommendations Tracker. The Audit Committee also receives reports from the Trust's External Auditors, including the annual management letter and other reports, agreed as part of their annual plan.

The Trust is fully committed to preventing fraud or bribery within the organisation and will act against those identified to have committed fraud against The Queen Elizabeth Hospital, Kings Lynn, NHS Foundation Trust. A statement detailing this commitment is published on the Trust's website.

The Trust complies with the NHS Counter Fraud Authority Standards for Providers: Fraud, Bribery and Corruption. The Trust takes a positive stance in countering bribery and fraud against the organisation and the NHS in general and actively seeks to ensure that an appropriate, yet proportionate response is taken to allegations of fraud and bribery.

The Local Counter Fraud Specialist (LCFS) reports to the Director of Finance and Resources and attends Audit Committee meetings to report on the work undertaken. The LCFS has during the past year undertaken counter fraud awareness work through face to face presentations and regular newsletters. The LCFS has also ensured that a programme of fraud awareness materials has been published for staff via the Trust intranet.

Throughout the past fiscal year, the counter fraud culture has continued to be embedded into the Trust and work has been undertaken against each of the four areas of action set out in the NHS Counter Fraud Authority Standards for Providers: Fraud, Bribery and Corruption, namely, Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account.

An assessment against the criteria of the NHS Counter Fraud Authority Self Review Tool (SRT) was undertaken in 2017/18 and resulted in an overall rating of Amber / partial compliance. This was followed by a quality assessment in November 2017. The outcomes from the assessment have been considered and an action plan has been agreed with management to address areas for improvement.

A fraud risk assessment was undertaken in-year and this identified the Trust's fraud risks as declarations of interest, locum timesheets, leavers' termination forms, procurement and IT risks. Management has agreed actions to address all the findings reported by the Local Counter Fraud Service during 2017 / 2018.

Nine LCFS referrals were investigated during the year and these included cases of working whilst sick, fictitious timesheets, fraud by false representation and abuse of position amongst other alleged offences.

From the allegations investigated there were no particular trends identified and no frauds perpetrated as a result of weaknesses in systems or processes.

Well-Led

The regulatory definition of a 'well-led' organisation is one where the leadership, management and governance of the organisation ensure the delivery of sustainable high quality person-centred care, support learning and innovation, and promote an open and fair culture.

The Board submitted its self-assessment against the Well-Led framework to NHSi in December 2017. Since then, the Trust has been addressing identified areas for improvement and has in place a comprehensive Board Development Programme. The Trust is anticipating a CQC Well-Led assessment as part of the inspection that began in April 2018.

The Trust has received Well-Led support from NHSi, including Board and committee observations and feedback in March and April 2018.

The Trust commissioned an internal audit of Divisional Governance in 2017/18 (reasonable assurance). The Divisional Governance Structure was reviewed in 2017/18 to support the introduction of the Trust's new Operational Management Structure from April 2018.

The Care Quality Commission (CQC) and Quality Risk

At the time of writing, the Trust is subject to CQC inspection (April 2018). The CQC's report is expected in the late spring / early summer of 2018. At its last CQC inspection in June 2015, the Trust was rated:

• **Overall Rating for the Trust**	**Requires Improvement**
• Are Services at this Trust safe?	Requires Improvement
• Are Services at this Trust effective?	Good
• Are Services at this Trust caring?	Good
• Are services at this Trust responsive?	Requires Improvement
• Are services at this Trust well led?	Good

The Trust engages openly and transparently with the CQC, responding to queries in a timely fashion and recently benefitting from the learning derived from CQC activities, such as a Maternity Forum.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust has in place a 'Quality Matters' programme and oversight group, driving Quality Improvement at the Trust and supporting the Trust's preparation for CQC inspection. The Group reports to the Quality and Patient Safety Committee and has developed a comprehensive action plan to address areas for quality improvement

In 2017/18, an Internal Audit was undertaken of the Trust's methodology for providing assurance to the Board in respect of CQC compliance. The Internal Audit provided 'reasonable assurance' (amber/green).

Additional detail concerning the Trust's arrangements for Quality Governance is set out in the Quality Report section of this Annual Report.

A Quality and Safety Summit was held in January 2018.

Public and Staff

The public, including public Foundation Trust members and Healthwatch representatives are involved in the risk management process within the Trust through their involvement in the Patient Experience Committee of the Governors' Council (PEC), mock CQC inspections and Patient-led Assessments of the Care Environment

(PLACE) inspections. Service users are also involved through a number of very active service user groups and of course, via their responses to patient satisfaction surveys.

The public is represented by elected Governors' participation in projects and on key committees such as the Quality and Patient Safety Committee and Ethics Committee.

Public Governors attend and secure feedback on the Trust's services from the GP Patient Participation Groups in the area served by the Trust.

The Governors' Council reviews quality, operational performance, workforce and financial information and risk as part of its statutory duty to hold the Non-Executive Directors to account for the performance of the Board. The Governors' Council meets six times a year. In 2017/18, the Trust has reviewed its governance arrangements, aligning the meetings of the Board of Directors and Governors' Council to improve governor oversight and opportunities for challenge and 'holding to account'.

The Governors' Council's views have been taken into account in the development of the Trust's Corporate and Quality Strategies.

The Patient Experience and Business Committees of the Governors' Council review detailed quality, performance and financial risk and report back to the Governors' Council at every meeting.

Governors receive a comprehensive induction on election to the Council and are also invited to participate in 'Governwell' development programmes for governors, delivered by NHS Providers. In 2017/18, an in-house development workshop was also arranged for Governors on 'Effective Questioning'.

Staff are expected to provide safe clinical practice, report incidents and potential hazards, be familiar with the Trust's Risk Management protocols and departmental risk issues, comply with all Trust policies and procedures and take reasonable care of their own safety and the safety of others. The Trust uses a Datix-web system for the reporting of incidents. All reported incidents are reviewed regularly.

A new 'RISC' (Reporting of Information for Safer Care) reporting telephone line was introduced at the Trust in the spring of 2018. This line provides an additional way for staff to raise concerns and will complement but not replace our existing Datix and Whistleblowing methodologies.

The Trust has a well-developed Whistleblowing Policy, which aligns with the national 'Freedom to speak up: whistleblowing policy for the NHS' and a range of both internal and external arrangements are in place for staff to be able to raise concerns. All Whistleblowing cases are reported to the Board. In 2017/18, the Trust appointed an independent Freedom to Speak Up Guardian. This important post is currently held by a Non-Executive Director, pending substantive reappointment to the post. The Freedom to Speak Up Guardian has reported to the Board and quarterly to the National Guardian's Office.

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

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

The Trust agreed its Workforce Race Equality Standard Action Plan in 2017/18 and delivery is being monitored by the Workforce Committee.

The Board takes feedback received from its patients and its staff very seriously and in 2018/19, will be using feedback secured from compliments, complaints, surveys and 'listening' to inform its Quality Strategy, Organisational Development Strategy and Behavioural Framework.

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5 Review of economy, efficiency and effectiveness of the use of resources

The Board of Directors has specified within the Trust's Standing Financial Instructions and the Scheme of Delegation, appropriate delegated authority levels throughout the Trust. Executive Directors and managers have responsibility for the effective management and deployment of their staff and other resources to optimise the efficiency of each division.

Each year, the Board of Directors agrees budgets and annual plan targets that incorporate significant efficiency improvement requirements. All efficiency, cost improvement and transformation plans are Quality Impact Assessed and the delivery of those improvements is monitored at divisional level. Regular meetings take place with Executive Directors to review performance in delivering plans.

The Trust remains in breach of the terms of its licence as a result of concerns about its financial sustainability and is expecting the opinion of the external auditor to reflect this in respect of the Trust's economic, efficient and effective use of resources.

The Board considered its 'Going Concern' position at its meeting in April 2018 and after consideration of risks and uncertainties agreed that:

> 'The use of the going concern basis is appropriate but there are material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a going concern, in which case these should be disclosed.'

The Trust reports on the delivery of its financial plans at regular meetings with the Regulator, NHSi.

The Trust has been financially challenged in 2017/18, due in large part to lost income and temporary staffing costs required to maintain safe levels of staffing.

The Trust understands that the financial challenge for 2018/19 and beyond will be significant and that delivery of its plans, including the Control Total agreed with the Regulator will require considerable levels of Cost Improvement Programme (CIP) delivery, robust controls and transformational ways of working.

The Trust is working strategically with the Norfolk and Waveney Sustainability and Transformation Partnership (STP) and other partners to secure the sustainability of the regional and local healthcare system.

The Trust has a range of systems and processes in place to provide assurance that resources are used economically, efficiently and effectively. These include:

- Standing Financial Instructions and Scheme of Delegation
- Financial Management Policy Suite
- Anti-Fraud and Anti-Bribery Policy Suite
- Management of Conflicts of Interest and Gifts, Hospitality and Commercial Sponsorship Policy (revised in 2017, in line with national policy)
- Executive management of Trust finance and activity plans
- Regulatory reviews of Reference Costs
- Lord Carter review – 'Operational productivity and performance in English NHS acute hospitals' and the 'Model Hospital' toolkit
- Cost Improvement Programme (Quality Impact Assessed)
- Service Line Reporting / Patient-level Information and Costing (PLICs)
- Procurement Strategy (assimilating Lord Carter recommendations)
- 'Getting it Right First Time' (GIRFT) reviews

The Trust has reported on 'Use of Resources' to the Board in 2017/18 and is expecting an external 'Use of Resources' assessment early in 2018/19.

Assurance is provided by Internal and External Audit and by independent and peer reviews.
Through the Internal Audit programme for 2017/18, the Trust has commissioned a range of audits to provide assurance that resources are used economically, efficiently and effectively:

- Key Financial Controls – (substantial assurance)
- Payroll – (substantial assurance)
- Capital (reasonable assurance)
- Financial Forecasting (reasonable assurance)
- Estates Management (partial assurance)

All internal audit recommendations are being addressed and delivery progress is monitored by the Audit Committee.

6 Information governance

Information risk is managed through the Information Governance Committee, which reports to the Trust Executive Committee. The Trust has nominated an Executive Director to fulfil the role of Senior Information Risk Owner (SIRO) and has assessed compliance with the requirements of the NHS Digital Information Governance Toolkit and signed the annual Information Governance Assurance Statement in March 2018. It assessed itself as 'green/satisfactory' with a compliance score of 80%, which is a pre-requisite of unconditional registration with the Care Quality Commission. Internal Audit also undertook a review of the systems and processes supporting the Trust's submission.

During the year, there have been three serious incidents that required disclosure in relation to personal data. Following internal investigations and the remedial measures put in place, alongside existing policies and procedures, the Information Commissioner's Office stated that no further action was required in all three cases.

The Trust continues to take a range of steps to reduce information governance / data security incidents. These actions include weekly trust-wide communications and incident reports, mandatory annual data security training for all staff and the installation of confidential waste bins and high-profile posters at key trust staff exits, to encourage staff to check that they are not taking patient identifiable information, such as handover notes off site.

The Trust is preparing for the General Data Protection Regulation (GDPR) in May 2018 and in 2017/18, commissioned an advisory Internal Audit review of it processes and readiness for GDPR implementation. The Trust also commissioned an advisory audit concerning Cyber-Security at the Trust. A number of actions have been agreed to respond to the recommendations of both the Cyber-Security and GDPR audits, which will be monitored by the Audit Committee.

7 Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Trust has presented its Quality Report as part of its Annual Report and Accounts based on a range of Quality indicators that were agreed by the Board and which are monitored on a regular basis through Integrated Performance Reports, including Quality and Operational performance. The Governors' Council has selected a local indicator for audit in 2017/18, as required.

The Board of Directors is satisfied that the messages within the Quality Report accurately reflect the

information that it has received on a regular basis throughout the year.

The report has been shared with the Trust's commissioners, Governors, Healthwatch and Norfolk Health Overview and Scrutiny Committee, all of whom have been given the opportunity to provide formal comment for publication within the report.

The Board is assured that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data, after taking assurance from a range of sources, including:

- Comprehensive Policy Suite and methodology to ensure that policies are kept up to date
- Regular implementation update reports on the delivery of the Trust's Quality Strategy, to the Quality and Patient Safety Committee
- External Audit's limited assurance review of the Quality Report and an audit of data
- The Information Governance Toolkit assessment
- External benchmarking from Dr Foster
- Regular performance reporting against key performance indicators (KPIs)
- External review of performance information e.g. CCG Clinical Quality Review Meetings (CQRM)
- Commissioning of independent review of data and information e.g. Emergency Pathway review
- Internal Audit - Data Quality – 62 Day cancer Target 'Amber/Green' (Reasonable Assurance)

The Quality Report development process is led by the Chief Nurse, with support from the informatics team.

8 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Risk Committee, Clinical Governance Committee, Quality and Patient Safety Committee, Finance and Performance Committee and Health and Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is further informed in a number of ways. The Head of Internal Audit, through the Audit Committee, provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the Internal Audit work programme.

Internal Audit reviewed the Board Assurance Framework in 2017/18 giving an overall rating of 'Green' (Substantial Assurance).

During the year, internal audits were conducted in the following areas:

- Safeguarding Children and Vulnerable Adults (Partial Assurance)
- GDPR Preparedness – advisory
- Data Quality – 62-day Cancer - (Reasonable Assurance)
- Payroll - (Substantial Assurance)
- Key Financial Controls - (Substantial Assurance)
- Board Assurance Framework - 'Green' (Substantial Assurance)
- IG Toolkit Fieldwork - advisory
- CQC (Reasonable Assurance)
- Payments to Staff (Reasonable Assurance)
- Capital (Reasonable Assurance)
- Financial Forecasting (Reasonable Assurance)
- Divisional Governance (Reasonable Assurance)

- Estates Management – (Partial Assurance) N.B. This audit was not part of the Trust's Internal Audit plan for 2017/18. Rather, the audit was an Estates-led initiative requested by the Acting Deputy Director of Estates, in recognition of some identified gaps in governance assurance and to secure an independent view upon which to base his improvement plans.
- Risk Management – (Partial Assurance)
- Cyber Security – Advisory
- Appraisals – (Partial Assurance)
- Record Keeping – (Reasonable Assurance)
- Applications Control Framework – (Reasonable Assurance)

Robust management action plans and follow up audits have been agreed to address any risks, control weaknesses and ongoing compliance issues identified in all Internal Audits. The delivery of these actions is monitored by the Audit Committee. Particular focus has and will be given to the four partial assurance opinions and the findings from the Cyber-Security and GDPR reviews.

The Head of Internal Audit opinion for 2017/18 is as follows:

> 'The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.'

As detailed above, the Board, its committees and sub-committees have a key role in maintaining and reviewing the effectiveness of the system of internal control. The terms of reference for all committees reporting to the Board require them to monitor risk within their scope and to review the relevant sections of the Board Assurance Framework to ensure that the Trust's principal risks are properly articulated and that there are adequate sources of assurance on effective controls.

I also gain assurance from executive managers within the organisation, who have responsibility for the development and maintenance of the system of internal control. The Board has received regular reports on risk, performance and clinical/quality governance.

The Trust seeks to learn and improve from the results and recommendations made in internal audit and external audit reports, clinical audits, the Information Governance Toolkit assessment, Serious Incident reporting and external benchmarking.

I take additional assurance from programmed, ad-hoc and commissioned external reviews, inspections and accreditation visits. These external reviews provide me with an independent view and recommendations. In 2017/18 independent reviews have included:

- Peer Reviews e.g. Critical Care
- Human Tissue Authority review
- JAG Accreditation
- Breast Screening Review
- NHSi review of Mortality Surveillance Group
- Emergency Care Improvement Programme (ECIP Review)
- Getting it Right First Time (GIRFT) reviews
- HEE review – Obstetrics and Gynaecology
- NHS Digital reviews concerning Cyber-Security

The Trust has responded to concerns raised as a result of these reviews and progress in addressing issues and recommendations is monitored by the appropriate committees. Since 'independent review' is a strong source of assurance for the Board, progress in this respect is also articulated through the Board Assurance Framework.

My review is further informed by recommendations made by the external auditors in their management letter and other reports; the review mechanisms in place for the risk register, reviews undertaken by the CQC and other external assessment and accreditation bodies.

9 Conclusion

I took up my role as CEO and Accounting Officer of The Queen Elizabeth Hospital, King's Lynn, NHSFT in May 2017. My AGS review and my broader observations as I approach the first anniversary of my appointment, lead me to conclude that while progress has been made in many areas in 2017/18, there remain significant challenges for the Trust in 2018/19, relating to:

- Financial delivery, productivity/efficiency and sustainability
- Emergency pathway and operational performance sustainability
- Nurse and medical staffing sustainability
- Embedding and sustaining quality improvements
- Cyber-Security
- GDPR

The Trust's Internal Audit team has identified four 'partial assurance' areas and no 'Red' / 'no assurance' findings. In respect of those areas where controls need to be strengthened, I am satisfied that recommendations are being addressed in a timely fashion.

I am assured that no significant control issues have been identified in 2017/18.

I believe that the controls in place at the Queen Elizabeth Hospital, King's Lynn will support the Trust in addressing it challenges going forward and in delivering its objectives.

Jon Green – Chief Executive
Date: 22/5/2018

Quality Report

2017/18

Contents

Part 1: Statement on Quality

The Board of Directors for The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is pleased to present its Quality Report for 2017/18. This report provides an account of the quality improvements achieved in year and describes the changes that have taken place to operational structures and associated governance arrangements to ensure a sound base on which to develop a new Quality Strategy for the organisation during the coming year.

This Quality Report therefore sets out to inform commissioners, stakeholders and the public that rely on its services how the Trust has:

- Strengthened governance and accountability within both its clinical services and the organisation as a whole;
- Delivered its quality priorities for 2017/18 as set out in the Quality Report last year;
- Responded to feedback and information from complaints, PALS enquiries and incidents and from views expressed in patient and staff surveys and online feedback, to ensure that areas for improvement are identified and acted upon and that lessons are learnt and shared throughout the organisation;
- Monitored and improved its clinical practice through participation in clinical audit and research;
- Performed in relation to its core clinical indicators and CQUIN activity;
- Developed and set out its quality priorities for 2018/19.

The Trust has maintained a focus on quality improvement in all its clinical services and throughout the organisation as a whole despite the operational pressures that have affected the Trust, particularly during the winter months. Against this overall backdrop of quality improvement, we have focused on delivering our specific quality priorities identified in last year's Quality Report. This has ensured that quality improvement has remained at the forefront of all that we do. At the same time we have undertaken a review of our key quality objectives in order to determine a new strategic direction for quality improvement for the organisation as a whole. This period of transition and change has continued throughout this year with further appointments to the Board, a review of operational structures and appointments to new managerial and governance posts. I have completed my first year in post as Chief Executive and feel that the ground work has been undertaken so that we can now put in place an ambitious programme of quality improvements for 2018/19 and beyond.

In line with our commitment to support the transition to seven day working there has been a focus this year on improving access to radiology services with two successful recruitment drives to attract appropriately skilled radiographers to meet the service demands and offer a 24 hours / 7 day service for sectional and plain film radiology.

Since spring 2015 the Trust has had a Quality Strategy that provided a framework for improvement under four clear objectives. These focused on ensuring that:

- Our patients are safe
- Our patients have the best possible experience of care
- Care and treatment is effective and compliant
- We build and sustain excellence as a care provider

During 2017/18 we decided to maintain this framework until our new Quality Strategy is launched during this coming year and so identified quality priorities that married with these key objectives:

- Reducing avoidable deaths in the Trust;
- Improvement in the care of our patients when their condition deteriorates on our wards;
- Improve the experience of children attending the Trust;
- Ensuring patients are seen by the most appropriate health professional at the right time and in the right place.

The Trust received its last inspection visit by the Care Quality Commission (CQC) in June 2015 and exited 'Special Measures' later that year but has remained focused on improving its current rating of 'Requires Improvement'. This has been supported by strengthening the governance framework within the Divisions and determining clear lines of accountability and responsibility for improvement. We have introduced new operational structures and processes to enable more effective management and use of resources and lastly,

strengthened processes for learning within complaints handling, incident reporting and following patient deaths.

During the year the Trust has developed a Quality Matters Group, led by the Chief Nurse, to systematically review all areas of Trust activity and ensure that where the CQC had identified the need for further improvement, this has been delivered. It also ensures that across the organisation, the Trust is continuing to deliver its services in accordance with the CQC's Fundamental Standards. At the time of writing this report we are subject to a CQC inspection visit and are therefore awaiting feedback on those measures we have put in place to date to ensure quality improvement and where further focus may be required in the future.

We have maintained our commitment to the national 'Sign up to Safety' programme and have continued to deliver improvements in patient safety focused on the four key work streams that reflect the Trust's quality priorities and which have led to direct improvements in safety for the patient:

- Management of the deteriorating patient
- Workforce planning
- Effective communication
- Harm reduction programme

These four primary drivers have driven a wide range of initiatives throughout the organisation linked through to the Trust's key quality improvement priorities, CQUIN schemes and other harm reduction strategies.

My fellow Board members and I recognise that our staff are central to delivering a high quality service to patients and their families. In order to emphasise the valuable contribution our staff make to the care patients receive, we have ensured that the strap line 'Staff, Patients, Community' has been adopted to underscore our commitment and to communicate that commitment to the workforce. This has been a challenging year for staff throughout the NHS and no more so than here in King's Lynn. We have endeavoured to support our staff through this period by:

- Streamlining the recruitment process to reduce recruitment time, track progress within the process and support staff in planning their services;
- Monitoring staffing levels on a daily basis to maintain safe staffing levels;
- Listening to staff and responding to feedback from staff surveys and the Staff Friends and Family Test;
- Reviewing the Trust values and consulting staff on developing a 'Behaviours Framework' to enshrine expected behaviours within the work environment;
- Maintaining and developing health and wellbeing initiatives and introducing stress management clinics and training sessions on Mental Health First Aid, in addition to the existing programme of fitness classes and access to the hospital gym;
- Continuing the recognition of achievement in demonstrating Trust values through an on-going programme of 'Values-in-Action awards' and 'Long service awards';
- Ratifying our Workforce and Development Strategy to establish our commitment to developing and supporting our staff;
- Maintaining our commitment to the apprenticeship programme and valuing it as a route for cultivating our own workforce for the future;
- Continuing to work in partnership with our trade unions to provide Lifelong Learning opportunities and welcoming the opening of the Inspire Centre in October 2017 as a venue for in-house training;
- Continuing to invest in Leadership & Management Development with participation in the regional Systems Leadership programme
- Supporting staff to attend Quality Service Improvement and Design and Emergency Care Improvement programmes and more locally within the Trust, through 'Leadership breakfasts' and 'Lean and Leadership' sessions.

In relation to our estate there has been further work undertaken as part of the Estates Strategy and in this last year the Trust has seen the:

- Installation of a Pharmacy Dispensing Robot to streamline dispensing and leading to both improvements in efficiency and safety;
- Development of a Primary Care Streaming facility alongside the Emergency Department to provide an alternative for patients requiring less complex immediate care;
- Commencement of car parking improvements to create 117 additional spaces to relieve site congestion;

- Commencement of upgrading and improving fire detection and compartmentation;
- Commencement of a 5 year rolling programme to replace and upgrade the roof and upgrade ten wards;
- Upgrade of lighting to highly efficient LED lighting;
- Upgrades to external footpaths;
- Procurement of Hydrogen Peroxide decontamination equipment.

Within this programme of change and transformation the organisation has successfully delivered improvements or maintained standards in many of its quality priorities, especially in the following areas:

- Continued to increase the recruitment of patients to participate in Clinical Research studies;
- Continued the reduction in hospital-acquired pressure ulcers achieving a further 44% reduction compared to the previous year;
- Introduced the Sepsis 6 screening tool on all wards and achieved the sepsis targets in accordance with the national CQUIN standards;
- Strengthened communication and escalation of concerns at ward level through the use of the SBAR tool and introduction of the Nightingale Project;
- Introduced 'Resus Huddles' twice a day to improve communication and responsiveness within the Resuscitation Team;
- Introduced the End PJ Paralysis programme to support patients getting up and dressed each day to improve patient experience and help prevent 'de-conditioning' and loss of functional ability during an inpatient admission;
- Implemented the Red2Green 100 day challenge to ensure patients' care and treatment is being actively taken forward each day of a patient's admission into hospital. We were invited to speak on our experience nationally with NHS Providers and NHS Improvement;
- Continued the vanguard 'Red Bag' project to improve communication and sharing of vital information with Care Homes whose residents are admitted into hospital;
- Implemented re-design initiatives in the Emergency department to limit waiting times and ensure patients have access to appropriate and timely care. This includes the implementation of 'Hot clinics', which GP's are able to refer patients to, Primary Care streaming and the 'Fit 2 Sit' initiative which offers patients the opportunity to sit rather than lie down in the department and improves timely access to trolleys for those patients requiring such management;
- Joined Cohort 7 of the National Acute Frailty Network which supports the Trust's Integrated Frailty project;
- Worked collaboratively across care boundaries to support a cohort of patients who frequently attend hospital services to better meet their care needs;
- Introduced the Blue Ribbon scheme which identifies patients who should not be subject to patient moves between wards to improve both patient experience and safety for this vulnerable group of patients;
- Met the flu vaccination target amongst frontline staff by December 2017;
- Developed, in collaboration with children, young people and their families, the Children's and Young People's Strategy to strengthen a child-centred approach to our services;
- Sustained improvement in the 'level of recommendation' FFT score for inpatient and day case patients, outpatients and maternity services achieving >95% overall for the year;
- Achieved a 15% reduction in the number of complaints received.

We have not only looked to improve the quality of services provided but also to focus on improving the quality of patient and carer experience. This year has seen initiatives to improve communication with patients and visitors by providing information screens in key sites within the organisation, the installation of an Infopoint near the main entrance and the use of pagers to improve the experience of waiting, whether in. Outpatient clinics or on Rudham Ward for parents with children having an operation. Further to our commitment to 'John's Campaign' we have extended the use of Carer's Cards to carers of patients with a learning disability or those supporting a patient experiencing an episode of delirium.

The Board and the organisation as a whole recognise that the Trust will continue to face challenges over the coming year and that ensuring a continuous improvement in the quality of our services will require a sustained focus to maintain improvements to date and an additional commitment to address those areas where further improvement is required. We will need to ensure that we:

- Respond positively to the recommendations of the CQC when their report on their inspection is finalised;
- Continue the two main streams of work from this year to make improvements to patient flow on the clinical pathway for emergency patients and to support the collaborative work with Primary Care, Community Services and Commissioners to ensure more appropriate care for frail, elderly patients;
- Enhance our complaints handling process by improving our immediate responsiveness and ensuring that all complainants receive a written response within the target response times;
- Improve engagement with the Friends and Family Test to increase response rates as well maintaining <95% level of recommendation;
- Maintain a programme of staff training and support to assist staff in preventing inpatient falls and achieving a further reduction where possible, in those leading to patient harm.
- Focus on strategies to improve infection control within all inpatient areas;
- Review our current documentation in relation to resuscitation so that it better supports patient and family consultation and provides clear guidance to staff;
- Maintain a real focus on recruitment and retention to address the challenges of recruitment in a changing environment.

However, in addition to these on-going work streams the Trust will focus on new quality improvement priorities that will inform the development of a new Quality Strategy during this year:

- Introduction of NEWS 2;
- Improvements in standards of infection control;
- Improvements in Medicines Management – Focusing on Anti-coagulation;
- Quality improvement programme around nutrition and hydration;
- Improve communication with patients who have a sensory impairment;
- Implement an improvement programme around documentation and note keeping;
- Develop a quality improvement plan in support of perinatal care;
- Ensure full compliance with LeDeR (reporting & learning from deaths in people with a learning disability);
- Improve understanding of the Mental Capacity Act 2005 amongst staff and how it is used within healthcare practice;
- Maintain and develop quality improvements within End of Life care.

The Trust has continued to be actively involved in the Sustainability and Transformation programme throughout 2017/18 and is committed to working with partners to look for solutions to those challenges that face the wider health and social care economy.

The Trust has maintained and developed its commitment to quality improvement during this period of organisational change and approaches the coming year with a strengthened organisational structure and the leadership in place to work with staff to further quality improvements during 2018/19. The development of our Quality Strategy will act as a springboard for future quality initiatives and will provide the framework for improvement over the next three years.

We await the outcome of our current period of CQC inspection and I look forward to enabling the Trust to positively respond to its recommendations and to leading the organisation to embrace the opportunities and embed the changes required to ensure future quality improvement for patients and staff alike.

I hereby state that to the best of my knowledge the information contained within this Quality Report is accurate.

Jon Green – Chief Executive
Date: 22/5/2018

How the Board of Directors Monitors Quality

In 2017/18 the Trust has continued to embed and keep under review, its Quality Governance Structure (see governance structure on the next page), with clear accountabilities at all levels of the organisation from divisional level right through to the Board via Board committees, including the Quality and Safety Committee. Assurance and quality risk is communicated across the governance structure, using the Chair's Key Issues methodology. The Board monitors quality performance at every meeting though its review of key quality metrics including patient satisfaction, hospital acquired infection, falls, pressure ulcers, serious incidents and mortality. Exception reports are prepared for the Board at every meeting to alert directors to any areas of concern and facilitate monitoring of plans in place to address those issues.

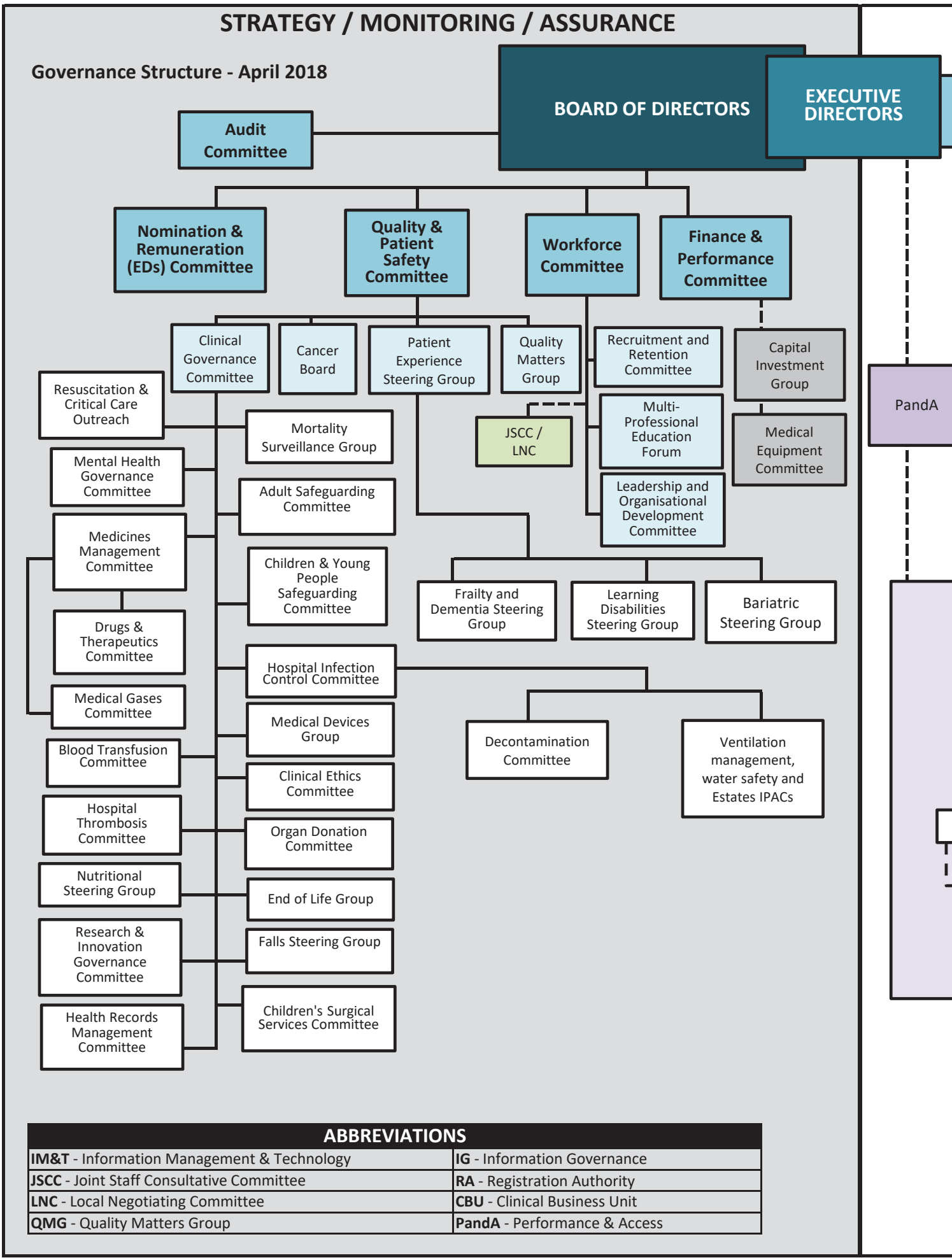
The Quality and Safety Committee has monitored the delivery of the Trust's Quality Strategy and has overseen the Trust's quality improvement work through the Quality Matters Group.

In addition to the executive Medical Director and Chief Nurse, the Board includes non-executive directors with clinical backgrounds. This Board skill-mix enhances the Board's scrutiny and challenge in respect of quality-related issues.

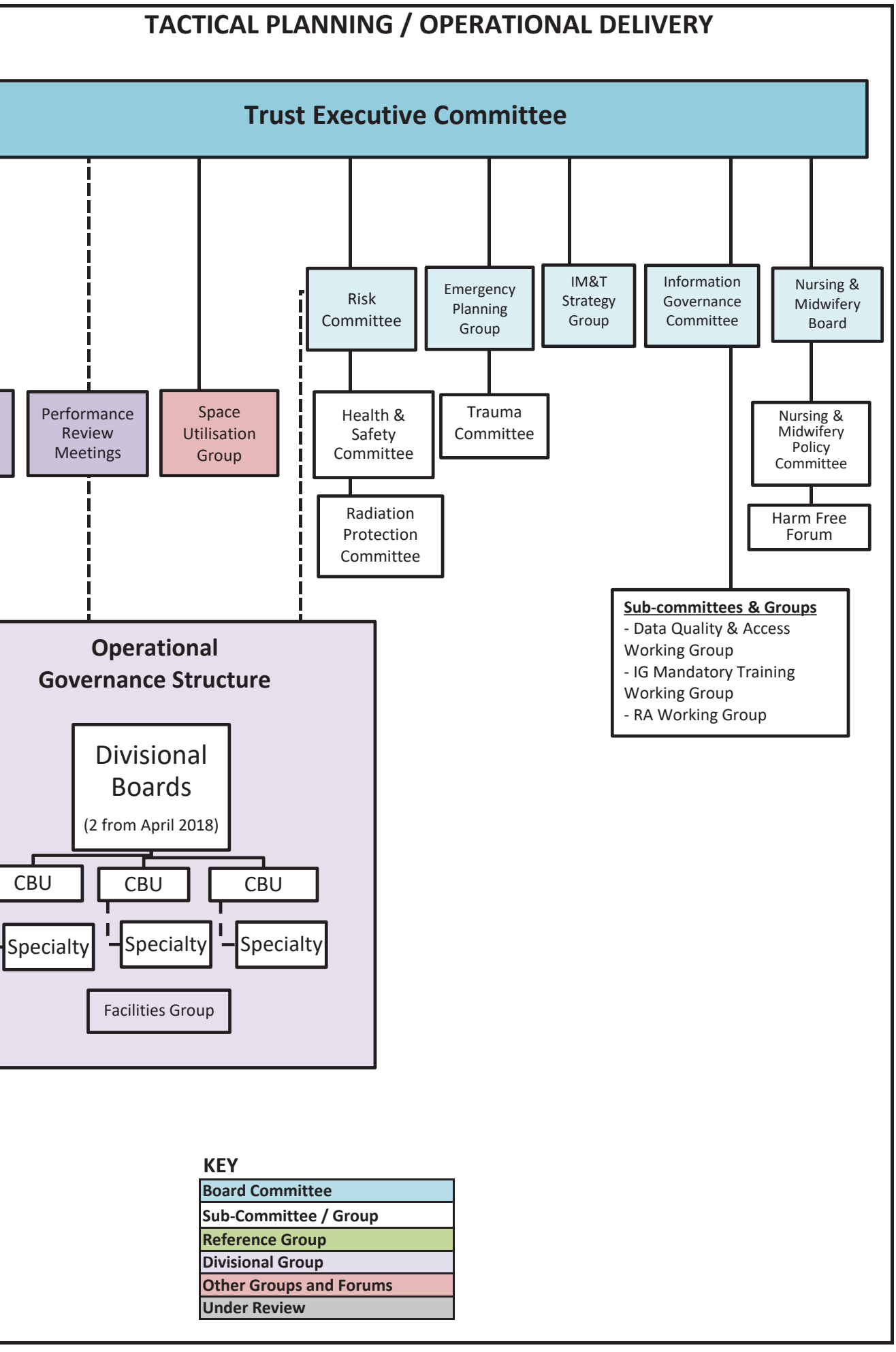
Other in-year work to improve the Board's visibility of the Trust's delivery of quality services has included:

- Mortality Surveillance Group developed and reporting to the Quality and Safety Committee;
- 'Learning from avoidable deaths' – policy and reporting introduced – reporting to the Quality and Safety Committee;
- In-depth 'Quality Enquiries' at the Quality & Safety Committee;
- 'Freedom to Speak-Up Guardian' – reporting to the Board and the National Guardian's Office;
- Ward accreditation scheme and new ward metrics reporting to the Board and Quality and Safety Committee;
- Independent, regulatory and peer reviews in key quality areas – reporting to the Board via the Board Assurance Framework, which also provides assurance in a comprehensive range of quality areas;
- 'Patient Stories' reporting to the Board at every public meeting;
- '15 steps' methodology enhanced and embedded for all non-executive directors;
- Safeguarding workshop for the Board;
- Understanding Dr Foster mortality information - development workshop for the Board.

Governance Structure



ABBREVIATIONS	
IM&T - Information Management & Technology	**IG** - Information Governance
JSCC - Joint Staff Consultative Committee	**RA** - Registration Authority
LNC - Local Negotiating Committee	**CBU** - Clinical Business Unit
QMG - Quality Matters Group	**PandA** - Performance & Access


TACTICAL PLANNING / OPERATIONAL DELIVERY
Trust Executive Committee
Risk Committee
Emergency Planning Group
IM&T Strategy Group
Information Governance Committee
Nursing & Midwifery Board
Performance Review Meetings
Space Utilisation Group
Health & Safety Committee
Trauma Committee
Radiation Protection Committee
Nursing & Midwifery Policy Committee
Harm Free Forum
Sub-committees & Groups
- Data Quality & Access Working Group
- IG Mandatory Training Working Group
- RA Working Group
Operational Governance Structure
Divisional Boards
(2 from April 2018)
CBU
CBU
CBU
Specialty
Specialty
Specialty
Facilities Group
KEY
Board Committee
Sub-Committee / Group
Reference Group
Divisional Group
Other Groups and Forums
Under Review

Incident Reporting and Never Events

Identifying and responding appropriately when things go wrong is a key part of the way that the Trust continually strives to improve the safety of patient services. Serious incidents are events where the potential for learning is so great, or the consequences to patients, families, carers or staff are so significant that they warrant our particular attention to ensure these incidents are identified correctly, investigated thoroughly and, most importantly, trigger actions that will prevent them from happening again (NHS England Serious Incident Framework March 2015).

The Trust can demonstrate through internal audit that the governance arrangements for Serious Incidents, the arrangements for timely reporting, root cause analysis, lessons learned and the development and monitoring of action plans provide 'reasonable assurance that the controls upon which the organisation relies to manage this area are suitably designed and consistently applied'.

Incident trends

There have been three Never Events declared in the last financial year. Robust systems are in place to ensure that scrutiny is applied by a senior team on a weekly basis to all moderate incidents and above, in order to identify any potential adverse incidents in need of further investigation and reporting.

Patient Safety Incidents	1.4.16 to 31.3.17	1.4.17 to 31.3.18
Total number of incidents	6142	7231
% of incidents resulting in severe harm or death	0.72%	0.41%

A total of 31 serious incidents have been declared in the period of which three were Never Events. The table below details the serious incidents by type over the previous five years. There has been a significant reduction in the number of Falls Serious Incidents. The internal process for declaration follows robust internal guidelines and is kept under review by the Clinical Commissioning Group (CCG).

	2013/14	2014/15	2015/16	2016/17	2017/18
Pressure Ulcers	69	52	16	2	0
Never Events	0	7	0	1	3
Falls	10	11	9	19	8
Other Serious Incidents	13	18	24	24	20
Total SIs	**92**	**88**	**49**	**46**	**31**

Incident date	STEIS Date reported externally	Summary of adverse events
16/04/2017	19/04/2017	Baby transferred out for specialist care
21/04/2017	28/04/2017	Baby transferred out for specialist care
19/04/2017	02/05/2017	Failure to act on results
03/05/2017	11/05/2017	Failure to prescribe clexane on discharge
29/04/2017	17/05/2017	Failure to rescue
02/05/2017	24/05/2017	Lack of availability of bed for cardiac patient
23/05/2017	02/06/2017	Inappropriate level of sedation
31/05/2017	09/06/2017	Failure to act on results
19/07/2017	21/07/2017	Information Governance - Breach of staff confidentiality
09/08/2017	11/08/2017	Baby transferred out for specialist care
11/10/2017	18/10/2017	Unexpected admission to NICU
14/10/2017	19/10/2017	Maternal DVT & PE

20/10/2017	01/11/2017	Still birth
06/11/2017	13/11/2017	Baby transferred out for specialist care
09/11/2017	17/11/2017	Failure to act on presenting condition in a timely manner
08/11/2017	27/11/2017	Long term drug user with DVT deteriorated in our care
09/10/2017	28/11/2017	C difficile outbreak
28/11/2017	08/12/2017	Failure to rescue
15/12/2017	21/12/2017	Information Governance - Breach of patient confidentiality
23/01/2018	26/01/2018	Never Event - Wrong site surgery (punch biopsy)
22/01/2018	02/02/2018	Never Event - Wrong site surgery (tooth extraction)
05/07/2018	09/02/2018	Never event - Unintentionally Retained Foreign Object
31/01/2018	16/02/2018	Cataract surgery abandoned

Examples of Lessons Learnt from Serious Incidents

- Be reactive to early warning scores.
- Recognise and escalate concerns quickly and re-escalate if need be.
- Utilise Caldicott procedures in protecting patients' data.
- Improve training and processes for falls awareness and risk assessments.
- Communication and confirmation with the patient is key to preventing wrong site surgery.

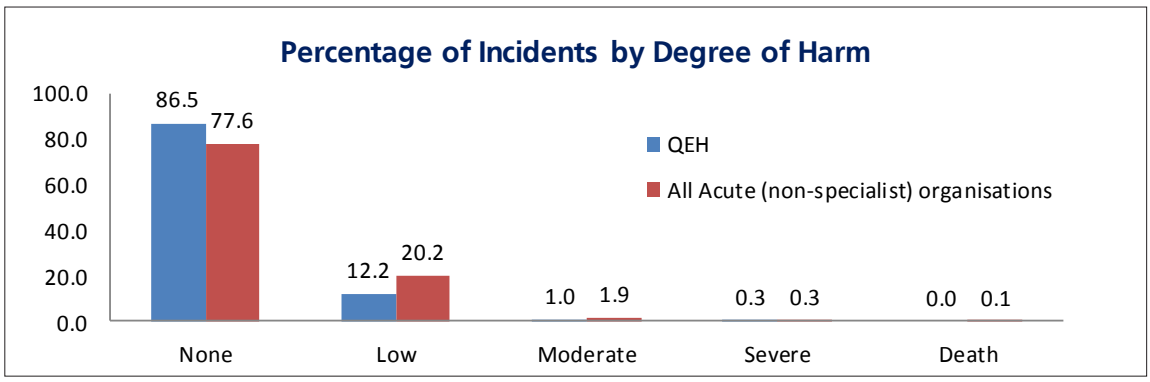
Duty of Candour

Central to national guidance for the management of serious incidents (NHS England Serious Incident Framework 2015) is the importance of working in an open, honest and transparent way where patients and their families are put at the centre of the process. This is inherently linked to the statutory guidance for `Duty of Candour`.

The Trust has put in place systems and processes to ensure compliance with the requirements associated with Duty of Candour (contained in regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). The key principles being:

- A general duty to act in an open and transparent way in relation to care provided to patients.
- The requirement to tell the patient (or their representative) as soon as is reasonably practicable after a notifiable patient safety incident occurs:
  - Provide a full explanation of what is known at the time, provide an apology and keep a written record of the notification to the patient;
  - Provide reasonable support to the patient;
  - Provide the patient with a written note of the discussion, and keep copies of correspondence;
  - Share the outcomes or results of any further enquiries and investigations in writing to the relevant person.

Comparative data on number and severity of incidents from the National Reporting and Learning System NRLS (1.4.17 to 30.9.17)



QEH Incidents / Degree of Harm				
None	Low	Moderate	Severe	Death
2,218	312	25	8	1

Management of Risk

During 2017/18 the central role of the Risk Committee has been pivotal to maintaining a focus on managing risk during a period of structural change within the Divisions. The electronic Risk Register is scrutinised and challenged by the Committee and owners of risks are required to re-visit their assessments on a regular basis and ensure plans are in place to reduce the level of risk or robustly manage that risk.

The weekly incident panel ensures that all incidents rated moderate or above are subject to senior clinical review and that investigations and root cause analyses are undertaken to identify factors leading to incidents occurring and ensuring that lessons are learnt and communicated throughout the organisation.

Sign up to Safety

Sign up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible. Sign up to Safety has a philosophy of local leadership and self-directed safety improvement. In March 2015 the Trust committed to the programme and produced a Safety Improvement Plan for 2015-16 that focused on four key work streams:

- Management of the deteriorating patient
- Workforce planning
- Effective communication
- Harm reduction programme

These four primary drivers have driven a wide range of initiatives throughout the organisation linked through to the Trust's key quality improvement priorities, CQUIN schemes and other harm reduction strategies. Improvements directly arising or linked through to this programme have included:

- Review of all deaths within the Trust and scrutiny at both Divisional level and at the Trust Mortality Surveillance Committee to ensure learning from deaths;
- Introduction of processes to support compliance with LeDeR (Learning Disabilities Mortality Review) programme;
- Provision of Falls Prevention study day to share best practice and launch a new post-fall protocol;
- Continuous focus on monitoring safe staffing levels using recognised assessment tools and responding to address any identified shortfalls;
- Re-structuring of the Liaison service to ensure more integrated working with Norfolk & Suffolk NHS Foundation Trust and to create a Lead Nurse role to develop and strengthen the service to patients with a concomitant mental illness or learning disability;
- Provision of a Patient Safety study day to provide training and share best practice;
- Further training on the use of SBAR (Situation, Background, Assessment, Risk) as a communication tool to support clear communication between health professionals;
- Introduction of the Nightingale project within the Surgical Division;
- Introduction of the Sepsis 6 screening tool;
- Introduction of a new non-invasive ventilation proforma in key areas.

Complaints and Compliments

The Patient Advice and Liaison Service (PALS) was first established in the NHS in 2002, to be a confidential point of contact for patient or relatives who may have concerns about their current or previous treatment. The department also receives general feedback, suggestions and compliments which are shared across the Trust. The Complaints Team and the PALS Department work alongside one another with the Complaints Manager overseeing both departments. The role of the Complaints Team is to ensure that formal complaints

are appropriately investigated and that a response is provided in a timely manner.

The PALS Department is continuously seeking to improve the service it provides and sets itself high standards, such as ensuring that all telephone calls and emails are acknowledged within the same working day. This is measured (along with other aspects of the service) with the 'Rate our Service' survey, which is included on all emails and on a compliment slip when information is provided in person.

The PALS Department continues to promote its service by featuring on the front page of the Trust's internet site, regularly visiting the wards, occupying an accessible location in the main entrance and having a prominent position on one of the Trust's newer initiatives, bedside placemats. The placemats are located on nearly all inpatient bed tables and provide guidance, contact details and information for patients and relatives. The Trust has also recently acquired screen advertising via televisions that are positioned outside the PALS Department and in other public areas around the hospital. The role of PALS and how to contact the department are included on the screens. This and other new promotions have coincided with a continued increase in the number of PALS contacts seen this financial year.

Presentations continue to be given promoting both the PALS role and that of the Complaints Team. This includes the Complaints Team presenting at the Trust induction on a monthly basis to all new staff and involvement with the education sessions of cohorts of nursing and medical teams. New staff members are guided on the need to try and resolve issues as and when they arise to ensure that a high level of patient experience is achieved and also to minimise the number of formal complaints received.

The subject codes used with the PALS Department continued to be reviewed and amended in 2017/18 to ensure that information is appropriately being logged. It is expected that during the next financial year, more subject codes will continue to be developed to limit the use of 'general information', so that more helpful information can be drawn from the recorded data on contacts. The use of the code 'general information' has been reduced during this financial year. During this financial year 4827 PALS contacts were logged (excluding compliments):

PALS Top Subjects	
General Information	752
Travel Expenses	281
Enquiry	204
Directions within the Trust	203
Complaints Procedure	187
Department Details	146
Discharge Arrangements	145
Access to Health Records	129
Parking Fine	129
General enquires	127
Clinical Care	124
Concern	121
In-patient Enquiry	117
Staff Attitude	105
Poor Communication	103

During the financial year, 1 April 2017 to 31 March 2018, the Trust received 361 formal complaints, which is a significant decrease of 15% (427) when compared to 2016/17.

Local Resolution Meetings are offered as soon as a complaint is received to try and encourage complainants to come and speak with the senior staff involved in the patient's care as it is known that this is a much more beneficial way of resolving complainants' concerns. A total of 45 meetings were held in the last financial year. As a result of any complaint, follow up actions are identified and undertaken and specific learning is shared to try and prevent a recurrence of the problem. This includes sharing the outcome of complaints at

relevant governance and clinical service line meetings to ensure that all staff share in the learning and not just those directly involved in the complaint.

Close relationships are maintained with the Legal Services and Risk Management Departments. The Complaints Team have the opportunity to raise any concerns that may be serious in nature with the Serious Incident Risk Panel which meets on a weekly basis. The relevant data is also shared with the Patient Experience Committee and Patient Experience Steering Group and is additionally summarised and included in the monthly report produced by the Patient Experience Lead for the Clinical Quality Review meeting with the commissioners.

The anonymous PALS report continues to be circulated on a weekly basis to all clinical divisions along with a separate monthly compliment report. These reports are shared with Divisional Directors, Clinical Directors, Matrons, Clinical Leads and Non-Clinical Administration.

The Complaints Team also continues to use the KO41a codes established by Hospital and Community Health Services Complaints (HSCIC) which has allowed for much more robust information to be obtained. The use of KO41a codes is recorded in a quarterly report submitted to HSCIC. The top themes are listed below which continue to highlight that staff attitude and communication, both with the patient and family members, continue to feature as one of the key causes of complaint:

Formal Complaints Top Subjects	
Communication with relatives/carers	25
Delay or failure to diagnose (inc e.g. missed fracture)	25
Delay or failure in treatment or procedure	21
Communication with patient	16
Attitude of Nursing Staff/midwives	16
Attitude of Medical Staff	16
Discharge Arrangements (inc lack of or poor planning)	11
Wait for operation/procedure	10
Appointment Cancellations	10

DatixWEB continues to be used as an administration tool. The system provides a learning tool for all areas, with some areas moving to a completely paperless complaints process. The Trust's average response rate to complaints has decreased this financial year, achieving a rate of 64% of complaints responded to within the set timeframe (88% in 2016/17 and 74% in 2014/15). The complaints process was changed in August 2017 to incorporate the Executive Team reviewing all formal complaint responses prior to the letters being signed by the Chief Executive. The Divisions are given 15 working days to respond to formal complaints to allow time for the Executive review to take place and for appropriate amendments to be made.

The compliance with responses being completed and received by the Complaints Department within the set timeframes has decreased. As a result, the formal complaints process has been reviewed and changes incorporated from April 2018. The changes include complainants receiving a courtesy call within 24 hours of the complaint being allocated and senior team engagement to ensure responses are completed in a timely manner. Training sessions for all staff involved in complaint responses is currently being arranged to roll out across the Trust following the changes in process.

The way in which complaints are received continues to show an increase in the use of the internet:

Complaint by Method	
Email	196
Letter	97
Complaint Form	38
Via PALS	16
Telephone	6

Letter from MP	3
Ward Visit	3
Window Enquiry	1
Social Media	1

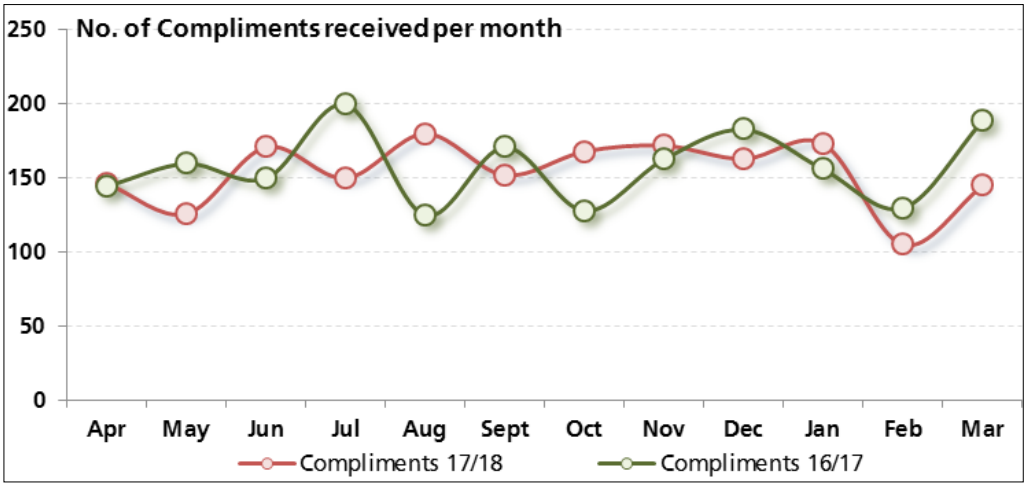
Along with the introduction of the PALS survey, the Complaints Team has continued to send satisfaction questionnaires to complainants one month following completion of the complaint. At present 122 questionnaires have been sent and 32 responses received. The questionnaires highlighted:

- 86% (28) confirmed that they had no problems in obtaining information on how to complain. Out of the four complainants who identified an issue, one was due to an email not being received and three respondents have not provided further information.
- 75% (24) felt that the Trust had dealt with their complaint.
- Within the questionnaire, the complainants are asked why they originally made the complaint and the following answers were provided (more than one answer was provided on some responses):
  - to prevent others suffering (24)
  - to be given an explanation/ information (13)
  - to be given an apology (12)
  - to have staff disciplined (5)
  - to receive compensation (2)
  - to see a change to practice (24)
  - to raise awareness (23);
- 100% of complainants were easily able to understand the format and language used in the acknowledgement letter.

The department continues to manage the process of reimbursing patients' travel expenses on a daily basis and the team processed 979 claims overall, equating to an average of 81 claims a month.

On occasion there are times when despite the Trust's best effort we are unable to resolve a complaint at a local level and the complainant remains dissatisfied. When this occurs, the complainant may seek guidance from the Parliamentary and Health Service Ombudsman (PSHO) to ask for an independent investigation into their complaint and financial redress. During this financial year, six complaints were referred to the PHSO. Two complaints which were investigated by the PHSO during 2016/17 have now been closed, with one not being upheld and the remaining one partially upheld. The complaint which was partially upheld resulted in the development of an action plan to address the issues of concern and these have been shared with the appropriate people and organisations.

Along with feedback and concerns which are shared with the department, the PALS team also log any compliments which are shared with them, either when it is made in person, by email or by way of a card sent directly to the ward. When a compliment holds identifiable information, such as an address, the Chief Executive sends a personal thank you. In 2017/18 the Trust recorded 1858 compliments and this represents a decrease in comparison to 2016/17 when 1909 compliments were received:



Part 2 - Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for improvement 2017/18

During the latter part of 2014-15 the Executive and Clinical Directors undertook a refresh of the Trust's Quality Strategy to ensure that it remained relevant, fit for purpose and able to be a 'living' strategy, central to driving quality improvements within the organisation. This was ratified in March 2015 and identified the priorities for improvement to be taken forward during the following two years.

Our key quality objectives focused on ensuring that:

- Our patients are safe
- Our patients have the best possible experience of care
- Care and treatment is effective and compliant
- We build and sustain excellence as a care provider

The Quality Strategy remained as the focal document underpinning quality improvement within the Trust until 2017 when it was due to be renewed. A decision was made at that time to pause and review the Trust's current position in relation to improvements in the quality of its services and to put the development of a new Quality Strategy on hold until the new Executive team had time to look at the Trust's successes to date and where the Trust should focus its energies to ensure quality improvement in the future.

In order to maintain quality improvement during this period, four quality priorities were identified for 2017/18 linked to the existing quality objectives:

Improve patient safety and reduce harm

- Reducing avoidable deaths in the Trust.

Provide the best possible patient experience

- Improve the experience of children attending the Trust.

Care and treatment is effective and compliant

- Improvement in the care of our patients when their condition deteriorates on our wards

Build and sustain excellence as a care provider

- Ensuring patients are seen by the most appropriate health professional, at the right time and in the right place.

These were informed by the views of our governors, commissioners and partner organisations and from comments and concerns arising from patient feedback. The Quality Priorities were shared locally and with the public via the Trust's internet.

Key priorities were identified for delivering quality improvement

Patient Safety priority	Reducing avoidable deaths in the Trust
Why is this a priority?	It has been identified that learning from deaths in hospital is important and provides opportunities to improve care for future patients. We want to be able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths ensuring that learning results in changes in practice. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon. This includes improving how we share the outputs from mortality reviews with frontline staff. National Quality Board has developed a framework on Identifying, Reporting, Investigating and Learning from Deaths in Care that is to be implemented from April 2017. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
Lead Director	**Medical Director**
What is our target?	• To develop objective and transparent measures for identification of avoidable deaths • Ensure that learning from those deaths is embedded across the Trust to prevent recurrence and to improve the quality of patient care.
What will we do to improve our performance?	• Embed the Multidisciplinary mortality review panel that has recently been established. • Ensure that learning from mortality reviews is adopted as a part of routine professional practice across the Trust. • Ensure that all deaths of people with a learning disability are reviewed in conjunction with the Learning Disability Liaison Nurse.
How will we measure and monitor our performance?	• Undertake mortality reviews on all deaths • Report avoidable deaths by department • Publish monthly mortality data and quarterly summary reports • Benchmark Trust mortality rates against national rates
How and where will progress be reported?	Regular reports and updates to: Mortality Surveillance Committee Quality & Safety Committee Board of Directors

Clinical Effectiveness priority	Improvement in the care of our patients when their condition deteriorates on our wards
Why is this a priority?	Patients who are admitted to hospital believe that they are entering a place of safety, and they and their families and carers, have a right to believe that they will receive the best possible care. They must feel confident that should their condition deteriorate, they are in the best place for prompt and effective treatment. It is important that any deterioration is consistently recognised and acted on promptly.
Lead Director	**Chief Nurse**
What is our target?	We will improve compliance with EWSS and PEWS to 95% and reduce the number of incidents of failure to detect and escalate.
What will we do to improve our performance?	EWSS training and use of 'observations made easy' training for all new staff or anyone unfamiliar with the ward so that all staff are confident and competent in undertaking clinical observations and acting on their findings. Introduction of the Nightingale Project - where team members identify and discuss patients who they are worried about and decide on the actions to take. Use of SBAR (Situation, background, assessment, response) as a communication tool to support escalation of concerns, to aid decision making, handover and documentation of action.
How will we measure and monitor our performance?	% Staff trained % of patients with accurate EWSS/ PEWS score % of incidents of failure to detect and escalate Number of unexpected cardiac arrests Audit use of SBAR proforma Reduction in number of incidents relating to failure to escalate
How and where will progress be reported?	Reports and updates to: Quality & Safety Committee Board of Directors

Patient Experience priority	Improve the experience of children attending the Trust
Why is this a priority?	Patient experience is a key element of quality alongside providing clinical excellence and safer care. Being in hospital can be a frightening for children and it is important that the Trust delivers services that are informed by the voice of children and young people. Care and treatment must be 'child centred'and focused on the needs of the child rather than on the needs of the service and must be provided in an appropriate environment.
Lead Director	**Chief Nurse**

What will we do to improve our performance?	Develop a strategy for Children and Young People. Ensure that the voice of children and young people are heard (not just parents' perspective). Actively involve children and young people and act on their suggestions.
How will we measure and monitor our performance?	% of FFT Response rate % of FFT likely to recommend Establishment of a Trust-wide Children's Steering Group Effective complaints and feedback process for children that they can and do use.
How and where will progress be reported?	Reports and updates to: Children's Steering Group Quality & Safety Committee Board of Directors
Build and sustain excellence	**Ensuring patients are seen by the most appropriate health professional, at the right time and in the right place**
Why is this a priority?	Delays in care are frustrating for patients and for the staff who are looking after them. They are often a symptom of a system failing to provide the right care, delivered by the right person, in the right place and at the right time. As the hospital faces growing demands for its services it needs to look for ways to reduce lengths of stay by optimising the delivery of care and ensuring that patients don't stay in hospital for any longer than is clinically necessary. This will not only free up capacity in the system but will also improve the quality of care and patient experience. We often keep patients in hospital for too long, making them wait for all sorts of things such as diagnostic tests, reviews, medication, social care packages and discharge papers. This waiting is not passive and it can be harmful as patients de-condition whilst in hospital and if they stay longer than is necessary, we are wasting their valuable time. The SAFER Patient Flow bundle has been shown to provide a framework for improving the effectiveness of service delivery and ensuring improved patient flow. http://fabnhsstuff.net/2015/08/26/the-safer-patient-flow-bundle/
Lead Director	**Chief Operating Officer**
What is our target?	Ensuring patients are seen by the most appropriate health professional, at the right time and in the right place

What will we do to improve our performance?	• Adoption of the SAFER Patient Flow bundle • Expected date of discharge used as a part of routine clinical practice • Implementation of early discharge for appropriate patients • Patients (and /or their next of kin) will be involved in developing their plan of care and made aware of their progress and the plan for discharge • Improve partnership working to ensure services are provided to patients in the most appropriate setting for the patient • Frequent attenders meetings will aim to identify the most appropriate interventions to support such attenders to manage their health & social needs outside the hospital setting • Delayed transfer of care meetings will work collaboratively to ensure that patients that are medically stable and fit to transfer out of hospital will be facilitated to transfer to a more appropriate care setting as soon as possible
How will we measure and monitor our performance?	Metrics used that demonstrate: • % of patients receiving senior review before 11am • % of patients discharged before 12 noon • % of patients with a LOS over 7 days reviewed by peers on a weekly basis • % of patients or their next of kin that can answer the 4 standard questions relating to their condition, treatment, progress and arrangements for discharge.
How and where will progress be reported?	Regular reports and updates to: Quality & Safety Committee Board of Directors

How we measured, monitored and reported our achievements in delivering our priorities

A Quality Improvement Implementation Programme was devised that clearly identified the key actions required to deliver our priorities and the performance metrics by which delivery would be measured. These were measured on a monthly basis and reported to the Board of Directors via the quality section of the Integrated Performance Report and quarterly through a summary implementation report to the Quality & Safety Committee.

The Trust's management and governance structure provided a framework for implementing change locally, monitoring progress and identifying any risks on delivery. Assurance on delivery and achievement was supported by the governance reporting systems and through Board review of the Board Assurance Framework.

How have we delivered on our priorities:

Priority 1	Reducing avoidable deaths in the Trust
	Patient Safety

1. To develop objective and transparent measures for the identification of avoidable deaths.

1. Background

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts - 'National Guidance on Learning from Deaths'. The purpose of the new framework was to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

The Guidance has outlined specific requirements in relation to reporting requirements. From April 2017, the Trust has been required to collect and publish specified information on deaths quarterly. This should be through a paper and Board item to a public board meeting in each quarter to set out the Trusts policy and approach (by end of Q2) and publication of the data and learning points by Quarter 3 .The Trust should include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subject to review, how many of these deaths were judged more likely than not to have been due to problems in care.

2. Current position and progress

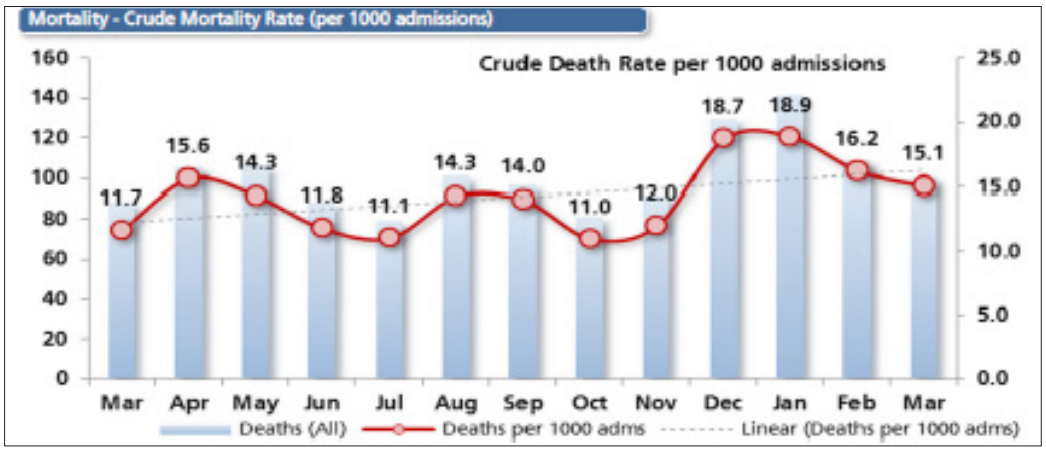
Learning from Deaths policy was ratified by the Board of Directors through public board papers and the policy is embedded within the organisation. Key diagnosis group deaths are receiving a full structured judgement review and consideration is being given to elements of the process to create a fast track. There is collaborative working between the mortality reviewer and the RCA investigator to save duplication. A summary report on progress was tabled at the Board meeting in January 2018.

3. Data Summary

Total number of deaths recorded since 1 April 2017:

Total number of hospital deaths recorded since April 2017												
Month	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
No:	105	106	86	79	101	97	81	92	122	141	108	100

Since April 2017 the Trust has recorded 1218 deaths. There is a variable trend of hospital deaths per thousand admissions, this is reflection of the acuity of the patients presenting.

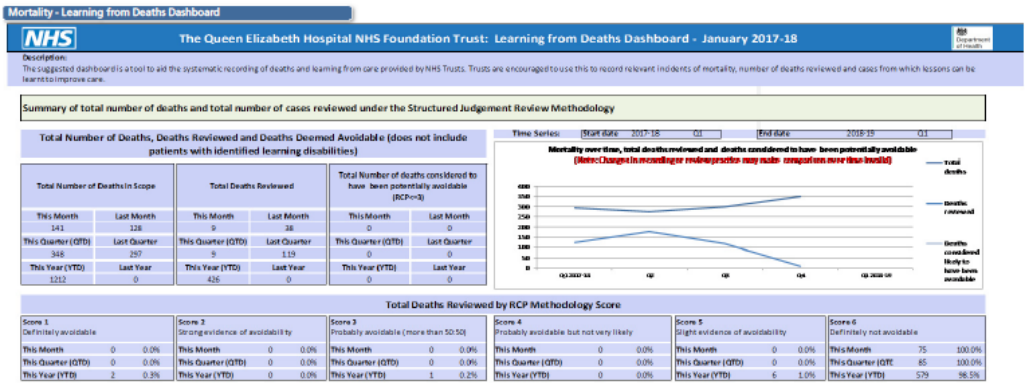
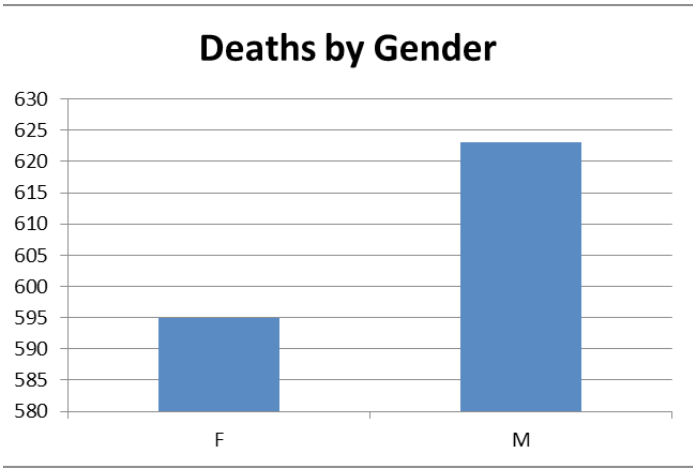


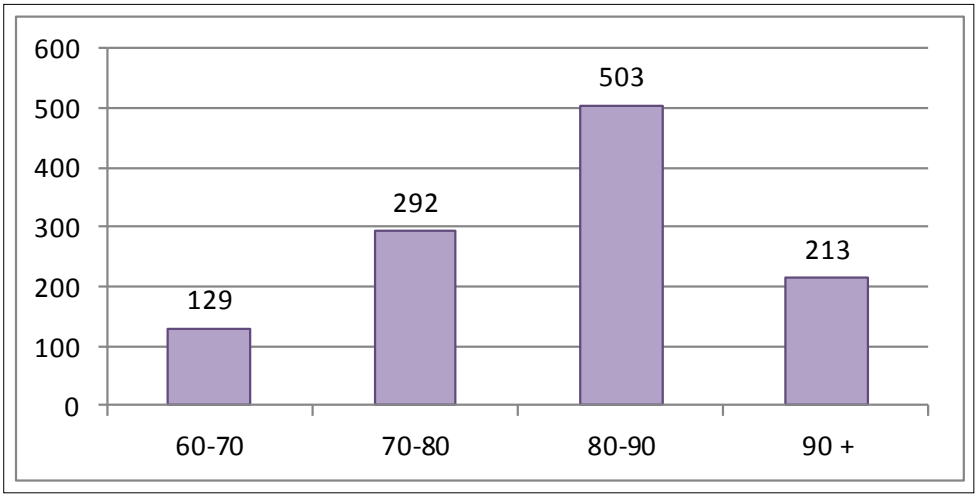
Our Hospital Standardized Mortality Ratio is improving:

The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust				
Changes in HSMR Casemix (Ordinary admissions only)				
	Oct 15 - Sept 16		Oct 16 - Sept 17	
	Trust	National (Non Specialist)	Trust	National (Non Specialist)
Activity	16,629	2,978,949	17,938	2,993,325
HSMR	112.9		101.4	
	%	%	%	%
Crude Rate	**5.9**	5.7	**5.7**	5.7
Expected Rate	**5.2**	5.7	**5.6**	5.9
Elective	**8.3**	13.2	**7.4**	12.4
85+	**19.0**	16.1	**19.4**	16.6
Cancer	**14.0**	15.7	**13.4**	15.6
Comorbidity	**55.4**	53.8	**55.5**	55.1
Palliative	**1.3**	3.4	**1.5**	3.6
Pneumonia	**7.8**	8.2	**7.5**	8.2
Abdo Pain	**7.5**	6.9	**7.3**	6.6
UTI	**6.7**	6.2	**5.3**	5.5
Septicemia	**3.4**	2.3	**5.8**	4.2
Syncope	**3.2**	2.1	**3.6**	2.0

4. Review of Deaths

This has occurred in accordance with the Trust's incident reporting and management policy and procedure. We currently triangulating our data with Complaints, Serious Incidents and Incidents to ensure that all deaths have been reviewed and learning captured where appropriate.

2. Ensure that learning from those deaths is embedded across the Trust to prevent recurrence and to improve the quality of patient care	A Mortality Surveillance Group is in place and all deaths are noted and subject to a review. The review of paper notes relating to mortality is subject to a delay in that the physical records are transported to different teams/areas. Our reporting is usually two months in arrears. This table reflects our position in March 2018:  Mortality - Learning from Deaths Dashboard NHS The Queen Elizabeth Hospital NHS Foundation Trust: Learning from Deaths Dashboard - January 2017-18 Description: The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care. Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities) Total Number of Deaths in Scope This Month 141 Last Month 128 This Quarter (QTD) 366 Last Quarter 397 This Year (YTD) 1212 Last Year 0 Total Deaths Reviewed This Month 9 Last Month 16 This Quarter (QTD) 9 Last Quarter 119 This Year (YTD) 426 Last Year 0 Total Number of deaths considered to have been potentially avoidable (RCP>=3) This Month 0 Last Month 0 This Quarter (QTD) 0 Last Quarter 0 This Year (YTD) 0 Last Year 0 Time Series: Start date 2017-18 Q1 End date 2018-19 Q1 Mortality over time, total deaths reviewed and deaths considered to have been potentially avoidable (Note: Changes in recording or review practice may make comparison over time invalid) Total deaths Deaths reviewed Deaths considered likely to have been avoidable Total Deaths Reviewed by RCP Methodology Score Score 1 Definitely avoidable: This Month 0 0.0%; This Quarter (QTD) 0 0.0%; This Year (YTD) 2 0.3% Score 2 Strong evidence of avoidability: This Month 0 0.0%; This Quarter (QTD) 0 0.0%; This Year (YTD) 0 0.0% Score 3 Probably avoidable (more than 50:50): This Month 0 0.0%; This Quarter (QTD) 0 0.0%; This Year (YTD) 1 0.2% Score 4 Probably avoidable but not very likely: This Month 0 0.0%; This Quarter (QTD) 0 0.0%; This Year (YTD) 0 0.0% Score 5 Slight evidence of avoidability: This Month 0 0.0%; This Quarter (QTD) 0 0.0%; This Year (YTD) 6 1.0% Score 6 Definitely not avoidable: This Month 75 100.0%; This Quarter (QTD 85 100.0%; This Year (YTD) 579 98.5% The Mortality Surveillance Group are currently reviewing the following alerts identified from Dr Fosters Healthcare Intelligence Portal application: • COPD • Leukaemias Initial analysis of inpatient deaths shows the most prevalent causes of death are: Pneumonia Sepsis **6. Analysis of Data** 6.1 Deaths by gender The data below shows the total number of deaths by gender since April 2017. There were 623 male deaths compared to 595 female.  6.2 Death by age group The youngest age was 16 and the oldest age was 102 years. Most deaths (58.5%) occur within the 80-100+ age group with 41% occurring in the 80 to 90 range and 17.5% in the 90 to 100+ range. Of the 1218 deaths recorded, 81 (6.7%) were under 60 years of age.



6.3 Learning Disability Deaths
15 deaths are being sent to LeDER for review as per procedure. These have been identified by the Learning Disability Liaison Nurse and reporting has identified these patients when they are admitted to hospital.

The Learning Disabilities Mortality Review (LeDeR) Programme is delivered by the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Work on the LeDeR programme commenced in June 2015 for an initial three-year period.

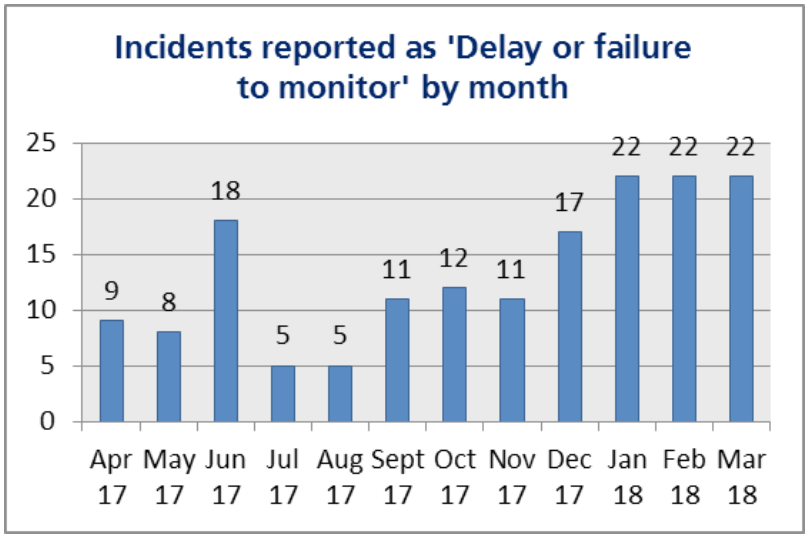
A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The Programme is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision. The LeDeR Programme will also collate and share the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements

7. Recommendations and learning

Below are examples of the recommendations that have been undertaken following the review of deaths either through the Incident Reporting and Management Policy and Procedure or Learning from Deaths Procedure. This is not an exhaustive list:

- On admission, ensure the consideration of previous DNACPR decision is checked. The discharge letter should state if a community DNACPR is in place or a DNACPR is in the notes (should be filed at front).
- If a patient has been in another hospital recently they must be isolated and screened for CPE. If you are unsure talk to the IPC team.

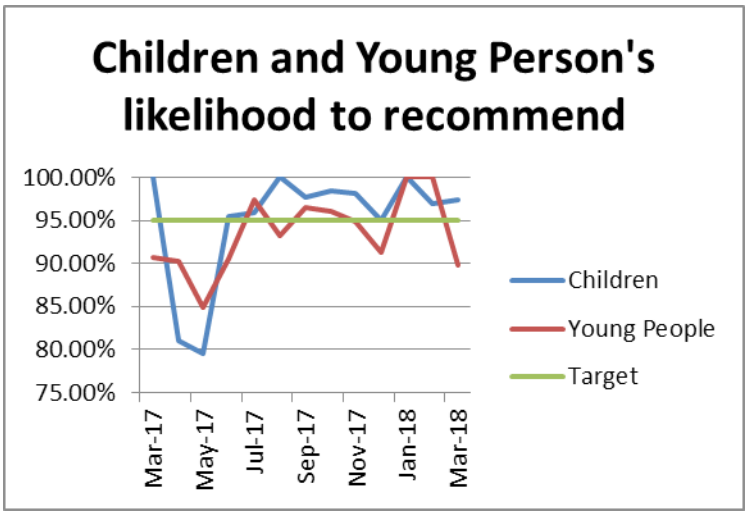
Priority 2	Improvement in the care of our patients when their condition deteriorates on our wards
	Clinical effectiveness
1. We will improve compliance with EWSS and PEWS to 95% and reduce the number of incidents of failure to detect and escalate.	**1. Background** Patients have an expectation that they are entering a place of safety when they come into hospital and that, should their condition deteriorate, this will be identified and appropriately addressed. The Trust has an established 24/7 Outreach service to support early identification and treatment of patients requiring additional support but this is dependent on initial identification by ward staff through the use of the Early Warning Score. Review of reported incidents has suggested that there are still occasions when there is a failure to recognise a deteriorating patient and escalate appropriately. **2. Current situation** All registered nursing staff and healthcare assistants trained to record clinical observations receive training on EWSS / PEWS as part of induction, preceptorship, NVQ training or the overseas nursing programme. Knowledge of EWS / PEWS is also included as part of the scenario mandatory training programme. Such training now includes education on the use of the SBAR communication tool and information on Sepsis 6 for the early identification of sepsis. Medical staff receive training as part of the core educational programme but receive additional training on telephone use of SBAR within the Trust. The Outreach team deliver a 15 minute induction slot to all doctors new to the Trust. During the last 12 months the following innovations have been introduced to support safer practice and each introduction has been supported with additional training: • Introduction of the SBAR screening tool on all wards. • Introduction of the Sepsis 6 screening tool. • Introduction of a new non-invasive ventilation proforma in key areas. Changes have been introduced to strengthen the work of the resuscitation team including: • Cancellation of test calls that were often poorly acknowledged and the introduction of 'Resus huddles' twice a day at 9.15am and 9.00pm for those assigned to the team. These take place in the Terrington Short Stay handover room and ensure appropriate handover of bleeps and clear guidance for the coming shift. • Audit of all cardiac arrest call outs by the Outreach team who attend each arrest. The Outreach team undertake a monthly audit of observation charts and recording of EWS on 15 patients /ward plus additional audits on compliance with completion of fluid balance charts. Currently this data is discussed within the Outreach service and poor results are fed back to the individual ward areas. EWS per set of clinical observations is monitored monthly and reported via the Board Integrated Performance report. During Q3 compliance sat at 96% and in Q4 compliance had improved to 98%. Incidents in which 'failure to monitor' is the key factor are reported via the Datix system and in 2017 – 18 the pattern of reporting does not suggest an observable improvement although the figures in the graph represent number of incidents and not rate of incidents per number of admissions.

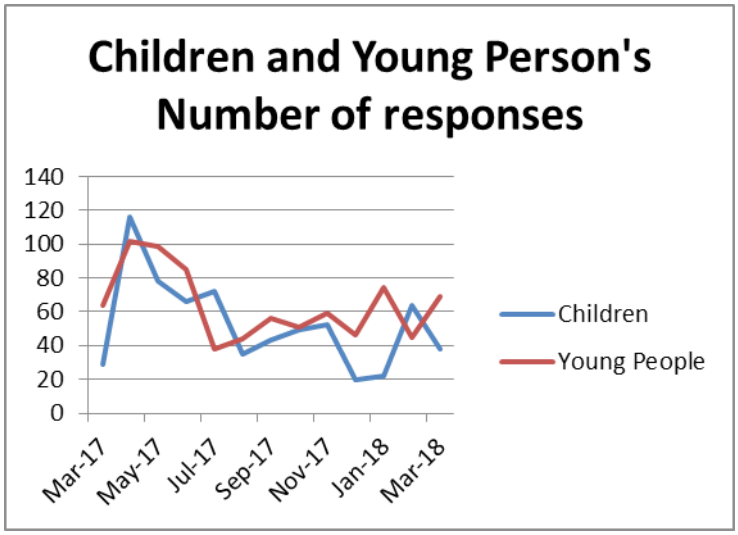


The Trust takes part in the National Audit of Cardiac Arrests and the data for quarter 3 & 4 was as follows:

Quarter	Total no. of calls	Peri-arrest	Cardiac arrest
October	24	23	1
November	32	23	9
December	31	25	6
January	30	14	16
February	26	13	13
March	27	17	10

These figures indicate that staff are requesting assistance for the deteriorating patient prior to cardiac arrest and demonstrate recognition of the deteriorating patient at ward level.

Priority 3	Improve the experience of children attending the Trust
	Patient Experience
1. We aim to improve the experience of children attending our hospital in all areas and departments.	**1. Background** Patient experience is a key element of quality alongside providing clinical excellence and safer care. Being in hospital can be a frightening experience for children and it is important that the Trust delivers services that are informed by the voice of children, young people and their carers. Care and treatment must be 'child-centred'and focus on the needs of the child rather than on the needs of the service and must be provided in an appropriate environment. We aimed to improve the experience of children attending our hospital in all areas and departments. The Trust chose to address the concerns of our youngest patients as one way to improve the quality of care at the Trust. In order to do this a benchmark of the current situation was required. This was undertaken by reviewing the Friends and Family Test feedback and the results from the latest National Survey of Children and Young People. For the purposes of FFT, the Trust's children-focused surveys are targeted at those up to the age of 8; the young persons' survey is targeted at those over 8 and into adolescence. **2. Current Situation** Below is a chart showing the likelihood to recommend the care received as reported by children and young people through the Friends and Family Test (FFT).  The FFT collects specific feedback from various clinics and areas across the Trust including A&E, Arthur Levin Day Surgery Unit, Paediatric Ophthalmology, Paediatric Clinics, PAU (Paediatric Assessment Unit) and Rudham Ward. There are other areas of the Trust which treat children and young people but specific cards are not available in these areas. In addition to 'likelihood to recommend' the care received the other benchmark that is monitored via FFT is the percentage of responses received:



During 2017-18 there have been expected fluctuations in both the response rates and the likely to recommend rates across the services. Overall the response rates have been over the target of 30% and in some areas like NICU have been 100%. The likely to recommend rates on the whole have been positive and either over the target of 95% or close to it.

Negative comments collected from the Friends and Family Test are returned to the area concerned on the day of collection and leads are requested to respond within 5 working days. This is then recorded and shared with other areas across the hospital.

The Trust has been involved in all mandatory national surveys of Children and Young People including the latest survey that was undertaken in 2016 with results released to the Trust in July 2017. This survey was carried out by Picker on behalf of the Trust. Following the survey results Quality Health (our 2014 survey contractor) and Picker (our 2016 survey contractor) were invited to present a seminar to staff and stakeholders identifying areas for improvement. A total of 35 questions were used in both the 2014 and 2016 surveys.

In total, 71 trusts participated in the survey facilitated by Picker. The average response rate for the 71 'Picker' trusts was 26%. At our Trust 763 patients were eligible for the survey, of which 210 returned a completed questionnaire, giving a response rate of 28%.

Compared to the 2014 survey, we did:

- Significantly better on 10 questions and did not have any questions where we did significantly worse. The scores show no significant difference on 25 questions.

Compared to the other trusts, we did:

- Significantly better than average on 7 questions and again had no questions where we did significantly worse. Our scores were average against other trusts on 56 questions.
-

An eleven point action plan was developed to address those issues important to patients and their parents and delivered in quarter 4.

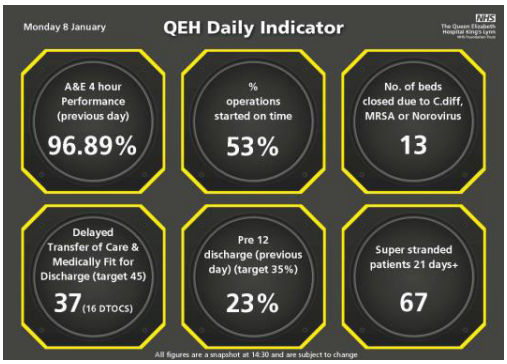
During Q4 the service engaged with children, parents and staff within the children's and young people's services to obtain feedback on what we were doing well, where services could improve and what developments they would like to see over the next few years. The feedback was then put into themes. A stakeholder event incorporating different specialties agreed the vision and the priorities for the services

	for the next 3 years. The strategy reflects the voice of the child and parents in developing and reviewing services. The children's and young people's strategy is in draft and due for sign off at the Quality & Safety committee in May 2018. It will form the foundation for improvements in services over the coming year.
Priority 4	**Ensuring patients are seen by the most appropriate health professional at the right time and in the right place**
Build and sustain excellence	
1. Ensuring patients are seen by the most appropriate health professional, at the right time and in the right place.	**1. Background** Adoption of the SAFER Patient Flow Bundle required training, design, development, embedding and a sustainable approach. Our overarching aim is to ensure all staff understood and recognise their part to play in patient time being the most important currency in healthcare. Ideally all patients would be seen by the most appropriate health professional at the right time and in the right place. The Trust agreed that SAFER would be adopted as part of our Quality Priorities and in April one particular aspect was identified which would support a rapid improvement in some aspects of SAFER. **2. Breakdown of SAFER** **S – Senior review.** All patients will have a senior review before midday by a clinician able to make management and discharge decisions. Embedding senior review: • Patients receive senior review in the morning on all wards. • Consultants and Doctors focus initially on the sick and the quick to manage critically ill and support flow from the Emergency Department (ED). • Medical Assessment Unit (MAU) and Terrington Short Stay (TSS) have second ward rounds in the pm. **A – All patients** will have an expected discharge date (EDD) and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting. Achievements • Development of a patient tracker to support EDDs has been developed and expanded now from a manual collection to electronic data collection with constraints in place to review by 10:30am each day Monday to Friday to help support and expedite patient discharge. • We can now sort and review all patients who have not had an EDD, have an EDD in the past and manage their journey proactively on every ward. • Wards update the point prevalence tracker daily before 10:00am • We are part of the Clinical Criteria for discharge work that is ongoing with ECIP. This is ongoing work that requires a bit more work to embed. It is being tested on some wards. • We have developed a template for wards to ask 4 key questions of patients, we ran this audit on the 5th January and are analyzing responses. From this we expect key pieces of work will drop out that will help us keep our patients informed about when they are going home. **F – Flow** of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

- We have now mapped flow from the Emergency Department (ED) to Medical Assessment Unit (MAU) and Terrington Short Stay (TSS).
- We have implemented a project to support lengths of stay (LOS) on MAU [target 46 hours] and TSS [72 hours].
- We have a lead consultant who is addressing admission criteria for base wards and communicating the importance of flow from the short stay wards to their wards pre 10:00. [flow attached]. This forms part of our Blue Book work which is held on the intranet in the Leadership Knowledge Exchange hub.
- We send out pre-12 discharges data to all wards and senior leaders [see email as evidence]

E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.

- We have implemented a 100 day challenge to drive pre-12 discharges.
- We have now implemented daily updates for all wards on the % pre-midday discharges and this goes to all Trust Leaders each day.
- We have included this and other metrics that support SAFER into our QEH Daily Hospital Health Check.



R – Review. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients') with a clear 'home first' mindset.

- We run a Chief Operating Officer (COO) led 'stranded patients' review twice a week; however our SAFER week post-Christmas has indicated that a weekly review on site with all partners would support this work better. This will be planned going forward as part of our on-going continuous improvement work.
- We run a platinum call twice a week to ensure we manage stranded patients.
- We also started in depth work pre-Christmas on our super stranded patients. These are patients with a LOS of 21 days plus and can account for 50% of bed days occupied.

3. Key focused projects that support and enable continuous improvement for the above

Three 100 Day Challenges across 2017/18

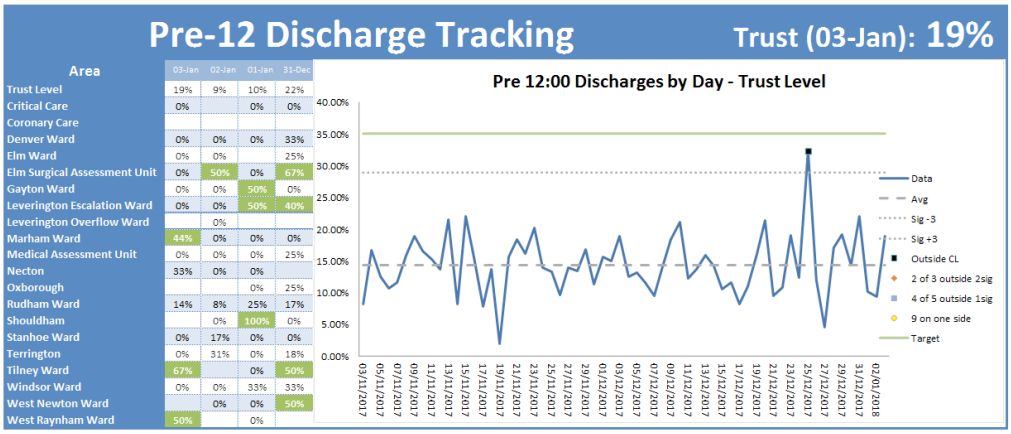
April – July 2017

Launch of Red2Green 100 day challenge with the aim of training staff about Red2green and identifying 'what is the patient waiting for?'
Supports all aspects of SAFER

Achieved

- 2,000 staff trained in Red2green by our PMO.

	• Development of manual constraints management support, all patient constraints captured at 10:30am and managed. • Increase in number of patients with EDD collected and management of patients past their EDD. • Implemented data capture for 7 day plus patients. • Trained 30 plus staff on the last 1000 days with Professor Brian Dolan and introduced training on lean & leadership. • Agreement to move nurses back to wards to support SAFER on the wards and therefore saved at least 90 minutes a day of nursing time coming to the Operations centre so staff could be focused on care. **September to December 2017** Launch of End PJ paralysis initiative. We recognise deconditioning of patients is crucial as is the last 1000 days of a person's life. This is why we have engaged passionate staff to support and drive this challenge. QEH also led on the East of England [EoE] 100 day challenge for this piece of work. **Achieved** We moved from one single ward [Windsor] supporting getting patients up dressed and mobile to all medical wards. • In 100 days we reported that just fewer than 9,000 patients had been dressed and mobilised. • We received donations of new clothing [5 boxes of outer and under garments and shoes. • We improved the patient experience. • As leads for the EoE challenge we supported getting under 100,000 patients up dressed and moving. **January to April 2018** Launch of Pre-12 Discharges work 3rd January 2018 **Achievements** Week 1 • We have a consultant lead for this challenge demonstrating engagement of our consultants and their colleagues in this work and approach to managing the problem. • We also have nurse -led support for this work to ensure engagement with staff across the wards. • We have data collection going to all wards on their performance. • We have a QEH performance indicator going out daily to all staff so everyone is aware of what we need to archive and how we are performing against targets in order to support flow.



Area	03-Jan	02-Jan	01-Jan	31-Dec
Trust Level	19%	9%	10%	22%
Critical Care	0%		0%	0%
Coronary Care				
Denver Ward	0%	0%	0%	33%
Elm Ward	0%	0%		25%
Elm Surgical Assessment Unit	0%	50%	0%	67%
Gayton Ward	0%	0%	50%	0%
Leverington Escalation Ward	0%	0%	50%	40%
Leverington Overflow Ward		0%		
Marham Ward	44%	0%	0%	0%
Medical Assessment Unit	0%	0%	0%	25%
Necton	33%	0%	0%	
Oxborough			0%	25%
Rudham Ward	14%	8%	25%	17%
Shouldham		0%	100%	0%
Stanhoe Ward	0%	17%	0%	0%
Terrington	0%	31%	0%	18%
Tilney Ward	67%		0%	50%
Windsor Ward	0%	0%	33%	33%
West Newton Ward		0%	0%	50%
West Raynham Ward	50%		0%	

Sustainability 2018

Moving into 2018 we will commence a baseline assessment of all the wards to address where MDTS are delivering the SAFER bundle in full and areas that may not have gripped the model. We will work with 2-3 wards initially in one Clinical Business Unit {CBUs} creating exemplar wards and roll this programme out across all wards within their respective CBUs.

The stranded patient work will take on greater focus and we will develop pathways to support those patients within the super-stranded that require additional support.

We are working closely with our system partners and will develop a discharge to assess model whereby patients will not need to wait in hospital for their assessment. We want to drive a Home First ethos within the health system.

Focus this year for SAFER will also rest on clinical drive and engagement and embedding robust board rounds to support SAFER and the patient journey. As our data analysis has become richer and we understand constraints to timely next steps for patients we will work on redesigning patient pathways.

We are working nationally with Professor Brian Dolan in a nationwide drive to get 1,000,000 patients up dressed and moving for the EndPJParalysis 70 day challenge from 17th April 2018. This will complete on the 70 year anniversary of the NHS.

Governors' Quality Priority

Monitoring cancelled operations

Month		No. of Operations cancelled at the "last minute"	Cancelled Operations - Not Re-adm within 28 days
01/04/2017	2017 4	27	0
01/05/2017	2017 5	37	0
01/06/2017	2017 6	24	2
01/07/2017	2017 7	18	2
01/08/2017	2017 8	20	0
01/09/2017	2017 9	15	2
01/10/2017	2017 10	31	0
01/11/2017	2017 11	28	3
01/12/2017	2017 12	41	3
01/01/2018	2018 1	38	8

01/02/2018	2018 2	70	6
01/03/2018	2018 3	66	26
01/04/2018	2018 4	33	9

In 2017/18 our Governing Body requested that the Trust reported each month on the number of operations cancelled and how many of those were not re-admitted within 28 days. These were reported each month to the Board as part of the performance report. Capacity pressures were at their greatest during the last quarter and particularly in the last month. Escalation beds were opened and patients diverted to Day Surgery as appropriate to support activity. Moving into the new reporting period the situation is has stabilised and is showing signs of improvement.

KEY PRIORITY PERFORMANCE

DELIVERING SAFE CARE

Reducing and Eliminating Healthcare Associated Infections

The Trust has in place objectives and a strategy for Infection Prevention and Control based on the criteria within the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance from the Department of Health and Care Quality Commission.

The Trust's compliance with the Code of Practice is monitored at least quarterly and reported through the Infection Prevention & Control Committee.

Management Structure for Infection Prevention & Control

The Trust has in place a robust structure for the prevention and control of infections led by the Director of Infection Prevention and Control, supported by an operational multi-disciplinary Infection Prevention and Control Team (IP&C team) and monitored by an Infection Prevention & Control committee that meets on a bi-monthly basis.

Trajectory for MRSA and Clostridium difficile

MRSA bloodstream infections (target = zero)

There have been no MRSA blood stream infections for the year 2017-18 associated with the Trust.

Initiatives that have been implemented have assisted with maintaining a zero tolerance of blood stream infection and blood culture contamination. These initiatives include blanket use of Octenisan Anti-microbial body wash for all inpatients (excluding admission areas) to reduce bacterial flora biomass on skin.

Screening rates for MRSA on admission and weekly are now maintained at 95% across the Trust. This has allowed quicker treatment of those patients who screen positive and early identification of any acquisition of MRSA colonisation with the Trust.

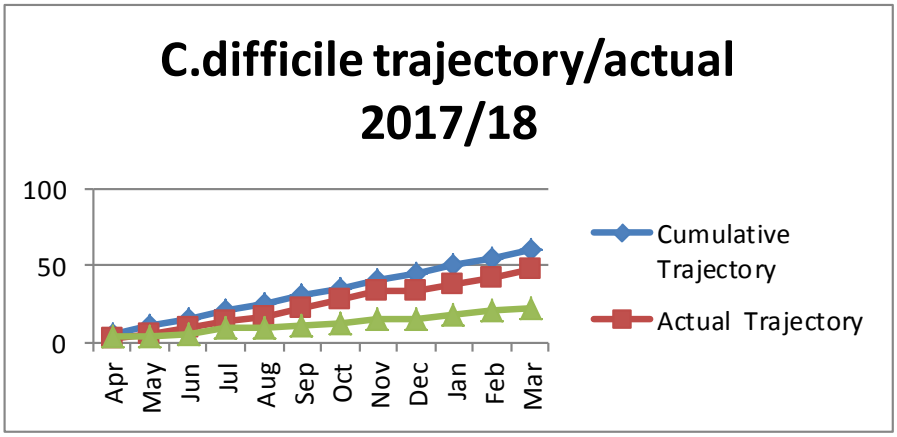
A programme providing competencies in Aseptic Non-Touch Technique (ANTT) for clinical staff across the Trust is continuing and to date around 85% of staff have received training. A new cannulation pack was introduced to the Trust and this has been implemented along with education in use of the pack and ANTT competencies.

Clostridium difficile associated diarrhoea – CDAD (target = 53)

The Health Care Acquired failure target for 2017-18 was no more than 53 cases apportioned to the hospital. The annual incidence of Clostridium difficile associated diarrhoea was 48 cases, this increase in the number of cases on the previous year was due mainly to outbreaks and periods of increased incidence (PIIs) across the Trust.

Following identification of transmission within the hospital a multi-agency team was invited into the Trust including partners from CCGs, Public Health England (PHE) and NHS Improvement (NHSI). The feedback identified areas that require improvement and an action plan was formulated as a result. Areas highlighted included standards and assurance of cleaning across the Trust, Community and Trust antimicrobial prescribing and general IP&C practices, including the placement and prompt isolation of patients with suspected/ confirmed infection.

Following CCG review eight of the 48 cases were deemed non-avoidable and although these cases remain on the Trust figures, no further actions could have been taken to prevent acquisition of the infection.



The current action plan is still in progress and monitored via HICC. A deep clean programme is planned as part of these actions and a decant area should be available from May 2018.

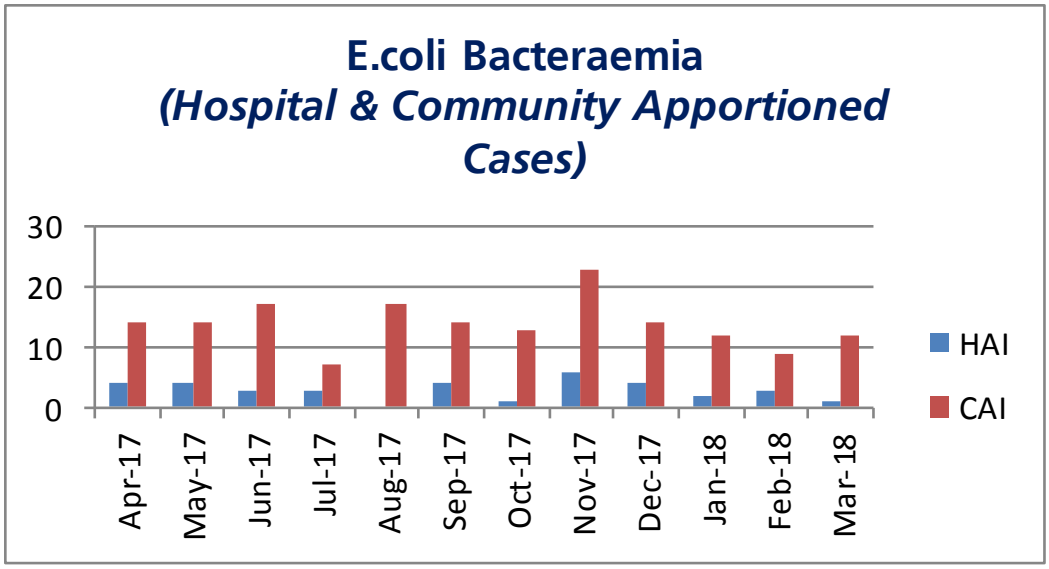
The IP&C team are undertaking a number of audits relating to IP&C practice. This is targeted trust-wide and in addition the wards identified as part of outbreaks of PIIs are targeted with a supportive measures programme which includes auditing and education.

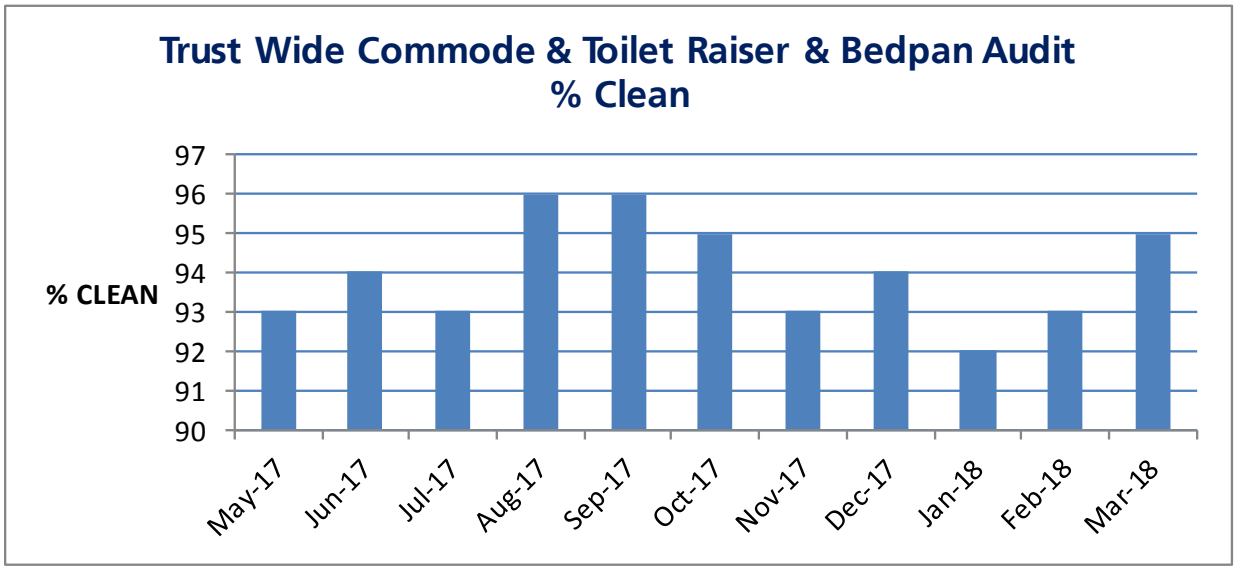
Challenges this year

Gram Negative Blood Stream Infections - In response to Lord O'Neill's challenge to strengthen Infection Prevention and Control (IP&C), the Secretary of State for Health has launched an important ambition to reduce Gram-negative blood stream infections (BSIs) by 50% by 2021. This can only be achieved by working together across the NHS and by starting to take action now.

One of our first priorities must be addressing Escherichia coli BSIs, which represent 55% of all Gram-negative BSIs. Latest data from Public Health England show a large variation in infection rates across clinical commissioning groups (CCGs). E. coli BSIs have increased by a fifth in the last five years and the trend is worryingly continuing upwards. This is an important patient safety issue. Furthermore, preventing BSIs should have a major impact on reducing the need to prescribe antimicrobials, which is a key way of reducing the rise in antibiotic resistance".

The IP&C team are currently working with CCG colleagues to identify causes of BSI both Community and Hospital Acquired. Although there are no official reduction targets set this year a quality premium for the CCG was set for a 10% reduction, April 2017 – March 2018.



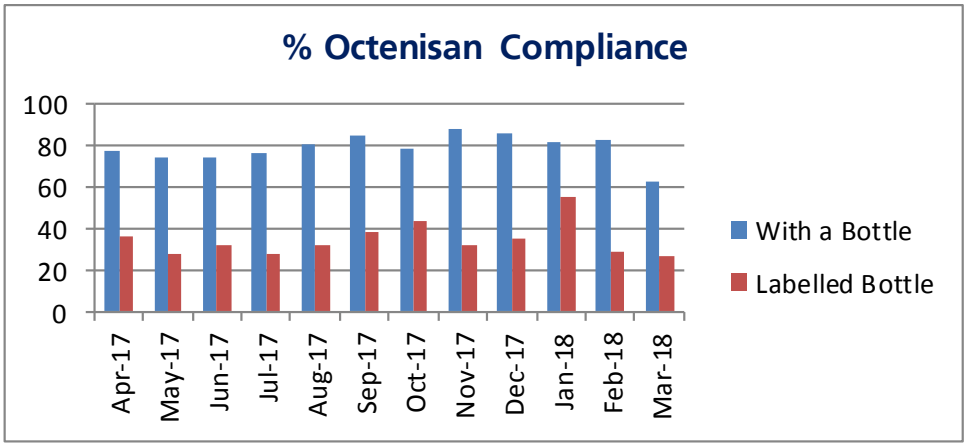


Supportive measures - In areas of concern i.e. A Period of Increased Incidence (PII) for MRSA/C Diff, a supportive measures package is implemented. This includes education and training for staff, as well as extra auditing to provide assurance that standards are maintained. During this period the following areas have been placed on supportive measures:

Ward	Reason
Elm	C diff
W Raynham	C diff
W Newton	C diff
Windsor	C diff
Stanhoe	C diff
Oxborough	C diff & MRSA
Gayton	C diff
Necton	MRSA
Terrington	IPC Practice
Tilney	C diff

Mattress Audit – An audit of all mattresses was undertaken with support from Invacare (suppliers of Trust mattresses). All mattresses were checked for staining and damage. Mattresses were replaced as required at the time;

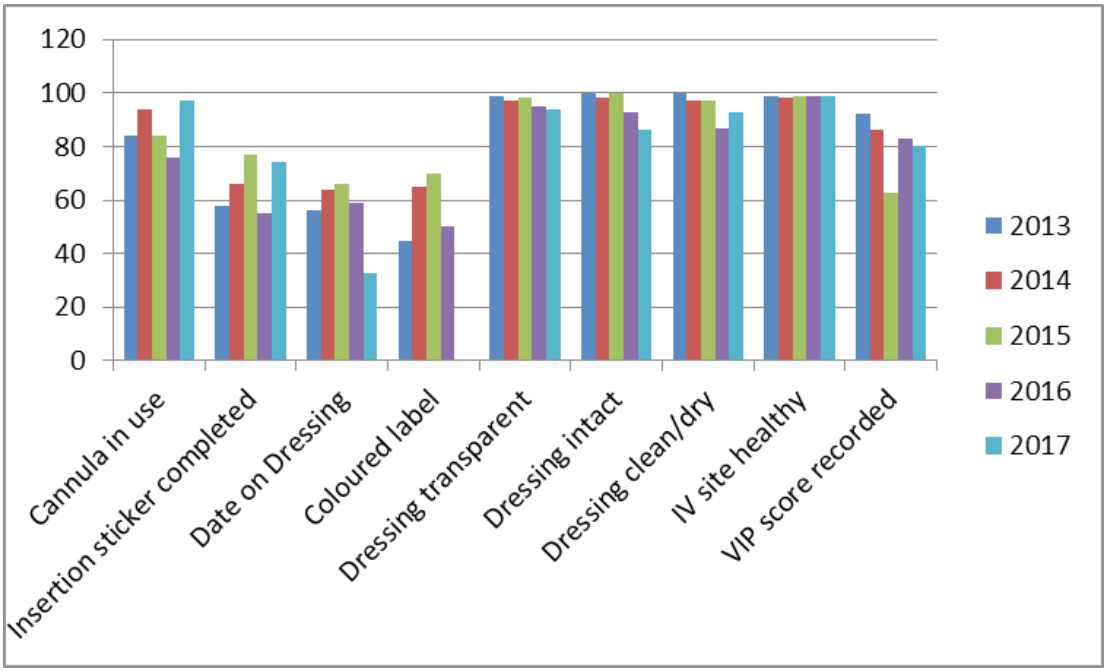
Octenisan Compliance – Since November 2016 when Octenisan body wash was introduced across the Trust the team have completed monthly audits in the use of this product. Ongoing education in the use of the product is still continuing but audits are highlighting areas of poor compliance which will be targeted with education from the team and Octenisan (Schulke Rep).



Completion of 0Stool Charts – Since January 2017 the IP&C team have audited the compliance with documentation on stool charts. It is Trust standard that all inpatients have a stool chart and this is completed daily.

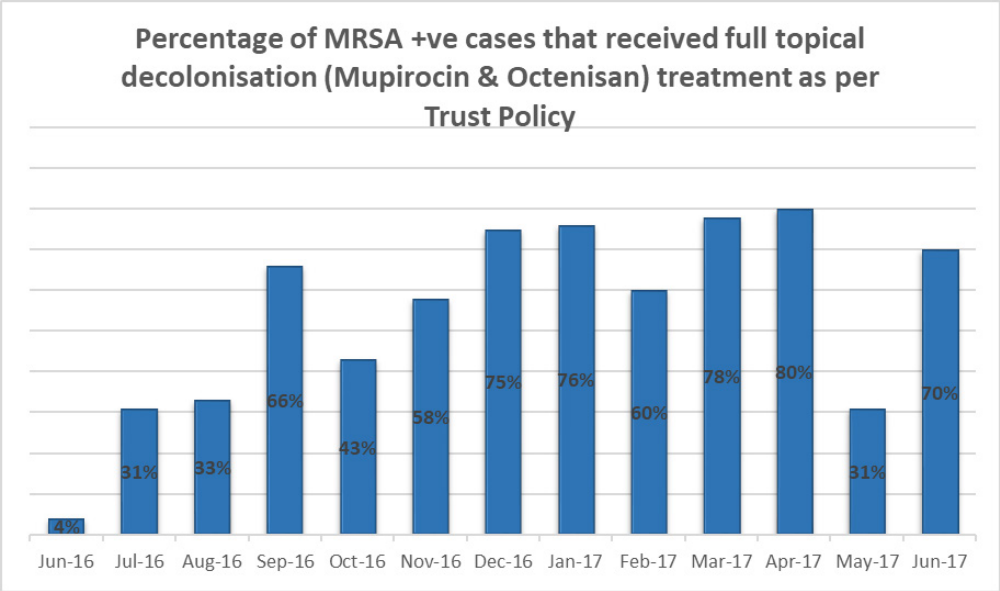
Annual Audits

Peripheral Cannula Audit – All inpatients were checked and if a peripheral cannula was found to be in situ this was audited as to clinical need, site inspection and documentation. The results were shared at the IP&C committee. Please see results in relation to previous years' audits:

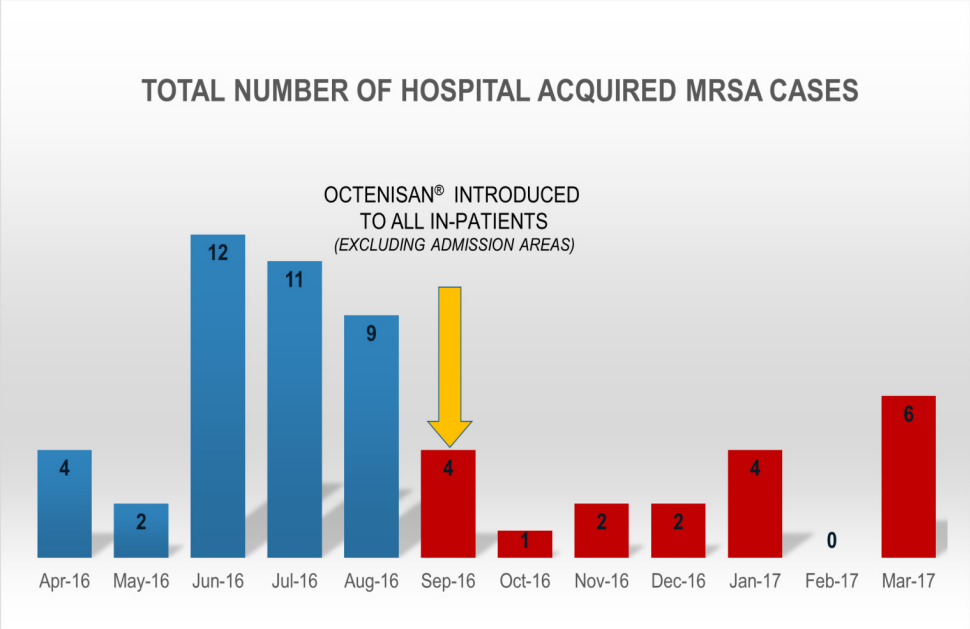


The new cannula pack was implemented and in addition to this audit B. Braun Medical Ltd undertook independent audits pre and post implementation focusing on insertion techniques and documentation. Results showed an improvement in practice generally but highlighted groups and areas of improvement required. Both audits have illustrated improvements in practice, the IP&C team audit highlighted documentation of insertion date on the cannula dressing was poor but compliance in general documentation was improved. No cannulas that required immediate action were found.

MRSA treatment and decolonisation compliance – This audit covered all patients that required decolonisation following a positive MRSA result and whether that received and completed and full course of treatment. In addition compliance with use of Octenisan as a preventative was also audited.



The chart below demonstrates number of hospital acquired MRSA from April 2016 to March 2017 and the reduction since the introduction of Octenisan body wash as a preventative measure:



Urinary Catheter audit – all patients in the Trust with a urinary catheter in situ were audited for compliance of documentation, care of catheter, need for catheter and whether a catheter passport was used. This audit was undertaken to ascertain general standards of care around catheters following an introduction of a quality premium for CCGs to reduce the numbers of gram negative BSI. With a further Quality premium in place for this year the IP&C Team plan to undertake further education and auditing of this area.

Question	Total Number of Catheterised Patients	Results Break-Down		% Compliance
		Yes	No	
Insertion Sticker record in notes	97	72	25	74%
Detailed documentation of catheter insertion		68	19	70%
Clerked in admission notes if admitted with a catheter		21	3	88%
Documented review date		16	81	16%
Valid reason why catheter is needed		81	16	84%
In date expiry sticker on bag		38	59	39%
Catheter looks clean		96	1	99%
Documented evidence around Catheter Care		39	58	40%
Evidence of a Catheter Passport		0	97	0%
Overall Average				**57%**

Training and Education

The IP&C team undertake training for all staff at the Trust; workbooks and teaching sessions are available for staff to attend. Staff also receive ad hoc education on clinical environments for example, when supportive measures are in place on an area or a particular training need is identified in an area. Compliance to mandatory and induction training is monitored by the training department.

ANTT

From October 2015 a programme of Aseptic non-Touch Technique (ANTT) has been introduced, all clinical staff are expected to complete the training and be signed as competent. The ANTT has been covered by IP&C Nurses as part of the IV administration training run by Practice Development Nurses. A new cannula pack was introduced in this year and with support from the B Braun Medical Ltd clinical education team, IP&C nurses have provided training in use of the cannula pack and ANTT procedures. ANTT is a practice framework for aseptic technique used widely in the NHS and internationally. It promotes safe and efficient practice providing standards and a framework to work and audit against. 85% of clinical staff across the Trust have now completed competencies.

Results and Surveillance

The IP&C team use a system called ICNET which provides real-time results directly from telepath (the lab results system). ICNET is linked to Patient Centre so the patient journey is also tracked through the hospital. Imports from telepath are received hourly and ICNET has a filtering system which allows alert organisms to be filtered and acted upon by the IP&C Nurses.

On average there are 15 imports a day to ICNET that require action from the IP&C Nurses.

Norovirus and Influenza are also imported to ICNET. The IP&C team request Norovirus testing when required within the Trust as part of assessing patients with symptoms of D&V. The IP&C team monitor bays and wards and advise on patient flow and risk when these Viruses require bay or ward closures.

The IP&C Team also undertake daily reviews of patients under isolation precautions either in single rooms or bays, risk assessing patients that require single rooms and those that can be managed within a bed space. The team liaises with the Operational team to ensure that those patients deemed as high risk IP&C are prioritised to a single room. This review also involves checking that specimens are sent promptly and correct

IP&C precautions are in place. This facilitates the appropriate use of the available isolation facilities.

Reducing avoidable mortality

In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.

A CQC review in December 2016 found that some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care.

National research suggests that up to approximately 3% of in-hospital deaths could have been avoided if the quality of care had been better. Monitoring overall hospital mortality data is recommended as it can indicate where there are problems with the quality of care. Several indicators are used nationally, including the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital Mortality Indicator (SHMI).

HSMR: Hospital Standardised Mortality Ratio

The Dr Foster indicator and perhaps the best known:

- Widely reported (including as part of the Dr Foster Good Hospital Guide and in the press);
- Risk of death based on diagnosis at first episode of care;
- Adjusted for palliative care;
- Does not include deaths after discharge;
- Based on 56 diagnosis groups representing 80% of hospital deaths.

SHMI: Summary Hospital Mortality Indicator

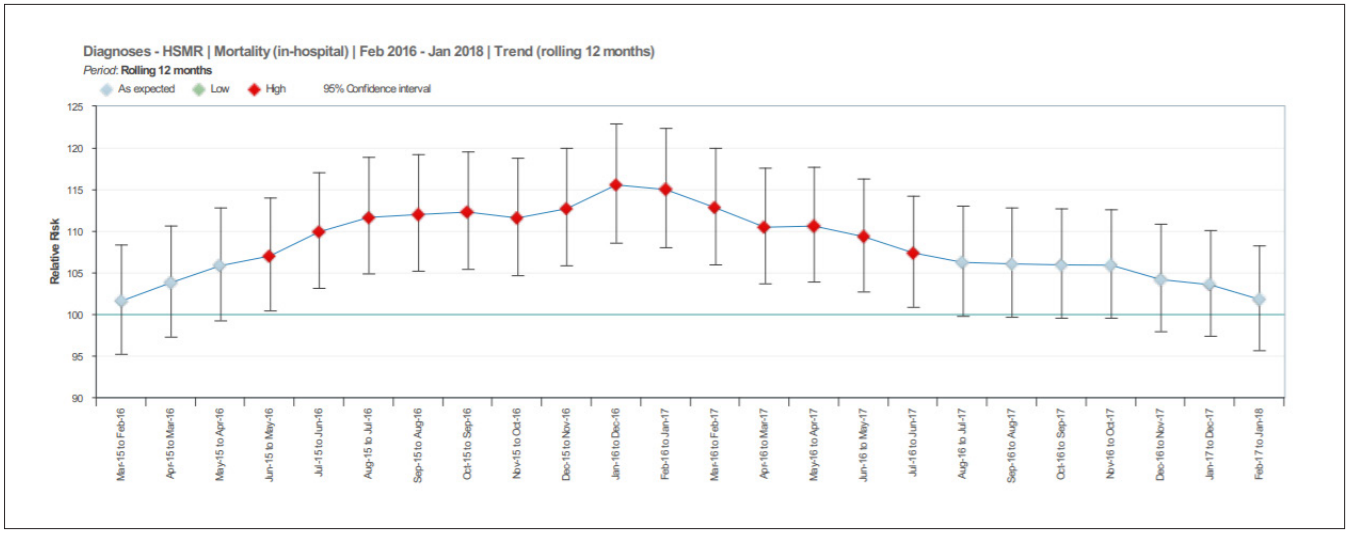
Was devised to replace other indicators and has become the 'national standard' it:

- Is available to the public on the NHS Choices website;
- Risk of death based on diagnosis at first episode of care;
- Includes deaths within 30 days of discharge;
- Has a rolling 12 month average, updated quarterly and published 6 months in arrears.

The Board of Directors receives monthly reports showing the HSMR and how this compares to our peer group of hospitals.

The HSMR is a measure of the number of patients expected to die compared to the number who actually died in a given period of time. For each patient, the risk of death is adjusted according to their main diagnosis, other diagnoses and co-existing factors. An HSMR of 100 reflects the expected situation. A lower HSMR indicates fewer deaths than expected, while a higher HSMR indicates more deaths than expected. Each year as hospital care improves, the HSMR will tend to drift downwards, and the indicator is therefore rebased.

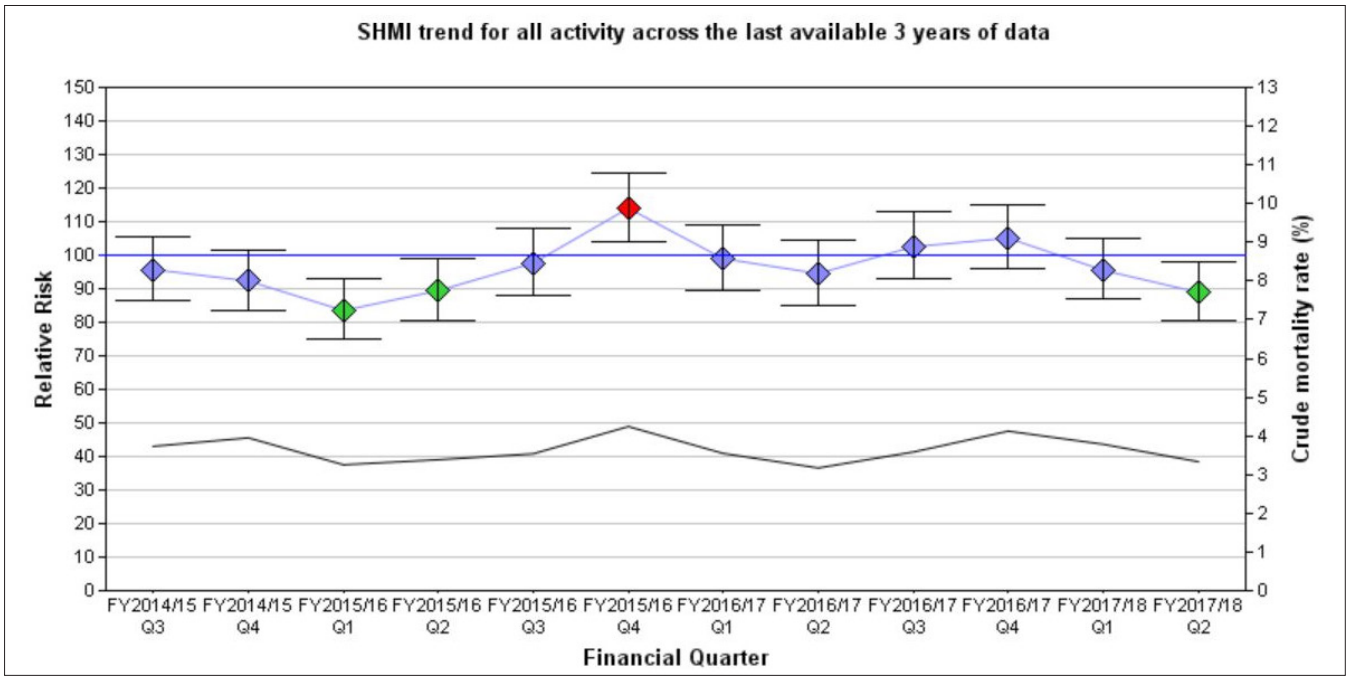
The graph below shows the HSMR trend from February 2016 to January 2018. Data is published three months in arrears and the last quarter is as yet unavailable.



The HSMR for the period from February 2017 – January 2018 was in the as expected range as follows:

Indicator	QEH (expected range)
Overall HSMR	101.8 (95.7 – 108.2)
Weekday	102.2 (94.9 – 109.8)
Weekend	104.9 (92.8 – 118.3)

In addition, the Board also monitors the SHMI. The data for the SHMI is published six months in arrears and for the period from October 2016 – September 2017 the SHMI was 0.9806. This is within the as expected range:



Avoidable mortality

A paper published in the BMJ by Hogan et al in 2015 suggested HSMR and SHMI bore no reflection on quality and a better measurement is the avoidability rate which identifies where improvements can be made. The Mortality Surveillance Group has adopted the national guidance on learning from deaths. Whether a death is avoidable or unavoidable the important issue is that lessons are learnt and that these are shared across the Trust and possibly across other healthcare organisations. The Mortality Surveillance Group is overseeing the embedding of the 'lessons learnt' process.

The Group has developed a process of case note review based on the Royal College of Physicians suggested guidance. The process includes all the suggested guidance plus items from the organisations earlier approach that are considered to be relevant to this Trust. An algorithm has been developed by a member of the Group to create greater consistency in deciding whether a death is avoidable or not.

Learning from deaths

Financial Year	Month	Total Deaths (not LD)	Total Deaths Reviewed (not LD)	Deaths Avoidable > 50% (not LD)	RCP1*	RCP2	RCP3	RCP4	RCP5	RCP6	LD Deaths
2017-18	April	104	43	0	1	0	0	0	0	43	1
2017-18	May	106	34	0	1	0	0	0	1	32	0
2017-18	June	83	45	0	0	0	1	0	0	47	3
2017-18	July	77	64	0	0	0	0	0	1	65	2
2017-18	August	100	43	0	0	0	0	0	0	44	1
2017-18	September	97	69	0	0	0	0	0	4	66	0
2017-18	October	78	41	0	0	0	0	0	0	57	3
2017-18	November	91	40	0	0	0	0	0	0	56	1
2017-18	December	128	38	0	0	0	0	0	0	84	1
2017-18	January	141	9	0	0	0	0	0	0	75	0
2017-18	February	108	0	0	0	0	0	0	0	10	0
2017-18	March	99	0	0	0	0	0	0	0	0	0

*RCP 1 – 6 Royal College of Physicians' Avoidability of death scale:
Score 1 'Definitely avoidable' to Score 6 'Definitely not avoidable'

Case reviews of deaths have demonstrated that the majority of deaths were unavoidable and part of the natural progression of the person's illness or injuries. However, linking with the findings of reviews from serious incidents there are some issues that have been identified and taken forward as learning within the organisation.

- The need to ensure that all staff are reactive to early warning scores.
- That staff have the confidence to recognise and escalate concerns quickly and re-escalate if need be.
- The need to continually re-visit training and processes for raising awareness about falls prevention and undertaking multifactorial risk assessments.
- The importance of having clear, unequivocal guidance on DNACPR decisions within a patient's health care records.
- The importance of isolating a patient and screening for CPE if the patient has been in another hospital recently.

These issues have been taken forward in a number of different ways. The Critical Care Outreach team monitor escalation processes and audits escalation. Where escalation has not met Trust standards this is fed back to the individuals and teams involved. Training is provided as part of induction. Additional training support is provided if poor compliance is identified.

The Falls Prevention nurse has supported practice at a local and trust-wide level through training, providing up to date guidance, undertaking audits and this year running a Falls Prevention Seminar to provide in-depth consideration of falls prevention and management to those that attended from the inpatient areas.

Guidance has been issued to all medical staff on the correct management of DNACPR decision-making and how to appropriately record and communicate decisions. A further review is taking place to review policy and processes and support staff with additional training.

Additional guidance on screening for CPE is now being built into admission paperwork to support compliance

with best practice.

Mortality Surveillance Group

The Mortality Surveillance Group is chaired by the Medical Director. The group meets monthly and reviews data from a number of sources, including Dr Foster. It monitors the HSMR, SHMI and diagnostic groups falling outside the expected range. The group also monitors high risk groups.

Following concerns raised nationally into premature deaths of people with a learning disability, all deaths are submitted via a national portal for independent review.

This year our HSMR has been within the expected range. Our crude death rate is also in line with our local peers. The Trust is reassured by our SHMI data which does not include an adjustment for palliative care and has stayed within the expected range.

End of Life

The Trust's End of Life Team and Steering group, which includes local partner organisations, has continued to focus this year on supporting patients at the End of Life to enable them to be discharged to their preferred place of care (PPOC) and death. The current audit results show, the number of patients achieving PPOC has dropped slightly to between 80-85%. This was mainly due to an increase of referrals during the winter months with only limited access to care and nursing home beds in the community.

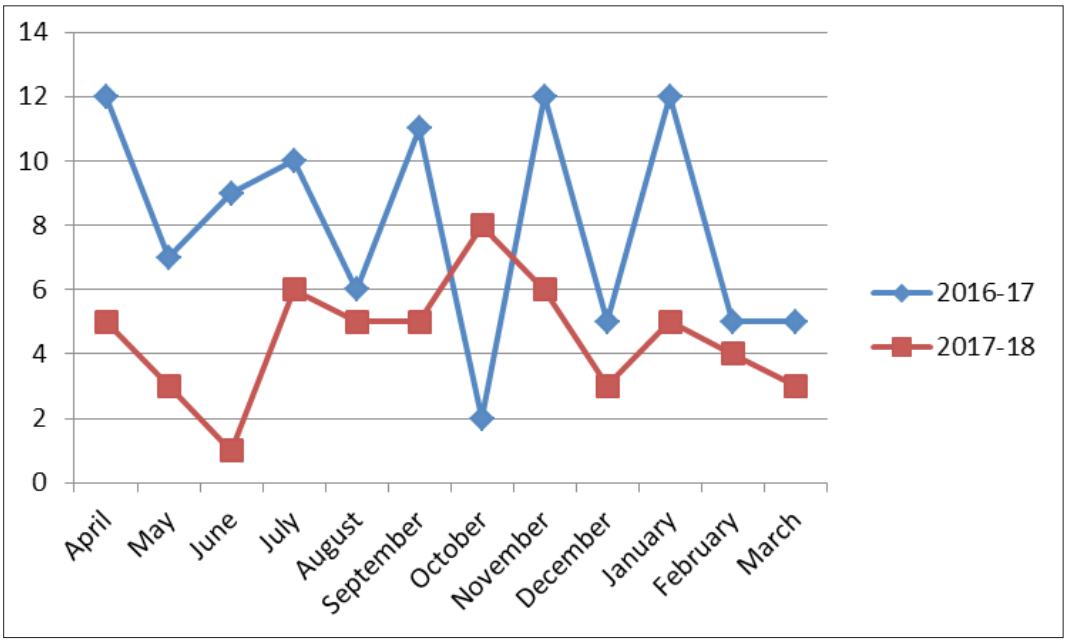
Close collaborative efforts between the Trust End of Life Team, Specialist Palliative Care Team at Norfolk Community Health and Care NHS Trust and NHS Improvement has continued through the year and has so far seen:

- Roll out of the Amber Care Bundle and the Individualised Plan of Care in the last days of life on nine wards so far and we continue to work with teams to embed these tools on all wards.
- The six ambitions for palliative and end of life care have been introduced to the staff via a stand in the hospital restaurant and on lanyard cards that also give anticipatory prescribing advice and these are also included on the front page of the new End of Life button on the intranet.
- The intranet page for palliative and End of Life Care has had a complete overhaul and now features a library and a resource page for all staff to access.
- An End of Life study day was held at the end of 2017 with an exceptional attendance of 56 members of staff from a variety of backgrounds and from several different organisations.
- An End of Life newsletter that is published quarterly and updates all members of the Trust about new projects etc and gives other departments an opportunity to provide updates on End of Life matters.
- Posters identifying the End of life team are now displayed on all wards.
- A new resources file has been introduced on all wards

Reduce the number of patients experiencing harm as a result of avoidable hospital acquired pressure ulcers

The standardised practice of the ASKINS bundle continues to keep pressure ulcer prevention at the forefront of our minds and to maintain/improve current standards. Table 1/Chart 1 shows the 2017/18 incidents by Financial Year (FY); there has been a 44% reduction in incidents. Incident data is sent out bi-monthly to the ward managers, along with the 100 days free data. An ASKINS checklist is completed for all hospital acquired pressure ulcers (HAPU) and results are sent to each ward manager and matron. The data helps to identify where specific training should be focused.

Table1/Chart1 - Pressure ulcer incidents 2017 - 2018 FY		
Month	**2016/17**	**2017/18**
April	12	5
May	7	3
June	9	1
July	10	6
August	6	5
September	11	5
October	2	8
November	12	6
December	5	3
January	12	5
February	5	4
March	5	3
Totals	**96**	**54**
% reduction on previous FY		**-44%**



Awareness campaign

'Care for my rear' was used to raise awareness of using a pressure relieving cushion once patients are well enough to start mobilising from bed to chair. Staff are generally very good at ordering the correct mattress but did not always remember a cushion. This appears to have improved.

Education/training

The SaIINTS link group continues, which is a collaboration of four link groups, to allow a more holistic approach to patient care and reduce the number of staff being released to attend the meetings. However, this has been reduced to four meetings per year due to poor attendance and workload for the leading specialties (Tissue Viability, IP&C, Nutrition and Dermatology). In addition the following training continues:

- Mandatory training – PU prevention is delivered by the Practice Development Team as part of a patient scenario;
- Induction – 12 sessions per year

- Overseas induction – now delivered with Trust induction.
- Preceptorship;
- Healthcare assistant training – monthly;
- Student nurses;
- Ward-focused training – this has reduced greatly due to general patient workload within the Tissue Viability team.
- Bespoke placements for students and Trust staff.

External training has been organised annually by the Tissue Viability Nurses (TVN) in collaboration with the Community Tissue Viability Nurse regarding the importance of accurate record keeping and this is delivered by way of a Mock Coroner's Court.

Expert Leadership

The focus on developing expert leadership continues with the following measures being implemented:

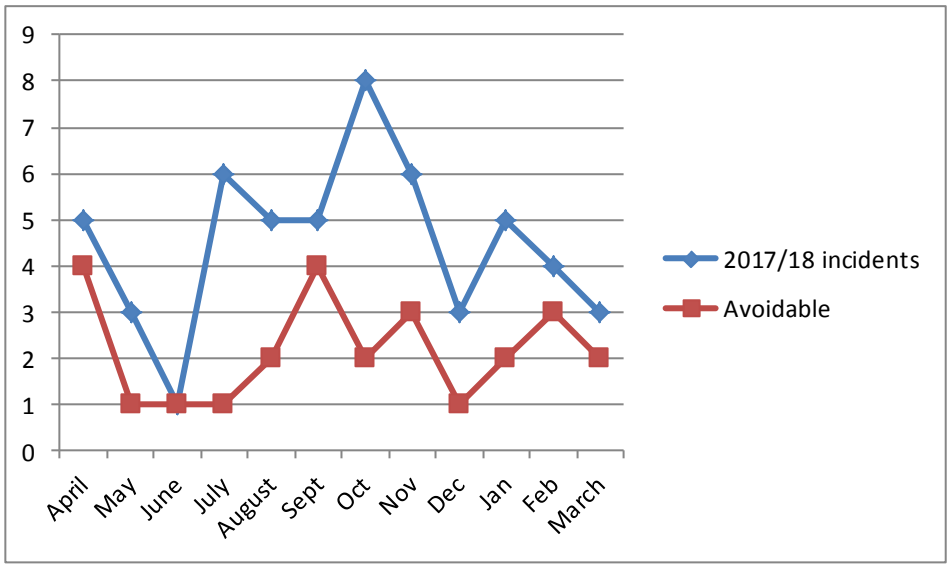
- Safety Thermometer data is collected on a monthly basis by the audit team and validated by the TVN. A monthly Harm Free Care Forum is chaired by the Deputy Director of Nursing and any issues raised as 'Chair's Key Actions' are escalated to the Quality and Safety committee meeting which meets monthly. Performance data is also submitted as part of the Trust's Integrated Performance report which is presented to the Board of Directors each month.
- Daily ward presence – Tissue Viability Nurses and Matrons
- Authorisation of the use of Nimbus 3 mattresses
- Evaluation of prevention equipment
- Dressings formulary – appropriate dressings/ creams in ward stock for prevention/ management of skin damage/ wounds (including pressure ulcers).

Avoidable v Unavoidable pressure ulcers

Following a change in the Serious Incident (SI) reporting framework in April 2015, not all hospital-acquired grade 3 and 4 pressure ulcers need to be reported via the Strategic Executive Information System (STEIS). The Trust follows the agreed reporting process with the Clinical Commissioning Group (CCG) as follows:

- All Grade 3 (or 4) hospital-acquired pressure ulcers are reported via Datix.
- The TVN sees the patient within 48 hours following a reported incident to assess and complete the review using the ASKINS criteria. This is sent to the appropriate ward manager/matron and Risk & Governance. The document is also uploaded to Datix.
- The Risk & Governance team then request a full Root Cause Analysis (RCA) from the ward manager, which should include an action plan for learning. If 'new' learning is identified, the RCA will be reported on STEIS and the RCA shared with the CCG.
- The TVN's also see patients within 48 hours following a reported incident of a hospital-acquired grade 2 pressure ulcer to assess and complete an ASKINS checklist to ascertain avoidability. The findings are fed back to the ward manager/matron and this again helps the TVN's identify where specific training should be focused.
- Although the figures are low, the general themes of the avoidable hospital-acquired pressure ulcers are:
  - Inaccurate risk assessment leading to inappropriate equipment.
  - Lack of documented evidence re: regular repositioning.

Chart 2 – Avoidable hospital acquired pressure ulcers v incidents



Listening to patients

Improving the patient and carer experience by listening to patients, their carers and the public and acting on what they tell us

Patient and public involvement is integral to how the hospital plans and improves its services. In 2017/ 18 the Trust actively engaged with patients, their carers and members of the public so that they could contribute to improving the quality of services that we provide.

In meeting this priority we identified three key strategies that would enable us to improve patient experience and introduce service improvements based on what patients and the public told us. These included:

- Improve the patient experience as measured by the Friends and Family test;
- Use learning from compliments, complaints, national surveys and feedback to enhance the quality of the services we offer our patients;
- Ensure the environment is appropriate for clinical care and a positive patient experience.

Measuring and reporting patient experience

The Trust seeks to capture patient and carer experience through a number of different methods including:

- Promoting the Friends and Family Test to receive anonymous but timely feedback;
- Hosting events for patients and the public;
- Seeking invitations to attend the meetings and events of organisations in the community to listen to their members' views;
- Listening to Patients' Stories at Board meetings;
- Participating in National Patient Surveys;
- Patient and public representation at key committees;
- Undertaking mock Care Quality Commission visits which include interviews with patients and carers (if they are present during the visit). The reports from these visits and any resulting action plans are considered by the Governors' Patient Experience Committee, the Trust Patient Experience Steering Group and by the Service Line Quality and Business Boards covering the wards or departments visited;
- Annual PLACE (Patient Led Assessments of the Care Environment) inspections;
- Reading and responding to patients' and carers' feedback posted on the NHS Choices and Patient Opinion websites, Facebook and Twitter.

The value of some of these activities is described in the following paragraphs:

Friends and Family Test (FFT)

The Trust has found the free-text comments submitted with the FFT responses invaluable in providing an insight into the issues and concerns that are important to patients. The FFT has enabled us to make changes based on patient feedback far more quickly than when awaiting results from other types of feedback. This feedback is shared with patients, staff and visitors and used in training courses to focus staff on the experiences that our patients have had and how we can improve things.

Hosting events

The Governor's Council and the patient experience team host events in conjunction with local statutory, community and voluntary sector partners. These events are open to all to provide information and advice about different long term medical conditions and this year two were held covering Cardiology and COPD and they provided information about the services and support available locally to support patients and their families.

The Hospital also held a Health Fair in October 2017 to welcome members of the public and staff to learn about the health benefits that small changes could make for staff and patients.

There is also a number of 'cafés' hosted by the hospital every week – twice weekly café run by West Norfolk Carers, a monthly café run by Age UK Norfolk and another run by King's Lynn and West Norfolk Borough Council's Careline offering advice about housing, benefits and information available via the Ask Lily website and advice line.

Attending events hosted by other organisations

Governors and the Patient Experience and Public Involvement Lead also attended meetings arranged by other local organisations; ensuring that we go to listen to patients and the public in their space rather than expecting them to always come to us. Key meetings attended included the Ask Lily Board Meetings, West Norfolk CCG Community Engagement Forum, Cancer Services User Group, West Norfolk Patient Participation Meeting and meetings of GP practice-based Patient Participation Groups. These meetings help the Trust gain insight into the experiences which patients have had of our services and to obtain feedback to help us plan how we can further improve. Feedback from these events is given at the Governors' Patient Experience Committee and the Trust's Patient Experience Steering Group.

Governors also attended meetings organised by other statutory bodies to understand how changes in the NHS are likely to affect our patients, raise concerns and learn more about the processes. These meetings included NHS Providers East Yorkshire/East of England Governors' Regional Workshop, Norfolk and Waveney STP event for Chairs, Lay Members, Governors and Non-Executive Directors, Healthwatch Norfolk STP Meeting.

Two of our Governors attended (and presented at) a recent Hospital Catering Association 'Enhancing the Dining Experience' to review and improve how and what food is provided to our patients.

Patient Stories at Board Meetings

To ensure that the patient's voice is heard at the Board, patients and their carers have been given support to enable them to tell their stories in person directly to the Board. This has allowed the Board to hear about their experiences first-hand and to learn from them about the aspects of care that patients value most. It also provides an opportunity for patients and carers to describe experiences of where care could have been improved and in so doing, enables the organisation to act on this feedback. During this last year the Board has heard the following stories that have led to action within the Trust:

- The experience of a relative supporting a patient at a distance and the associated problems this presented both for the relative and understanding care plans.
- The experience of a patient who developed delirium during two separate admissions for post-operative care following evacuation of sub-dural haemorrhages at Addenbrooke's hospital. Presented by the

patient and his wife.
- A patient's experience of two procedures, one in the private sector and one under the NHS at this Trust, comparing the experience of the pathway as well as care provided.
- A family's experience of the care received by a deaf child from birth to receiving cochlear implants 7 years later.
- The experience of a patient admitted initially as a surgical emergency with renal colic followed by an elective admission for planned surgery.

National Patient Surveys

During April 2017 to March 2018 the Trust took part in the following National Patient Surveys:

- National Adult Inpatients Survey 2017 – results to be published later in 2018 (preliminary received from contractor February 2018);
- National Cancer Patients Experience Survey 2017 – results to be published later in 2018;
- National Maternity Survey 2018 – results to be published later in 2018;

Published results of the national surveys can be found at: www.nhssurveys.org/ click on 'National Surveys' tab at the top of the home page, choose the survey you require then search for us under 'T' (The Queen Elizabeth Hospital King's Lynn).

Following their publication, survey results are presented to the relevant clinical and management teams, Executive Directors and members of the Governors' Patient Experience Committee and the Patient Experience Steering Group. Where necessary, action plans are developed (incorporating public representatives) and implemented to address any issues raised by the results. These are monitored through the Patient Experience Steering Group.

Some examples of how we have used feedback to improve the experience of patients and their carers:

- Patient placemats continue to be rolled out to all inpatient and day case wards to provide patients with information essential to their stay;
- Carer's Cards are being rolled out across the Trust to support those unpaid carers who provide emotional and personal support to patients especially those with dementia and learning disabilities.
- Decaffeinated tea and coffee made available to inpatients alongside caffeinated versions to allow patient choice but also to obtain the benefits of reducing caffeine intake whilst in hospital;
- Working with A&E Paediatric colleagues to create a leaflet to advise patients and their families about their likely wait time and provide information about facilities available whilst they wait.
- New information racks purchased and sited at key points around the hospital holding key hospital wide information – Complaints, PALS, Chaplaincy, Norovirus, Clostridium Difficile, MRSA, CPE, Information for Carers, Safeguarding, Falls Prevention, Going home, Delirium, Dementia, Your information, Visitors to adult wards, Pressure sores.
- Patients highlighted the lack of wheelchairs available at hospital entrances; the hospital fundraising executive established a campaign with the support of the local radio station KLFM to purchase 30 more wheelchairs.
- Cleanliness and untidiness at the front of the hospital commented on by patients that resulted in extra signage to support smoking cessation and highlight the smoking shelter facility and a review of cleaning rotations in and around the hospital front entrances to improve the patients / visitors first impression of the hospital.
- A number of clinics who regularly experience long waits for patients have introduced a pager system with a voucher for a hot drink – this relieves pressure on the waiting area and improves the patient experience. The patient is recalled to the waiting area when the patient on the list before them is called to their appointment.
- Areas where long waits are expected and commented on by patients have worked with the Communications Team to devise area specific posters to highlight that there could be a wait and where these waits are likely to be incurred during their patient journey. The posters were devised specifically for A&E and Ambulatory Emergency Care (AEC).

Communicating learning locally within wards and departments

- Wards and departments receive a monthly ward poster detailing number of surveys completed, likelihood to recommend, a selection of comments made by patients;
- All room for improvement comments are returned to area leads for action and support provided to make changes if required;
- A monthly report from our FFT Service Provider is made available electronically to senior staff across the Trust;
- All NHS Choices / Patient Opinion comments and the response we have made are distributed to lead staff in the areas concerned;
- Whole hospital improvements are promoted via a range of posters across the Trust.
- Improvements are discussed at sessions for clinical staff in mandatory training and through development courses.
- Actions taken in response to patient feedback shared across the Trust to other areas experiencing similar problems. Eg lack of information available to patients resulted in the bedside placemat being devised from an idea from United Lincolnshire Hospitals to be sited on all wards.
- Governors and Patient Experience have been involved in recent ward assurance and mock CQC inspections which resulted in shared learning across wards to improve both the staff and patient experience.

Using learning from complaints and compliments to enhance the quality of services for patients

The Trust is committed to providing an accessible, fair and effective means for users of its services to express their dissatisfaction or concerns about a particular service by either expressing an informal comment or raising a formal complaint. The Trust promotes a culture in which all forms of feedback are listened to and acted upon and the Trust recognises that such information is invaluable as a means of identifying problems and areas of good practice. As such, the information can be used as a tool to ensure that the organisation learns from complaints and puts in place changes that ensure improvements to services and a reduction in the likelihood of future complaints on the same issue.

The Trust aims to resolve all complaints locally through local resolution and will utilise all avenues at its disposal to achieve this to the satisfaction of the complainant.

A report is submitted to the Board every month as part of the Integrated Performance Report identifying the main themes arising from complaints and providing details of some of the actions that have been put in place following conciliation meetings.

In 2017/18 a wide range of changes were put in place following complaints and these included:

Key issues	Lessons identified	Action
Family raised concerns that their elderly relative had been admitted and discharged from the Trust six times since August 2016 and in their eyes the hospital was not dealing with his health issues.	Inadequate communication: • Despite discussions with the next of kin about the patient's prognosis the message had not been clearly understood. • The patient suffers from a number of co-morbidities and is moving towards the end of his life. He is in a residential home & the staff in the home have not been provided with strategies for dealing with the situation when he experiences a further decline in his condition requiring additional input from medical or nursing staff.	• The doctor took back to his team the need to improve communication with the patient and relatives regarding prognosis and the difference between being medically stable rather medically fit. By advising the patient that he was medically fit each time he was discharged gave both the patient and relatives the wrong impression. • Discharge planning staff advised to ensure that if the patient has already experienced a failed discharge the care needs should be re-assessed. • The relatives on this occasion agreed to speak with the patient's social workers to see if the patient could be moved into a more suitable care facility.
Patient had rigid endoscope procedure in ENT, found procedure to be very painful and that staff did not communicate clearly.	• To ensure patient documentation is correctly completed to ensure accurate record, this includes confirming which staff undertakes procedure if more than one staff member present during consultation. • To ensure effective communication with patients and ensure they are able to comfortably tolerate the treatment provided.	• To remind all surgical doctors of the importance of accurate record keeping. • To remind all of the surgical team of the importance of effective communication with patients during their treatment.
A patient has received a number of cancelled appointments due to the services at Littleport Surgery being under review.	Lack of information shared with the patient	To update the website accordingly to ensure that patients are kept up to date and to amend clinic letters where possible to include more detailed information.

Patient discharged without potassium levels being checked. Patient taken to the Discharge Lounge in a hospital gown and was discharged with the incorrect catheter bag. Lack of information during admission and after the patient's death.	• The need to maintain the dignity of patient's at all times. • Ensure patients are discharged with the correct urinary catheter bags. • Improve communication with patients and their families and ensure decisions regarding actions being taken/not taken are fully explained.	• Clothing for patients is now available in the Discharge Lounge. • Staff advised to check the type of urinary catheter bags provided to patients. • All staff involved in the patient's care have been advised regarding their attitude and reminded of the importance of good communication and the need to explain why actions have been taken or not taken.
Staff attitude towards patient during labour and post-delivery. Poor communication regarding feeding. Delay in diagnosis.	• Clear communication from staff is required, ensuring that patients are supported and any issues are fully addressed at the time • Ensure that the individual needs of patients and their partners are considered in the Maternity Service and that information is provided as required to support new parents.	• Feedback to be provided to team members in relation to staff attitude and how information was presented. • Concerns regarding diagnosis discussed in Local Resolution meeting to provide explanation to patient. • Apology given to patient

On a rolling monthly basis the Complaints Department undertakes a retrospective audit of all the recorded actions to determine whether they have been fully implemented and embedded in practice.

Sometimes patients and carers speak with the Patient Advice and Liaison Service (PALS) to raise suggestions rather than complaints. These suggestions vary and have included ways to improve the hospital grounds, for example the replacement of a drain cover at the front entrance and improvements to the car park. Other examples include changes to clinic appointment letters to remove information that is no longer relevant and incorporating a set process in Radiology to assist patients who do not receive their appointments via letter.

Compliments are always shared with the departments and teams concerned and are a valuable affirmation of where we have provided a service that has met or exceeded the expectations of patients and their families.

Ensuring the environment is appropriate for clinical care and a positive patient experience

Estates 2017/18

The Trust has continued to invest in the Estate in working to improve the overall patient experience with the following projects:

- Development of an A&E GP Streaming facility;
- Installation of a Pharmacy robot;
- Commencement of car parking improvements to create 117 additional spaces to relieve site congestion;
- Commencement of upgrading and improving fire detection and compartmentation;
- Commencement of a 5 year rolling programme to replace and upgrade the roof and upgrade ten wards;
- Upgrade of lighting to highly efficient LED lighting;
- Upgrades to external footpaths;
- Procurement of Hydrogen Peroxide decontamination equipment.

In the new financial year of 2018-19 we are looking at undertaking the following improvement initiatives:

- Modifications to the heating mains pipework to significantly reduce heating costs;
- Further upgrades of lighting to highly efficient LED lighting
- Refurbishment of hospital street corridors;
- Upgrade to Maternity ventilation systems;
- Replacement of Autoclaves in the Sterile Services Department;
- Upgrading the electrical infrastructure to the Main Kitchen.

Supporting our staff

Our aim is to deliver high quality patient care which is supported by a workforce that is engaged, highly skilled and competent. The quality of experiences and outcomes of people who use our services are a direct result of interactions with staff.

We want to be an employer of choice, attracting and retaining quality staff whilst supporting them with continued development, identifying talent to succession plan for the future, whilst creating a flexible workforce that can adapt to the ever changing environment whilst maintaining financial stability. 'Growing our own' workforce strategies will form an important part of our sustainable future workforce.

A new Workforce and Organisational Development Strategy was developed and approved by the Board of Directors in October 2017. The new strategy focuses on 'Recruit, Retain and Manage Well'.

The Workforce and Organisational Development Strategy outlines the development of specific targeted areas of work that will refresh and develop strategies of their own to sustain the long term development of the Trust including:

- Recruitment and Retention Strategy
- Medical Workforce Strategy
- Leadership at all Levels Strategy
- Health and Wellbeing Strategy
- Staff Survey Action Plans

Leadership Development

Accelerating challenges in healthcare have made it imperative that front line clinicians, particularly nurses and midwives, have the leadership capability to drive radical service redesign and improvement. The ability to influence and lead change at the front line is now central to delivering this agenda at all levels within the hospital. The Trust has a responsibility to both identify our leaders of the future and support all staff in the role they do today.

Given this context the Trust continued to support a number of leadership and development programmes to enable staff at all levels achieve their roles in delivering excellent quality patient care and support service functions to ensure high performing teams.

The Trust participated in a new Systems Leadership programme sponsored by Health Education England from May 2017 to March 2018 aimed at developing leadership skills in working across boundaries. The programme was delivered through five cohorts across each participating locality (West Norfolk, Central Norfolk, Great Yarmouth & Waveney, East Suffolk & North East Essex and West Suffolk). Delegates will work collaboratively on an integration related project to improve their systems leadership competencies across four domains; individual effectiveness, relationships and connectivity, innovation and improvement and learning capability building.

Talent Management

During 2017/18 the Trust has been developing its Strategy and Framework for Talent Management across the e44jmployee life cycle. This will be consulted on during spring 2018 and through the launch of a new

Behaviours Framework which when finalised, will be embedded in all key human resource processes. Our recruitment and appraisal process will be the first to be modelled around the agreed framework which has been designed in response to direct feedback from Staff.

Our delivery programme will be a balance of proven success at other local organisations and bespoke delivery for the Trust where the need requires. A partner trust has been recognised nationally for their approach to implementing Talent Management and has agreed to share their materials and learning, which this Trust will use. Regional funding is supporting this roll out via an external agency so at no direct cost to the Trust.

Lifelong Learning

Lifelong Learning is a partnership programme between the Trust and our recognised trade unions; it aims to give staff learning opportunities to help with confidence and encourage access to personal development. The opportunities do not necessarily relate to work, with classes including wellbeing activities such as Pilates, yoga, dancing and sewing as well as continuing support for dementia awareness sessions. The approach to partnership working in setting up Lifelong Learning and the development of a dedicated centre (The Inspire Centre) resulted in the Trust being recognised at the national HPMA awards ceremony in June 2017.

Trust Values

The Trust values are embedded into processes, for example values-based recruitment. In addition, we have also continued with monthly values-in-action awards where staff can be nominated for a particular value, providing details of how the staff member has put the Trust values into action within their role. These values-in-action awards are presented by the Trust Chief Executive and details of the award winners are communicated throughout the Trust.

Values-in-Action Awards

Between April 2017 and March 2018, 153 members of staff have between them received values awards. The breakdown of the values awards is as follows:

45 - Compassion
21 - Courage
4 - Curiosity
53 - Pride
51 - Responsibility

Long Service Awards

The Trust recognises staff long service and the following numbers of staff received an award presented by the Chief Executive and Trust Chair for reaching 40, 30, 20 or 10 years' long service from 1 January 2017 to 31 December 2017.

40 years : 1 staff
30 years : 4 staff
20 years : 11 staff
12 years : 17 staff

Staff Engagement

The Trust recognises that by developing an engaged, enabled and empowered workforce, which is well-led and supported, the Trust can ensure its staff are getting the best possible experience, and in turn patients are getting the best care. The aim is to improve staff engagement further by introducing new methods to engage with staff for example a weekly Team Brief, staff listening sessions, team meetings.

The Trust encourages open and honest communication throughout the organisation and Executive Team members have an 'Open door' policy. The Executive Team members have also been assigned 'buddy' areas which they visit and engage with staff.

The Trust has continued to focus on staff engagement through a range of activities such as Chief Executive Briefing sessions. This involves monthly open staff sessions with the Chief Executive that provide staff with an opportunity to offer feedback and ask questions while also allowing staff an opportunity to find out about recent developments and to receive updates relating to current performance. Other successfully implemented communication methods include 'Friday Round-Up', which is an email of all key messages sent to all staff every week, and 'The Knowledge', a Trust weekly publication for all staff.

Staff Survey 2017

The Trust Staff Survey 2017 was provided to 3136 staff to complete, 1434 surveys were completed providing a response rate of 46% an improvement of 1% from the previous year. There was not a significant change between the Trust Staff Survey Results for 2016 and 2017.

Staff Survey 2017 – Results

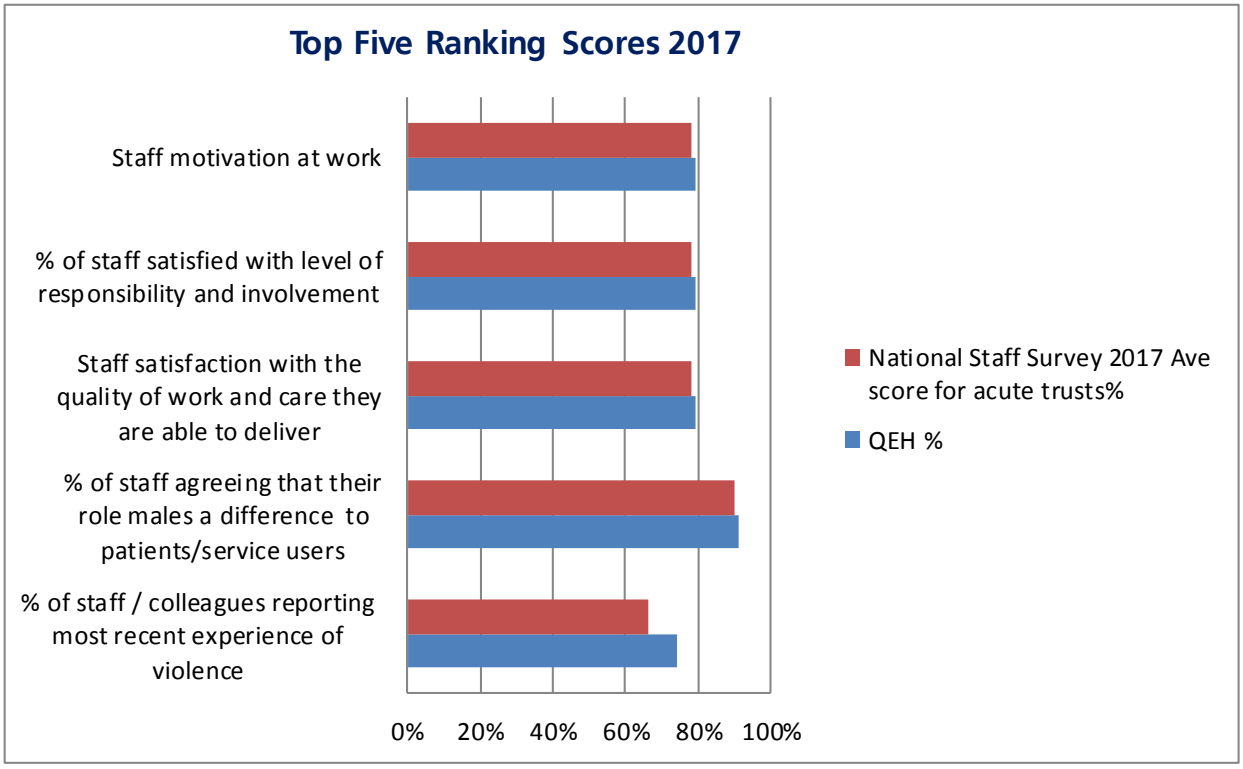
The figure below shows how The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The Trust's score of 3.75 was below (worse than) average when compared with trusts of a similar type.

The table below shows how our Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2016 survey:

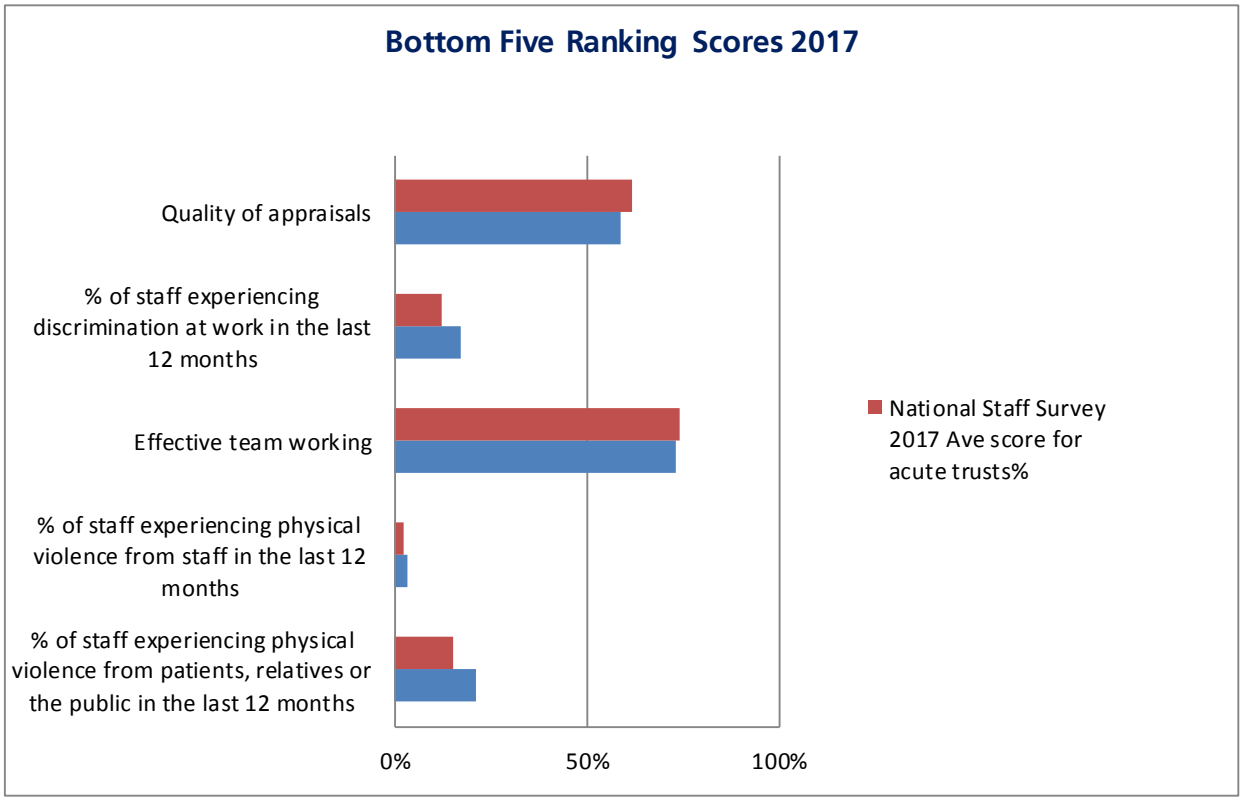
OVERALL STAFF ENGAGEMENT	Change since 2016 survey	Ranking, compared with all acute trusts
	No change	Below (worse than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment	No change	Below (worse than) average
KF4. Staff motivation at work	No change	Above (better than) average
KF7. Staff ability to contribute towards improvements at work	No change	Average

The Trust will be working with staff to identify and put actions in place to improve the experience of staff and to improve the scores for each of these key findings. The plan is to work to improve these scores further in the next staff survey through the development and monitoring of action plans.

The Trust Top Five Ranking Scores 2017



The Trust Bottom Five Ranking Scores 2017



Development of Staff Survey Action Plans

The Trust Executive Team have implemented new ways to communicate the results of the staff survey to staff throughout the Trust including walking copies of the results to the management 'buddy' areas.

The sub group of the Leadership and Organosational Development Committee that reports to the Workforce Committee met to plan the actions and feedback.
As a result of this the Director of Human Resources has been commissioned to use the results from the Staff Friends and Family Test, Behaviour workshops and this survey to draft a new behaviours framework for the organisation.

The results of the Staff Survey have also been filtered by division and the HR Business Partner team are working with managers and staff to understand and plan local change that would also make a difference to staff.

However, it is also recognised that there was not a significant change between the Trust Staff Survey Results for 2016 and 2017. The results were also disappointing when compared with some local trusts and national performance.

From the analysis of the results, the Trust has identified the need to improve results in the following areas:

- Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months;
- Percentage of staff experiencing physical violence from staff in the last 12 months;
- Effective team working;
- Percentage of staff experiencing discrimination at work in the last 12 months;
- Quality of appraisals.

Staff health and wellbeing is promoted in the Trust through a number of incentives and activities. The Occupational Health Department provides or has at its disposal, many services that staff can access; these include immunisations, physiotherapy sessions and help with smoking cessation. Insight confidential telephone advice service is available to staff to contact regarding personal matters and offers a 24 hour, 7 day a week advice line. In addition, in partnership with Unison, a variety of classes are available to staff to participate in through their Lifelong Learning programme. The Trust has successfully focused on:

- Improving support across musculoskeletal, mental health and physical activities;
- Providing a selection of healthy food for staff to purchase and
- Improving uptake of flu vaccinations by frontline healthcare workers.

The Trust takes any incident of harassment, bullying and abuse very seriously, whether it arises from a patient, a member of the public or another member of staff. Advice for staff is available in person by contacting their Human Resources Business Partner or on the Human Resources intranet site, where there are links to leaflets and policies to aid staff to report such incidents.

Staff Friends and Family Test (SFFT)

The Trust is committed to improving the engagement of staff with the Staff Friends and Family Test during 2017/18. Further analysis of staff feedback and development of action plans will take plan with a renewed emphasis on providing responses to staff on positive actions and changes made due to feedback received.

The Staff Friends and Family Test was introduced during 2014/15 and requires NHS Providers to ask their workforce two simple questions:

Would you recommend your Trust to friends and family as a place to come for treatment?
Would you recommend your Trust to friends and family as a place to work?

The table below illustrates the level of participation since the test was launched in 2014/15:

The number of responses to the Staff Friends and Family Test has improved over the last year 2017/18.

Quarter	1	2	3	4
No of responses received 2014/15	119	96	Undertaken as part of the annual staff survey	485
No of responses received 2015/16	372	291	Undertaken as part of the annual staff survey	365
No of responses received 2016/17	338	266	Undertaken as part of the annual staff survey	245
No of responses received 2017/18	411	459	Undertaken as part of the annual staff survey	450

The Trust will focus in 2017/18 on improving participation in the Staff Friends and Family Test and will be asking additional questions to find out more from staff about their experiences of working at the Trust and also in terms of receiving care to support the development of improvement plans.

QUALITY PRIORITIES FOR IMPROVEMENT 2018/19

The Quality Priorities for 2017/18 focused on progressing national priorities, building on achievements to date and ensuring that improvements were sustained and strengthened while the new Executive team came into post and developed its approach to quality improvement. In addition, the Trust chose to include the experience of children as one of its priorities in contrast to previous years where the focus had been largely on the majority patient group, namely the frail, older patient.

The Executive team has now been in post one year and in 2018/19 the Trust is intending to have a much broader and more ambitious set of quality improvement priorities. These Quality Priorities will underpin the development of a Quality Strategy to take forward quality improvements over the next three years.

Objective	Actions	Outcome measure
Patient Experience		
1. Improve patient and family experience in end of life (EoL) care.	Local actions led by EoL Steering Group and Palliative Care team.	Reduction in EoL- related complaints. Improved rating using the End of Life Quality Assessment tool, which measures achievement against the NICE End of Life Quality Standards.
2. Improve communication with patients who have a sensory impairment such as deafness or visual impairment.	Programme of training and awareness-raising amongst staff in collaboration with local voluntary groups. Focus on improving the management of hearing aids with inpatients and the more widespread usage of hearing loops.	Positive feedback via FFT, PALS and NHS Choices' comments. Reduction in complaints.

Patient Safety		
1. Introduction of NEWS2	Trust-wide programme of training to support the introduction of NEWS2 with changes to accompanying written guidance and patients' clinical observation charts.	Development of programme to introduce NEWS2 presented to the Clinical Governance Committee with clear dates for training and trust-wide implementation. Audit of practice following implementation.
2. Ensure improvements in infection control within the Trust.	Review, implement and monitor Cleaning Standards in all clinical areas. Fully implement Matron's Charter.	Sustained improvements in audits of practice. Reduction in hospital-acquired infections.
3. Ensure improvements in Medicines Management – Focus on the use of anti-coagulants.	Put in place measures to improve assessment of risk and prescribing practice.	No failures in practice identified during root cause analyses of incidents of VTE. Reduction in VTE's and recorded complications from the use of anti-coagulants.
Effectiveness		
1. Improve the quality of perinatal care.	Develop a co-joint clinic involving midwives, obstetricians and psychiatrists.	Development plan in place by end of Q1. Clinic in place and seeing patients by Q3. Identify and monitor key outcome measures for mother and baby.
2. Implement a quality improvement programme to support better nutrition and hydration in patients.	Review Food and Drink Strategy and set new objectives for 2018/19.	New objectives in place by end of Q1. Quarterly reports to Quality & Safety committee demonstrating progress in meeting objectives. Objectives delivered by end of Q4.
3. Enhance learning from deaths in people with a learning disability to support improvements in care.	Review and revise processes for ensuring that all deaths in people with a learning disability are identified and referred to the LeDeR programme. Internally examine every death of a person with a learning disability and involve the Learning Disability Liaison nurse in the review.	Full compliance with reporting to LeDeR – reported to the Quality & Safety committee quarterly. Results of all internal investigations to be made available to the LD Steering Group and any learning shared across the organisation via Divisional Governance structure.

Build and sustain excellence		
1. Undertake an improvement programme to support better documentation and note-keeping.	Develop and implement a programme of training with all levels of medical and nursing staff to support best practice in line with Royal Colleges' and Regulatory Bodies' standards.	Weekly audits of patients' health records provide evidence of improvements in practice.
2. Improve understanding of the Mental Capacity Act 2005 amongst staff and how it can support improvements in the quality of care for the patient.	Develop and implement a programme of training with all levels of medical and nursing staff to support best practice in the use of the Mental Capacity Act 2005 within health care practice.	Staff in all clinical areas are able to explain when and how to use the MCA 2005 within their health care practice. Audits of patients' health records provide evidence of use in practice.

This improvement plan will be implemented through our current management and governance structure and its implementation and outcomes will be monitored through monthly reporting of individual objectives to the Board as part of the Integrated Performance report and as an overall improvement plan on a quarterly basis by the Quality & Safety Committee.

2.3 STATEMENTS OF ASSURANCE FROM THE BOARD

Review of services

During 2017/18 The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust provided and/or sub-contracted 45 NHS services. The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100% of these NHS services.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust for 2017/18.

2.4 PARTICIPATION IN CLINICAL RESEARCH AND CLINICAL AUDIT

Participation in Clinical Research

The number of patients in 2017/2018 receiving relevant health services provided or sub-contracted by The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust that were recruited between 1st April 2017 and 4th April 2018 to participate in research approved by a research ethics committee was 899.

This included 851 patients recruited to NIHR portfolio studies and 48 patients recruited to non-portfolio studies. In 2017/18 the Trust was involved in conducting 50 NIHR portfolio and 10 non-portfolio clinical research studies.

This is a continuing increase on the previous year and reflects both the result of new approaches championed by the Research Department and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust's increased focus and support of improvements in health care and outcomes for patients by encouraging all clinicians, whenever possible, to offer participation in all the research studies that are applicable to our patients. The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has continued to contribute to the national drive to identify new and improved treatments and ways of working. Our clinical teams provide information to patients and their families about the opportunities that are available to participate in innovative and cutting edge research trials and aim to introduce the resultant new treatments that benefit patients into their practice as the outcomes of research becomes available to the NHS.

Participation in Clinical Audits and National Confidential Enquiries

During the reporting period 2017/18, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust engaged in 44 National Clinical Audits and 5 National Confidential Enquiries covering the relevant health services that The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust provides. During that period the Trust participated in 95% of the National Clinical Audits and Patient Outcomes Programme (NCAPOP) and 100% of the National Confidential Enquiries which it was eligible to participate in. In addition The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust participated in a further 5 National Audits (Non-NCAPOP) recommended by Healthcare Quality Improvement Partnership (HQIP).

National Clinical Audits 2017/18

The National Clinical Audits and National Confidential Enquiries that The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust was eligible to participate in and for which data collection was completed during 2017/18 are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Audit Title	Participation	% of cases submitted
Acute		
Case Mix Programme - Adult Critical Care (ICNARC) (CMP)	Yes	TBC%
National Emergency Laparotomy Audit (NELA)	Yes	Awaiting report
Sentinel Stroke National Audit Programme (SSNAP)	Yes	TBC%
Trauma Audit Research Network (TARN)	Yes	66-77%
Consultant Sign Off (RCEM)	No	0%
Severe Sepsis and Septic Shock (RCEM)	No	0%
Asthma Care in Emergency Departments (RCEM)	No	0%
SHOT review	Yes	100%
Cancer		
National Bowel Cancer audit (NBOCAP)	Yes	70%
National Lung Cancer Audit (NCLA)	Yes	100%
National Oesophago-gastric Cancer audit(NOGCA)	Yes	>90%
Prostate Cancer(Urology)	Yes	71%
Head and Neck Cancer Audit	Service is carried out in tertiary care settings	
Cardiology		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	TBC%
Cardiac Arrest Audit (NCAA)	Yes	Requested%
Heart Failure	Yes	TBC%
Diabetes		
National Diabetes Audit	No	Trust software not compatible
National Diabetes Foot Audit	Yes	95%
National Diabetes in Pregnancy (NPID)	Yes	100%
National Diabetes Inpatient Audit (NADIA)	Yes	100%
Surgery		
Elective surgery (National PROMs Programme)	Yes	100%
National Hip Fracture Database (FFFAP) (NHFD)	Yes	96.4%
National Joint Registration (NJR)	Yes	97%
National Obstetric Anaesthesia Database(NOAD)	No	0%

Nephrectomy Audit (BAUS)	Yes	100%
Surgical Site Infection (SSI)	Yes	100%
UK Registry of Endocrine and Thyroid Surgery (UKRETS)	Yes	80%
Vascular surgery (VSGBI Vascular Surgery Database)	Service is carried out in tertiary care settings	
Other		
Pain in Children	Yes	TBC%
Fractured Neck of Femur	Yes	TBC%
National Audit for Rheumatoid and Early Inflammatory Arthritis	Audit not collecting data 2017/18	
National Audit of Dementia	Audit not collecting data 2017/18	
Inflammatory Bowel Disease	Yes	TBC%
National Comparative Audit of Blood Transfusion	Yes	100%
National COPD Audit Programme (BTS): Emergency use of Oxygen	Yes	Data collection on-going
Adult Asthma (BTS)	No	0%
Procedural sedation in Adults	Yes	100%
Renal Replacement Therapy	Service is carried out in tertiary care settings	
LeDeR Programme (HQIP)	Unavailable to Trust for 2017/18	

Audit Title	Participation	% of cases submitted
Women and Children		
Asthma Audit (Paediatrics) (BTS)	Audit not collecting data 2017/18	
British Society of UroGynaecologist (BSUG) audit	Yes	70%
Community Acquired Pneumonia Audit (Paediatric) (BTS)	No	%
Each Baby Counts (5 year project)	Yes	Five year project
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
National Neonatal Intensive & Special Care Audit Programme(NNAP)	No	100%
National Paediatric Diabetes Audit	Yes	100%
UK Cystic Fibrosis Registry	No	0%

National Confidential Enquiries 2017/18

Audit Title	Participation	Eligible Number	Actual Submissions
Perioperative Diabetes	Yes	8	3 (37.5%)
Acute Heart Failure	Yes		In progress
Child Health clinical outcome	Yes	6	Complete
Young Persons Mental Health	Yes	5	Complete
Cancer in Children Teens and Young Adults	Yes		Currently in progress

National Audits – Actions and Outcomes

The reports of 3 national clinical audits that the Trust participated in were published between 1 April 2017 and 31 March 2018 and have been subject to local review. A brief overview of the national findings is outlined below with both national recommendations and where appropriate, any specific local follow up actions. Some are still subject to local review.

National Lung Cancer Audit (NLCA) – Made recommendations that lung cancer services should set out to achieve, covering data quality, process of care and treatment.

National findings:

- The rate of patients being seen by a lung cancer nurse specialist (LCNS) has improved, with 71% of patients being seen and 58% having an LCNS present at the time of diagnosis
- 37% of patients are alive at least 1 year after diagnosis, which is a significant improvement to the 31% diagnosed in 2010.
- There has been a further increase in the number of patients receiving surgery and 17.5% of non-small cell lung cancer patients diagnosed in 2016 received surgery compared to 16.7% of patients diagnosed in 2016.

National recommendations:

- Performance status and disease stage should be recorded in at least 90% of cases.
- FEV1 and FEV1% should be recorded in at least 75% of patients who have stage I–II disease and a PS of 0–1.
- MDTs should consider whether their approach to cohorts such as older patients, and patients with comorbidities, is in line with best practice guidelines (National Institute for Health and Care Excellence (NICE).
- All patients should have access to local smoking cessation and pulmonary rehabilitation services.
- All providers that do not have a separate diagnostic MDT meeting should implement one during the next 12 months.

National Joint Registry (NJR) – The audit report for 2017 with surgical data gathered 31st December 2016. Figures for the Trust is as follows:-

- 662 procedures (2016) = 85%
- Number of consultants (2016) = 9
- 97% consent rate (Cases submitted to NJR with consent confirmed)
- 99% Link ability (valid Patient NHS number compared with number of procedures on NJR)
- 44% male patients
- Average age at Operation = 71.7

Findings:

- Revision estimates following primary joint replacement procedures remain low. E.g. Hips - revision estimates <5% at 13 years;
- Positive outcomes for knee replacement, ankle, shoulder and for the first time, elbow joints;
- Shoulder data now distinguishes between stemmed & non-stemmed humeral implants and allows for analysis of which implants are most frequently used;
- Revision rates in knee replacement demonstrates a consistent link to age when replacement took place:
  - Median age of 69yrs rate of revision is 4% at 13 years;
  - Total knee replacement <60yrs rate of revision increases and is 10% for patients under 55yrs;
  - Unicondylar replacement the revision rate is 25% for patients under 55yrs.

National COPD Audit – The National COPD Audit Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit (NCA) Programme.

National findings:

- A reported increase in the median number of emergency, respiratory and COPD admissions (although it is not known whether this is due to increased prevalence or acuity of the cohort, or to a rise in avoidable admissions);
- The majority of COPD patients were treated on non-respiratory wards where specialist care access is lowest;
- Improved provision of palliative care and integrated, cross-sector services;

- Reduced access to respiratory teams and cross-sector care at weekends;
- The median length of stay remained unchanged from that reported in 2014, at 4 days;
- Inpatient mortality fell marginally (3.9% reported in 2017 vs 4.3% reported in 2014).
- Access to non-invasive ventilation (NIV) within optimal timeframe is variable.

National recommendations:

- Early specialist review;
- Improved access to respiratory teams in all sectors;
- All current smokers are identified and offered smoking cessation pharmacotherapy;
- Ensure that all patients requiring NIV on presentation (ie that have evidence of respiratory acidosis) receive it within 60 minutes of the blood gas result associated with the clinical decision to provide NIV and within 120 minutes of arrival for those who present acutely.

Local action:

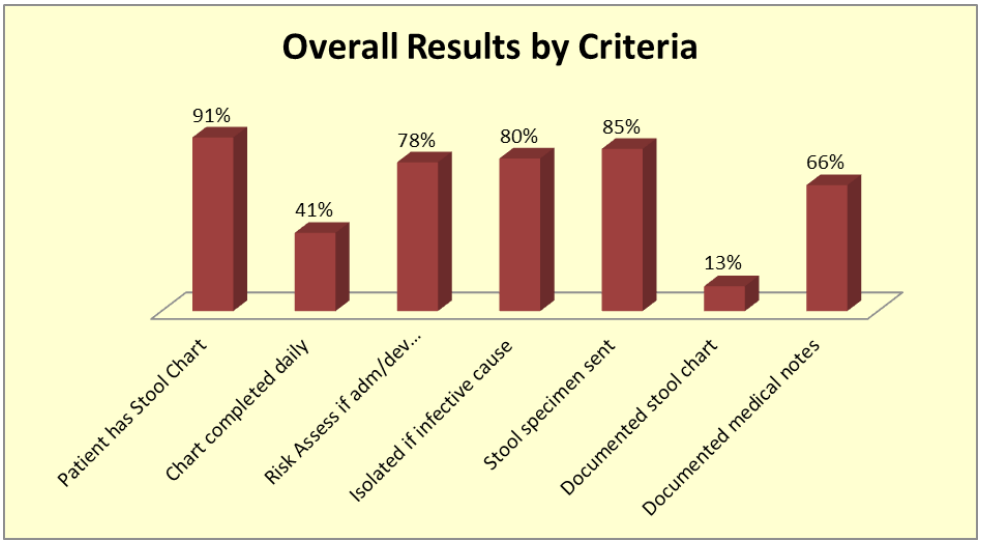
- Business case in progress to support the creation of a NIV bay within the Respiratory ward;
- Consultation across the healthcare economy to provide a COPD pathway for patients.

Local Clinical Audit

The reports of 89 local clinical audits were reviewed by the provider in 2017/18. A selection of these audits is outlined below and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

Infection Prevention & Control (IP&C) – Loose Stools Audit – The purpose of this audit was to identify if every adult inpatient had a stool chart in place & that these were being maintained. The audit also focused on identifying if systems were in place to ensure that patients who are admitted with diarrhoea or develop diarrhoea during admission are assessed & managed appropriately.

Findings against criteria:



Follow up action:

- To improve compliance of the documentation around loose stools the IP&C team have introduced the use of a Diarrhoea & Vomiting assessment tool across all areas.
- A poster has been designed to help staff decide if they should send a specimen for testing.
- The IP&C team will continue to provide education and support for clinical areas as well as building & maintaining relationships with these areas.
- Following root cause analyses on Clostridium difficile cases, findings are fed back to the ward managers & clinicians.

Cardio-Respiratory – Appropriateness of Rapid Access Clinic Referrals - The Rapid Access Chest Pain linic changed the referral form in 2016. This audit was undertaken to see how effective the different GPs surgeries were at filling in the referral forms correctly and providing the additional information needed to complete the referral, for example the results of ECGs and blood tests. This is to ascertain whether documentation is complete and accurate.

Findings:
Standards have not been met. It was found that from the 50 referrals analysed, only 18 had been completed correctly.

Follow up action:
- The findings of this audit need to be shared with the GPs surgeries so that there is an understanding that all referrals need to be submitted with ECG and blood tests attached to them before they can be accepted.
- Share findings with Choose & Book Specialist to inform GPs that the referral will be rejected until it is complete.

Obstetrics & Gynaecology – External Cephalic Version (ECV) for Breech Presentation Audit – The audit aimed to analyse the safety and effectiveness of the ECV service provided by the Obstetrics & Gynaecology department at The Queen Elizabeth Hospital, King's Lynn. It aimed to evaluate how closely the Royal College of Obstetrics and Gynaecology (RCOG) guidelines were followed as well as identifying areas of strengths and weakness.

Findings:
- At the Trust all women who were diagnosed with breech position were offered an ECV. The standard was met.
- The use of tocolytics is recommended by the RCOG as it is shown to increase the success rate of ECVs. All the patients received 250mcg of Terbutaline. The standard was met.

Follow up action:
- Service to continue to be provided in line with Guidelines.

Dermatology – Monitoring of patients on Azathioprine at the Trust – To check that current clinical practice at the Trust is compliant with the British Association of Dermatologists' clinical guidelines, in order to maintain patient safety.

Findings:
- The study has shown adequate blood monitoring both for pre-treatment blood tests and maintenance monitoring.

Follow up action:
- All patients taking Azathioprine should continue to have blood monitoring as recommended in the BAD guideline.
- All Clinicians to remind patients taking azathioprine of their increased risk of skin cancer at each consultation, and record that this discussion has taken place in the medical record.

Trust Wide – Consent to Surgical or Medical Procedure – The aim of this audit was to review compliance with the Trust Policy on Consent to Examination and Treatment. A total of 61 medical records were reviewed using a pre-designed data collection form. Approximately 150 records were examined in total but only 61 were relevant / appropriate.

Findings:
- 61 sets of patient records were audited and all of them contained consent forms for the recorded procedures.
- All records:
  - o Documented common risks
  - o Met a legal minimum standard

- o Were signed by:
  - Practitioner
  - Patient (save for one)
- o Were dated

Follow up action:

- Support the use of Procedure Specific Consent Forms which will prevent inadvertent omission of a key risk or benefit in the pre-procedural exchange of information;
- Remind staff that all handwriting must be legible as there was a small variation from complete compliance with the requirements of practice by clinicians where improved handwriting may have solved the issue.

Patient Experience/Satisfaction

In addition to the Friends and Family Test feedback cards, specialties have participated in the following 7 patient experience or patient satisfaction (service evaluation) studies in 2017/18:

- Radiology – Radionuclide Imaging patient experience audit
- Pharmacy – Patient experience audit
- Information Governance – Information Governance Tool Kit
- General Surgery – Breast Care
- Endoscopy – Endoscopy Clinic
- Cardiology – Rapid Access Chest Pain Clinic
- General Surgery – Stoma Care

These have all been reported locally within individual specialty governance meetings and shared with team members.

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

A proportion of the income received by The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between The Queen Elizabeth Hospital, Kings Lynn, and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. The monetary total for income in 2017/18 conditional on achieving these quality improvement and innovation goals and the monetary total for the associated payment in 2016/17 are as follows:

Acute		Specialist	
2016/17	£3,453,807.00 *Full achievement*	2016/17	£158,774.00 *Full achievement*
2017/18	£3,473,982.00 *Achievement still to be determined*	2017/18	£190,580.00 *Achievement still to be determined*
2018/19	£3,632,335.00 Available	2018/19	£186,555.00 Available

Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at www.qehkl.nhs.uk and included within this document.

CARE QUALITY COMMISSION & MONITOR

Care Quality Commission

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'Requires Improvement'. The last CQC inspection was in June 2015.

The Trust was formally rated:

Overall Rating for the Trust	Requires Improvement
Are Services at this Trust safe?	Requires Improvement
Are Services at this Trust effective?	Good
Are Services at this Trust caring?	Good
Are Services at this Trust responsive?	Requires Improvement
Are Services at this Trust well-led	Good

As a result of the improvements identified by the CQC in its 2015 inspection report, the Trust was removed from 'Special Measures' in August 2015. The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has no conditions on its registration and the Care Quality Commission has not taken enforcement action against The Trust during the reporting period from 1 April 2017 to March 2018.
Following the appointment of a new Executive Team during 2017, the Chief Nurse was appointed the Executive Lead for the CQC and the Quality Improvement Group was reviewed and restructured in October 2018 forming the new Quality Matters Group.

In November 2017, the Trust appointed an Associate Chief Nurse for Quality Improvement to support its preparation for its 2018 CQC Inspection and its on-going service delivery in accordance with the CQC's fundamental standards of care.

The purpose of the Quality Matters Group is to oversee, drive and monitor the delivery of the Trust's Quality Improvement Objectives through the development of a Quality Improvement Plan, to ensure the Trust's consistent compliance with the Care Quality Commission's Fundamental Standards. The governance arrangements are being strengthened to provide assurance to the Quality Committee and Board of the Trust's compliance with the Fundamental Standards and alignments with the Key Lines of Enquiry.

The CQC inspection of 2015 identified areas of poor practice where the Trust must make improvements which formed the MUST actions. These MUST actions are aligned to regulated activity:

Regulation 17, Good Governance	Decontamination of cystoscopies Clinical data for maternity Management of appointment systems.
Regulation 12, Safe Care and Treatment	Medicine Management Resuscitation Trolley Checks Record Keeping
Regulation 18, Staffing	Staffing levels within defined areas

The 2016/17 report highlighted areas of immediate action and improvement work undertaken by the Trust. Changes to the Executive Team slowed the progression of these actions during 2017, but a review of these MUST actions has been carried out by the Quality Matters Group since November 2017 and closure reports submitted for all actions with the exception of the management of Appointment Slot Issues (ASIs). The Trust is currently below the 92% trajectory for 18 weeks incomplete pathways and has agreed a recovery trajectory with the West Norfolk Clinical Commissioning Group and NHS Improvement for the achievement of the 92% target.

The MUST action closure reports included evidence addressing the original concerns and the on-going monitoring and assurance arrangements which will form part of the Quality Improvement Plan.

In February 2018 The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust received a Provider Information Request in preparation for its forthcoming unannounced CQC Inspection. This Provider Information Request (PIR) was submitted within the set timeframe of three weeks on the 26th February 2018. The Trust will expect its CQC Unannounced Inspection to commence within twelve weeks of receiving the original PIR on the 5th February 2018.
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has not participated in any special reviews

or investigations by the Care Quality Commission during the reporting period of 2017/18.

SECONDARY USER SERVICES (SUS)

The Trust submitted records throughout 2017/18 to the Secondary User Services for inclusion in the Hospital Episodes Statistics which are included in the latest published data. As of January 2017, SUS data which included the patient's valid NHS number was:

- Inpatient — General medical practices 100% — NHS number 100%
- Outpatient — General medical practices 100% — NHS number 100%
- Emergency Dept — General medical practices 100% — NHS number 100%

INFORMATION GOVERNANCE ASSESSMENT REPORT

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (RCX) Information Governance Assessment Report overall score for 2017/18 was 80% and was graded Green (Satisfactory).

CLINICAL CODING ERROR RATE

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust was not subject to a Payment by Results (PbR) clinical coding inpatient quality audit during the reporting period from 1 April 2017 to 31 March 2018 by our regulators because audits are now being targeted on trusts with a higher error rate. The Trust completed internal coding audit reviews for evidence for the Information Governance Toolkit. These audits did not reveal any particular areas of concern. However, the results are based on 200 notes for each audit out of 104,840 notes coded each year so the results should not be extrapolated further than the actual sample.

Accuracy	Percentage achieved
Primary diagnoses	95.00%
Secondary diagnoses	93.19%
Primary procedures	93.94%
Secondary procedures	90.08%

Data Quality

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust will be taking the following actions to improve data quality:

- Continue monitoring data quality via SUS submission dashboards
- Continue the data quality forum to investigate and correct data quality issues
- Carry out regular audits on the recording of data across the Trust

2.5 REPORTING AGAINST CORE INDICATORS

Indicator	Summary Hospital-Level Mortality Indicator (SHMI) SHMI is a hospital-level indicator which measures whether mortality associated with a stay in hospital was in line with expectations. SHMI is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by the Trust. SHMI is not an absolute measure of quality but it is a useful indicator to help Trusts understand mortality rates across every service provided during the reporting period. A Lower score indicates better performance					
	Reporting period	**QEHKL**	**National average**	**Highest score**	**Lowest score**	**Banding**
The data made available to the Trust by the Information Centre with regard to:	**Oct 11 - Sept 12**	0.9993	1	1.0511	0.9494	2
	Jan 12 - Dec 12	0.9899	1	1.041	0.9408	2
	April 12 - March 13	1.0154	1	1.0669	0.9658	2
	July 12 - June 13	1.0067	1	1.0579	0.9573	2
	July 13 - June 14	0.9771	1	1.0286	0.9276	2
	July 15 - June 15	0.8833	1	0.9295	0.838	3
	Oct 15 - Sept 16	1.0138	1	1.0642	0.9653	2
	Jan 16 - Dec 16	1.0098	1	1.0596	0.9618	2
	April 16 - March 17	0.9814	1	1.0295	0.9349	2
	July 16 - June 17	0.9806	1	1.028	0.9348	2
	Oct 16 - Sept 17	0.9797	1	1.0267	0.9344	2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period (the palliative care indicator is a contextual indicator)	**June 11 - July 12**	14.5	18.6			
	Oct 11 - Sept 12	18.8	19.2			
	2013/14	15.2	NA			
	2014/15	14.3	26.1			
	2015/16	10.8	NA			
	2016/17	11.1	NA			

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust is banded as a '2' which is 'as expected' mortality. This correlates with information gained from local clinical quality meetings.

The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services by:

- Recruitment of nursing staff to vacant and new posts and daily monitoring of staffing levels to ensure minimum ratios were achieved across the Trust;
- Continued monitoring and investigations of mortality through the Mortality Surveillance Group;
- Improved pathways for emergency admissions including the Ambulatory Emergency Care unit, GP streamlining 'Hot clinics' and GP referral pathways for advice;
- Further use of the 'care bundles' approach to standardise early treatment of emergency conditions;
- Continued emphasis on routine harm prevention including sustained rates of risk assessment for venous thromboembolism, falls and nutritional status and compliance with routine measures of infection control.

Footnote: NA = Not Available

Indicator	Patient Reported Outcome Measures (PROMs) scores PROMs measure a patient's health-related quality of life from the patient's perspective using a questionnaire completed by patients before and after four particular surgical procedures. These questionnaires are important as they capture the extent of the patient's improvement following surgery.				
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL**	**National average**	**Highest score**	**Lowest score**
The Trust's patient reported outcome measures scores for groin hernia surgery	2011/12	0.081	0.087	0.143	-0.002
	2012/13	0.126	0.085	0.277	-0.1
	2013/14	0.132	0.086	0.2	-0.033
	2014/15	0.087	0.081	0.273	-0.17
	2015/16	0.008	0.088	0.61	-0.14
	2016/17	NA	0.087		
The Trust's patient reported outcome measures scores for varicose vein surgery	2011/12	0.240	0.095	0.240	0.047
	2012/13	0.081	0.093	0.239	-0.155
	2013/14	0.171	0.102	0.23	-0.043
	2014/15	NA	0.1	0.264	-0.051
	2015/16	NA	0.1035	0.532	-0.14
	2016/17	NA			
The Trust's patient reported outcome measures scores for hip replacement surgery	2011/12	0.450	0.416	0.532	0.306
	2012/13	0.492	0.438	0.621	0.247
	2013/14	0.628	0.447	0.724	0.177
	2014/15	0.489	0.442	0.765	0.187
	2015/16	0.377	0.453	1.0095	0
	2016/17	0.390	0.438	0.533	0.328
The Trust's patient reported outcome measures scores for knee replacement surgery	2011/12	0.285	0.302	0.385	0.18
	2012/13	0.403	0.319	0.557	0.115
	2013/14	0.466	0.339	0.683	0.073
	2014/15	0.458	0.328	0.745	0.055
	2015/16	0.48	0.334	0.912	-0.175
	2016/17	0.326	0.320	0.395	0.237

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- Results are monitored and reviewed as part of the quality schedule agreed with local commissioners;
- NA indicates where numbers are so low statistically analysis cannot be performed.
- Data for varicose vein and groin hernia operations will no longer be available.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services by:

- The monitoring of PROMs is undertaken within Information Services as well as within the Clinical Business Unit.

Indicator	Re admission rates The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.				
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL**	**National average**	**Highest score**	**Lowest score**
percentage of patients aged— (i) 0 to 15;	2013/14	11.10%	NA	14.20%	7.80%
	2014/15	10.48%	8.4%	NA	NA
	2015/16	11.7%	NA	NA	NA
	2016/17	10.86%	NA	NA	NA
	2017/18 (To end of Feb 18)	10.39	NA	NA	NA
And (ii) 16 or Over	2013/14	7.51%	7.0%	NA	NA
	2014/15	8.02%	8.0%	NA	NA
	2015/16	7.9%	NA	NA	NA
	2016/17	8.59%	NA	NA	NA
	2017/18 (To end of Feb 18)	9.24%	NA	NA	NA

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

Readmission rates are monitored monthly at Divisional and Board level;
Data is provided from both NHS England and Dr Foster.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services by:

Maintaining high quality outcomes for its patients to reduce the readmissions required;
Working within the health system to ensure discharges are safe and appropriate.

Indicator	The Trust's score with regard to its responsiveness to the personal needs of its patients during the reporting period. This indicator which is based on data from the National Inpatient Survey, forms part of the NHS Outcome Framework		
The data made available to the Trust by the Information Centre with regard to: The overall patient survey score	**Reporting period**	**QEHKL score**	**England**
	2013/14	73.7	76.9
	2014/15	76.4	76.9
	2015/16	77.7	77.3
	2016/17	75.9	76.7
	2017/18	TBC	TBC

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has worked with the inpatient survey provider (Picker) to ensure a random and fair sample of its patients have been questioned.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services by:

- Continuing to focus on recruitment of nursing staff to vacant and new posts to ensure that minimum staffing ratios are achieved across the Trust;
- Monitor staffing levels on a daily basis and support areas under pressure so that patients receive the care that meets their needs;
- Focusing on improving the urgent care pathway;
- Introducing new initiatives to support better communication and improved care for older, vulnerable patients – red trays for personal aids; placemats providing information on the ward area and the 'red bag project' to support better communication with Care Homes;
- Making improvements to the patient environment to support a better patient experience;
- Ensuring a daily presence of the Matron for the area on the wards to monitor the provision of care and to be available for patients and relatives to speak to and raise issues as they arise;
- Providing a process of weekly feedback to clinical areas from FFT process including access to all written comments and highlighting those areas achieving the highest response rates;
- Responding to and following up all comments on NHS Choices, Patient Opinion & Healthwatch.

Indicator	Staff friends and family test				
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL**	**National average**	**Highest score**	**Lowest score**
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	2012/13	58	65	94	24
	2013/14	49	67	93	39
	2014/15	52	67	89	38
	2015/16	76	79	96	58
	2016/17	72	80	98	44
	2017/18 Q2 Snapshot	73	81	100	43

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- Responses to the Trust Staff Friends and Family Test are independently reviewed.

The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Providing regular open discussion sessions with the Chief Executive to provide an opportunity for staff to be provided information on key matters such as the performance of the Trust and to feedback on their thoughts and comments and to ask questions;
- The Executive team have 'buddy' areas that they visit and ensure opportunities to gain feedback from staff and to answer queries.
- Staff behaviour workshops were held to understand from staff expectations regarding behaviours towards them and their experiences. Following the analysis of feedback from the workshops and other surveys including the Staff FFT a new behavioural framework has been developed that will be launched in May 2018.
- Developing and 'growing our own' staff to fill registered and unregistered nursing roles and continuing with successful international nurse recruitment. further cohorts are planned.
- The development and implementation of Life Long Learning Yoga and Pilates classes for staff and promoting other benefits such as the Staff Gym
- Reward and recognition – Monthly Values in Action staff awards, long service awards
- Communication via the 'Friday Round-Up' trust wide staff communication email and the 'Knowledge' weekly magazine to improve communication and ensure that staff are well informed of key issues in the organisation.

Indicator	Patient Friends and Family Test Accident and Emergency				
The data made available to the Trust by NHS England FFT Data Pages	**Reporting period** (annual information not available hence March of each year used as snapshot)	**QEHKL score**	**National average**	**Highest score**	**Lowest score**
The percentage of patients during the reporting period who would recommend the Trust to Friends and Family	March 2014	86	86	99	53
	March 2015	92	87	99	58
	March 2016	90	84	99	49
	March 2017	91	87	100	46
	March 2018	90	NA	NA	NA

The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust follows FFT Guidance;
- The Trust has worked with an external FFT provider to manage the administration of the service and validate data prior to upload to NHS England.

The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of it services by:

- Ensuring feedback is available monthly to all senior staff to cascade to colleagues across the Trust;
- Sharing feedback with patients and the public through ward noticeboards, Trust information screens and additionally to staff through regular Trust wide internal communications methods – The Knowledge and Friday Round Up;
- Reviewing negative feedback, sharing with colleagues and providing an action plan to resolve issues highlighted by patients if appropriate;
- Monitoring feedback following changes to ensure that impact has been positive by reviewing both positive and negative feedback;
- Sharing actions between areas;
- Triangulating FFT feedback with Complaints, PALS, NHS Choices, Twitter, Google Review, national surveys and other forms of feedback and reporting internally and externally to the organisation (to Commissioners) monthly;
- Incorporating aspects of the FFT at all patient experience training for staff from induction through to specific training sessions for different staff groups.

Indicator	Patient Friends and Family Test Inpatients				
The data made available to the Trust by NHS England FFT Data Pages	**Reporting period** (annual information not available hence March of each year used as snapshot)	**QEHKL score**	**National average**	**Highest score**	**Lowest score**
The percentage of patients during the reporting period who would recommend the Trust to Friends and Family	March 2014	86	94	100	75
	March 2015	91	95	100	78
	March 2016	95	96	100	72
	March 2017	96	96	100	82
	March 2018	95	NA	NA	NA

The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust follows FFT Guidance;
- The Trust has worked with an external FFT provider to manage the administration of the service and validate data prior to upload to NHS England.

The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of it services by:

- Ensuring feedback is available monthly to all senior staff to cascade to colleagues across the Trust;
- Sharing feedback with patients and the public through ward noticeboards, Trust information screens and additionally to staff through regular Trust wide internal communications methods – The Knowledge and Friday Round Up;
- Reviewing negative feedback, sharing with colleagues and providing an action plan to resolve issues highlighted by patients if appropriate;
- Monitoring feedback following changes to ensure positive impact has been by reviewing both positive and negative feedback;
- Sharing actions between areas;
- Triangulating FFT feedback with Complaints, PALS, NHS Choices, Twitter, Google Review, national surveys and other forms of feedback and reporting internally and externally to the organisation (to Commissioners) monthly;
- Incorporating aspects of the FFT at all patient experience training for staff from induction through to doctors' mandatory training sessions.

Indicator	Patient safety incidents and the percentage that resulted in severe harm or death.				
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL score**	**National average for small acute Trusts**	**Highest score**	**Lowest score**
The number and rate of patient safety incidents reported within the Trust during the reporting period	**Based on 1000 bed days**				
	April 2015 - Sept 2015	47.93	38.25	74.67	18.07
	Oct 2015 - March 2016	41.76	39.31	75.91	14.77
	April 2016 - Sept 2016	37.90	34.74	71.81	21.15
	Oct 2016 - Sept 2017	35.31	40.14	68.97	23.13
	April 2017 - Sept 2017	*33.59	42.84	111.69	23.47
The % of such patient safety incidents that resulted in severe harm or death during the reporting period	**Based on 1000 bed days**				
	April 2015 - Sept 2015	0	0.1	0.7	0
	Oct 2015 - March 2016	0.3	0.4	1.4	0
	April 2016 - Sept 2016	0.7	0.6	0.9	0
	Oct 2016 - Sept 2017	0.7	0.4	2.1	0
	April 2017 - Sept 2017	0.3	0.4	1.5	0

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has actively promoted an open culture and encouraged the reporting of incidents to ensure lessons are learnt, this has also positively influenced the reporting rate. The QEH will continue to promote a positive reporting culture measured against the national benchmark and align strategies which learn from best practice methods.

Examples of the safety improvements and risk reduction strategies put in place this year include:

- Reorganisation of the Risk and Governance team including recruitment of a new Deputy Director of Patient Safety.
- Commissioned an internal review of Risk Management with positive actions.
- Arrangement and promotion of a Queen Elizabeth Hospital Patient Safety Conference to deliver positive messages and learning from incidents.

Indicator	Patients admitted to hospital who were risk assessed for venous thromboembolism				
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL score**	**National average**	**Highest score**	**Lowest score**
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	2012/13	97.12%	93.87%	100%	80.9%
	2013/14	97.58%	95.77%	100%	79%
	2014/15	97.51%	96%	100%	79%
	2015/16	97.49%	95.53%	100%	78%
	2016/17	97.78%	95.53%	100%	63%
	2017/18	97.05%	Full year data not yet available	Full year data not yet available	Full year data not yet available

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The coding team check that all admitted patients have been risk assessed;
- There was a small loss of data in Jan/Feb 2018 due to the switch from paper to electronic record-keeping in the Ambulatory Emergency Care.
- The data is shared monthly with clinical teams and reviewed and monitored through the specialty governance meetings.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services by:

- Achieving on-going recognition as a Venous Thromboembolism Exemplar Site due to consistent good practice.
- Undertaking a Root Cause Analysis (RCA) on all patients diagnosed with VTE following hospital admission in previous 3 months continues to identify Hospital Associated Thrombosis (HAT). During 2017/18 74 cases were identified as requiring a RCA, of which 6 (8.1%) were not risk assessed. 25 cases (33.8%) were potentially preventable and required completion of section 4 of the RCA. Of these, 22 were not given thromboprophylaxis but in accordance with the Trust guidelines. All cases were fully investigated and action plans monitored. Teaching was carried out when required.
- Use of compression hosiery – All staff providing compression hosiery received training from the hosiery company in accordance with NICE guidelines: 'Patients eligible for compression hosiery must be measured by a trained person'. This is an on-going programme.
- FFT has consistently been 100% that our service would be recommended to family & friends.

Indicator	Clostridium difficile infection rate				
The data made available to the Trust by the Information Centre with regard to:	Reporting period	QEHKL score	National average	Highest score	Lowest score
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	2010/11	23.5	29.7	71.2	0
	2011/12	25.1	22.2	58.2	0
	2012/13	12.5	17.3	31.2	0
	2013/14	28.0	14.7	37	0
	2014/15	28.3	15	62.6	0
	2015/16	27.6	14.9	67.2	0
	2016/17	15.2	13.2	82.7	0
	2017/18	32.4	NA	NA	NA

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The accuracy of data is thoroughly checked by the infection prevention and control team and crossed checked with the laboratory (external assurance) prior to submission.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services by:

- Addressing outbreaks and periods of increased incidence promptly undertaking measure to reduce any further transmission;
- As part of outbreak plan undertaking a multi-agency Trust walk round with feedback to identify and action areas of concern;
- Implemented a robust action plan to implement on going measures to prevent any further transmission;
- Reviewed standards, methods and assurance of cleaning across the Trust;
- Targeted education on areas/wards of high incidence of C difficile;
- Undertaken training on use of sporicidal wipes for use by clinical staff across the Trust;
- A robust audit programme including Hand hygiene, PPE usage, isolation and environmental cleaning;
- Antibiotic stewardship and engagement with wider community.

Indicator	Maximum 6 Week Wait for Diagnostics				
The data made available to the Trust by the Information Centre with regard to:	Reporting period	QEHKL score *	National average	Highest score	Lowest score
Performance against the operational standard of less than 1% of patients waiting six weeks or longer for a Diagnostic Test, from time of Referral.	2012/13	0.30%	1.10%	100.0%	0.0%
	2013/14	0.31%	1.58%	39.0%	0.0%
	2014/15	0.64%	1.54%	34.6%	0.0%
	2015/16	0.34%	1.74%	60.0%	0.0%
	2016/17	0.25%	1.06%	52.3%	0.0%
	2017/18	2.45%	1.60%	100.0%	0.0%

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

DEXA

The deterioration in the Diagnostic waiting times has primarily been driven by the introduction of the DEXA scanning service that was commissioned at the Trust from 1st September 2017. The handover from the original Provider did not highlight a number of issues which were inherent within the service. Since taking the service on, the Trust has been proactively working to resolve these issues. The main reasons for the breaches have been down to service capacity, machine down time and there being no dedicated administrative support for the service.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services by:

DEXA
The Trust has implemented a number of remedial actions to resolve these issues which include now running the service for 3 days a week rather than only 2, and putting in place dedicated administrative support for the service. The Trust therefore expects to have the DEXA backlog cleared and to be achieving the required standard by the end of May 2018.

** All percentages shown above represents the % performance as at the end of each financial year, ie March snapshot performance only. We do not use the full YY/YYs performance, as each month's performance is a snapshot against a WL Total at month end, and not a cumulative total.*

The only exception to this is the National Average, Highest Score and Lowest Score % Totals for 17/18, which are based on Feb 2018 as March 2018 data not yet available.

Part 3 OTHER INFORMATION

NATIONAL, LOCAL AND SYSTEM-WIDE CQUINS

Priority 1

HEALTH & WELL-BEING

Why do we need to improve?

In 2015 Public Health England estimated the cost of sickness absence to the NHS at £2.4bn. Work in the NHS can often be physically, emotionally and psychologically demanding, providing NHS services 24 hours a day, 365 days per year. There is an opportunity for the NHS as an employer to impact positively on staff overall health, well-being and happiness.

Staff retention rates are shown to improve when staff feel their employer cares about their health and wellbeing, which in turn leads to improved team cohesion and better working environments.

The NHS health and well-being review led by Dr Steven Boorman and NICE guidance have outlined the link between staff health and wellbeing and patient care, including improvements in safety, efficiency and patient experience. This is the second year of this improvement programme.

Aim and goal

To improve in three specific areas:

1a Improving support across musculoskeletal, mental health and physical activities
1b Healthy food for NHS staff, visitors and patients
1c Improving uptake of flu vaccinations by frontline healthcare workers

1a Improving support across musculoskeletal, mental health and physical activities

What did we do to improve our performance?

At the start of the project the Trust was already providing a number of health and well-being initiatives for staff including counselling services, staff physiotherapy, staff gym, smoking cessation support, cycle to work scheme and classes including yoga, dance and pilates as part of the Lifelong Learning programme. However, services were provided by different departments and teams and it was difficult for staff to explore the full range because they were not centrally communicated. Promoting the various initiatives was piecemeal.

An intranet portal 'Just For You' was produced as a central resource point for information on staff health and well-being initiatives. This was broadened to include all benefits available to Trust staff. It became apparent to the team that although electronic communication works for many people, others either have no computer access at work or are too busy to access information. To resolve this, a 'poster-trail' was mapped across the Trust site to provide information to all staff in their work places and this is regularly refreshed to promote health and well-being activities with mental health and musculo-skeletal health in particular being targeted.

Due to the refurbishment of the Social Club building several classes stopped in August 2016 so numbers from April '16 do not reflect the true take up. Since opening the Inspire Centre on 12 December 2016 there have been several promotions to re-instate the momentum that the classes had, but a further challenge has been the time change of the classes due to the new contract on the Inspire Centre which meant moving classes from a 5.30 start to a 6pm start.

An extra yoga class was provided for 4 months from May 2017 to August 2017 to support Theatre staff

attending but this was then discontinued following changes to shift patterns.

Our Lifelong Learning flyer now features in the new core induction booklet handed out to new staff on induction day. This combined with the video which plays on induction day does help to get the word out, and we do usually have new attendees following this each month. Staff who have been having physiotherapy at the hospital also enquire about the classes. Information is also included in other teaching sessions and via advertising in the weekly Knowledge.

In addition the following have been arranged:

- Weekly Stress Clinics;
- Mental Health First Aid courses were arranged in conjunction with MIND;
- Workplace Health Assessments now have a health and wellbeing section for new employees.

How we monitored and reported progress

Data has been collected throughout the year on the number of staff participating in each of the initiatives together with staff feedback.

Outcome

Since July 2014 approximately 340 staff have taken part in various physical/social activities implemented through the Lifelong Learning Project, which has led to enormous benefits for staff. There are 110 members of Tone Zone (the hospital gym) and this includes 42 new members.

Lifelong Learning classes continued throughout 2017 and included:

- Body Blitz (high intensity interval training)
- Yoga sessions
- Spanish conversation classes
- Dance classes
- Sewing (providing many health and well-being benefits from a therapeutic perspective)

A campaign was launched to promote classes again after the summer 2017 break and all classes offered a free taster session (funded by Unison).

There have been a few changes with the classes in 2018 due to changing circumstances of instructors. The dance classes finished but as we are always keen to sustain the momentum of health and well-being opportunities, this was soon replaced with Jazzercise, an aerobic workout incorporating modern dance movements. For the introduction of this class we offered a free taster session. It is an extremely popular class and the Trust currently has 20 staff signed up.

The yoga class ceased at the end of 2017 as the instructor opened her own studio. As it was not possible at the time to source another instructor, information was sent out to staff signposting them to other instructors in the area.

Going forward:

Another yoga instructor has now been sourced and is due to start teaching on 6 June 2018. A free taster session is again going to be offered to staff to encourage attendance.

Staff have indicated (through the previous health and well-being survey), and also via verbal requests from staff in general, of their interest in having a Weight Watchers group. This is a new addition for 2018 and is also proving very popular. Sessions have been timed according to staff requests and take place prior to 8.30am.

1b - Healthy food for NHS staff, visitors and patients

Why did we need to improve?

The national drive to reduce obesity and the comorbidities associated with obesity such as diabetes, has focused this element of the CQUIN on improving the diet of members of staff, patients and visitors alike by encouraging healthy eating. The goals laid out in the CQUIN were to:

- Ban the promotion of high fat/ high sugar products;
- Ban the sale of high fat/ high sugar products at the checkout;
- Ban the advertising of high fat/ high sugar products at checkouts;
- Offer more healthy food and drink options.

What did we do to improve our performance?

The Trust has three locations within the hospital in regards to supplying food and refreshments to staff, visitors and patients plus vending throughout the site:

- The Hub – the main restaurant open to all on the first floor and operated by the Trust
- The Costa coffee shop and Amigo shop at the front of the hospital and operated by an external contractor
- The League of Friends shop at the main entrance of the hospital and run by volunteers with this charity-run facility.

All the three locations have continued to comply with the four outcomes for 2016/17 and these have been visually audited on a monthly basis as follows:

- No price promotions on sugary drinks or food high in fat;
- No advertising of sugary drinks or food high in fat;
- No promotion of sugary drinks or food high in fat at point of sale in the till area;
- Ensuring healthy options are available, including at night.

Progress has continued to be made and has been built on the achievements delivered in 206/17 and set out to ensure that:

- 70% of drinks lines stocked must have less than 5 grams of added sugar per 100ml. In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml);
- 60% of confectionery and sweets must not exceed 250 kcal;
- At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available should contain 400kcal (1680 kJ) or less per serving and not exceed 5.0g saturated fat per 100g.

Outcome

It is particularly notable the progress we have made with external partners.

Costa Coffee/Amigo shop - compliant with17/18 and still compliant for all four for 16/17

- All price promotions on sugary drinks and foods high in fat have been stopped.
- Banned all price promotions and offers on any sugary drinks and foods high in fat.
- Removed all unhealthy snacks/crisp etc. from checkout location.
- All hot drinks are made with semi-skimmed milk, no full fat milk on the premises.
- All pre-packed sandwiches have the required calorific value and a variety is less than 400 calories.
- All fizzy drinks are low calorie.
- No upselling at the tills (no offering of cream and marshmallows on hot chocolate etc.).
- All syrups for drinks are reduced sugar syrups.

Meetings with Costa take place on a bi monthly basis and at every meeting the CQUIN objectives are always discussed.

League of Friends shop

- All price promotions on sugary drinks and foods high in fat have been stopped.
- Banned all price promotions and offers on any sugary drinks and foods high in fat.
- Removed all unhealthy snacks/crisp etc. from checkout location.
- Reduced the number of confectionery lines.
- Increased the amount of baked crisp provided and the lower calorie popcorn option.
- All pre-packed sandwiches have the required calorific value and a variety is less than 400 calories.

1c – Improving uptake of flu vaccinations by frontline healthcare workers

What did we do to improve our performance?

There was a Trust-wide programme led by the Occupational Health Department to promote frontline healthcare worker uptake of the flu vaccine. The Occupational Health Department provided vaccine clinics during weekdays, weekends, evenings and early mornings in the Occupational Health Department and a number of peer vaccinators were identified across the organisation to enable frontline staff to access vaccination without leaving the clinical area.

The Trust's Communications team supported the campaign with regular updates about vaccine clinics and availability of work place vaccination.

How we monitored and reported progress

The Occupational Health Department monitored staff uptake on a weekly basis and were supported by Information Services and the Project Management Team. Two sets of statistics were monitored and reported:

ImmForm, is the system used by the Department of Health, the NHS and Public Health England to record data in relation to uptake against immunisation programmes and incidence of flu-like illness. Statistics are uploaded onto the system monthly throughout the campaign by Occupational Health, as in previous years.

CQUIN data. This was new for 2016/17, and our local indicator excluded bank staff and staff unavailable to be vaccinated because of either being inactive and not working, or long-term absent.

Outcome

Compliance with the programme this year ensured that the target of >75% was met at an earlier stage and in February 2018 the percentage of staff vaccinated was as follows:

Year	2016/17 CQUIN	2017/18 CQUIN
Percentage of front-line healthcare workers vaccinated for influenza	81%	78.6%

This comprised the following breakdown of frontline staff:

Staff Group	Medical	Nursing	AHPs	Support
No. of staff vaccinated	303	770	235	709

Priority 2

SEPSIS SCREENING

Why do we need to improve?

Sepsis is a common and potentially life-threatening condition in which the body's immune system goes into overdrive in response to an infection, setting off a series of reactions that can lead to widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean the blood supply to vital organs such as the brain, heart and kidneys is reduced – potentially leading to death or long-term disability. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 32,000 deaths in England attributed to Sepsis annually. It is estimated that out of this overall figure some 11,000 deaths could be prevented.

Aim and Goal

The aim is to incentivise providers to screen for sepsis in all those patients for whom this is appropriate and rapidly initiate intravenous antibiotics within one hour of presentation for patients who have suspected severe sepsis, Red Flag Sepsis or septic shock. This CQUIN covered both Emergency Department and Inpatient settings.

What did we do to improve performance?

Posters have been produced on a quarterly basis to demonstrate the up to date results of the CQUIN analysis and to remind providers of the importance of the 'sepsis six'. These have been displayed in all emergency areas in the hospital.

The sepsis Concise Care Bundle (CCB) has been made available electronically as a care plan on EDIS for use in the Emergency Department.

How we monitored and reported progress

The CQUIN for sepsis was reviewed and reported in two parts:

Part 2a:
Timely identification and treatment for Sepsis in the Emergency Departments Screening

(An audit of a random sample of 50 sets of patient records coded for sepsis per month)

The audit looked to determine the total number of patients presenting to the Emergency department and other units that directly admit emergencies who met the criteria of the local protocol and were screened for sepsis.

The Emergency Department screening element of the CQUIN requires an established local protocol that defines which emergency patients require sepsis screening.

Initiation of treatment and day 3 review

(An audit of a random sample of 30 sets of patient records coded for sepsis per month)
The number of patients sampled for case note review who:

- present to ED and other wards/units that directly admit emergencies with Red Flag Sepsis or Septic Shock for whom a decision to treat with intravenous antibiotics is made, and these are administered, both within 1 hour of presenting and;
- an empiric antibiotics review is carried out by a competent decision-maker by day 3 of the antibiotics being prescribed.

Part 2b:
Timely identification and treatment for Sepsis in acute inpatient settings screening

(An audit of a random sample of up to 50 sets of patient records coded for sepsis per month)

Total number of patients sampled for case note review who were admitted to the provider's acute inpatient services that met the criteria of the local protocol and were screened for sepsis.

The inpatient screening element of the CQUIN requires an established local protocol that defines which inpatients require sepsis screening.

Initiation of treatment and day 3 review

(An audit of a random sample of up to 30 sets of patient records per month)

The total number of patients sampled for case note review:

a. Where a patient is newly admitted, for whom in the course of their admission a decision to treat with intravenous antibiotics is made by a competent decision-maker, and these are administered, both within 60 minutes of the possibility that the patient has Red Flag Sepsis or Septic Shock being identified.
b. Where a patient is an existing inpatient, for whom a decision to treat with intravenous antibiotics, or to change the type of antibiotics previously prescribed, is made by a competent decision-maker, and these are administered, both within 60 minutes of the possibility that the patient has Red Flag Sepsis or Septic Shock being identified.

AND (for both of the above categories):

- an empiric antibiotics review is carried out by a competent decision-maker by day 3 of them being prescribed.

The quarterly data totals were then submitted to the commissioners via UNIFY.

Outcome

2a. Throughout 2017/18, 50 patient records were reviewed on a monthly basis for 2a (i) and up to 30 patient records were reviewed on a monthly basis for 2a (ii). The results are as follows:

a.i)

Quarter	% of patients who met the local criteria and were screened for sepsis (Emergency Patients)	
	Target	Actual
1	90%	98%
2	90%	100%
3	90%	100%
4	90%	100%

a.ii)

Quarter	% of patients who met the local criteria and were screened for sepsis (Acute inpatients)	
	Target	Actual
1	90%	90%
2	90%	87%
3	90%	91%
4	90%	85%

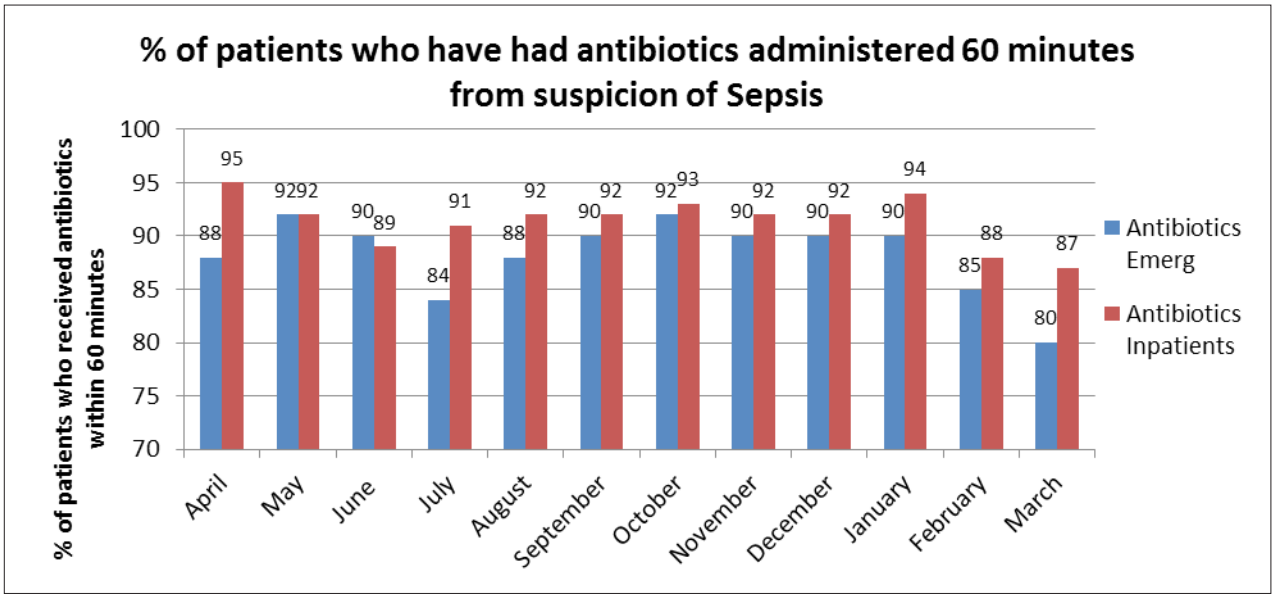
2b. Throughout 2017/18, up to 50 patient records were reviewed on a monthly basis for 2b (i) and up to 30 patient records were reviewed on a monthly basis for 2b (ii). The results are as follows:

b.i)

Quarter	% of patients where antibiotics clearly recorded as GIVEN within 60 minutes of arrival and empiric antibiotics review within 3 days (Emergency patients)	
	Target	Actual
1	90%	90%
2	90%	87%
3	90%	91%
4	90%	85%

b.ii)

Quarter	% of patients where antibiotics clearly recorded as GIVEN within 60 minutes of arrival and empiric antibiotics review within 3 days (Acute Inpatients)	
	Target	Actual
1	90%	92%
2	90%	92%
3	90%	92%
4	90%	90%



There has been an increase in Trust-wide education and audit presentations raising awareness of Sepsis 6. This has been delivered in key areas such as Emergency Department and Trust-wide via mandatory training from the Critical Care Outreach team. The Nurse Consultant for Critical Care has also undertaken teaching sessions presenting the audit results of patients admitted with sepsis into Critical Care to help raise awareness.

The Outreach team have been involved in collecting data for the inpatient audits and can prescribe first line antibiotics with a new patient group direction (PGD) acting as front line advocates for this group of patients.

Posters have been produced on a quarterly basis by the Audit team to demonstrate the up to date results of the CQUIN and raise awareness for staff.

Concise Sepsis care bundles are available via the electronic EDIS system in the Emergency Department and sticker format throughout the rest of the Trust. To date the Trust has achieved the sepsis, antibiotic stewardship and national CQUIN targets for both inpatient and the Emergency department consistently throughout the year.

Priority 3

IMPROVING SERVICES FOR PEOPLE WITH MENTAL HEALTH NEEDS WHO PRESENT TO A&E

Why do we need to improve?

People with mental health are three times more likely to present to A&E than the general population. More than 1 million presentations are currently recorded as being directly related to mental health. People with known mental ill health are five times more likely to be admitted to acute hospitals and 80% of these emergency admissions are recorded as being primarily for physical reasons. This highlights the need for acute hospitals to be equipped to detect and treat urgent mental health needs that are cited as the primary reason for presentation as well as improving identification of underlying mental health conditions where the primary presenting reason may be a physical health one.

The QualityWatch study also found that people with mental health had 3.6 times more potentially preventable emergency admissions that those without mental ill health in 2013/14 and that 'the high levels of emergency care use by people with mental health indicate that they are not having their care well managed and suggest that there are opportunities for planned care (inside and outside of the hospital) to do more. These people are well known to the healthcare system and are having many health encounters'.
[1]http://www.qualitywatch.org.uk/sites/files/qualitywatch/field/field_document/QualityWatch_Mental_ill_health_and_hospital_use_summary.pdf

Half of A&E attendees present with at least one long term condition (LTC) (Blunt, 2014)[2] while a House of Commons Health Committee (2014) reports the figure to be even higher at 68%. At least 30% of people with LTCs present with co-morbid mental health problems leading to poorer health outcomes (Cimpean and Drake, 2011)[3]. Although psychological factors are likely to be exacerbating symptoms and attendance patterns this cohort are rarely referred to psychological/mental health services because the reason for presentation is usually to meet medical needs (Blunt 2014).
[2]Blunt, I. (2014) Focus on A&E attendances. Nuffield Trust. http://www.nuffieldtrust.org.uk/research/focus-on-a-e-attendances
[3]Cimpean, D. and Drake, R. (2011) Treating co-morbid medical conditions and anxiety/depression. Epidemiology Psychiatric Sciences 2011;20 (2) 141-50

Acute services generally struggle to identify and manage the needs of individuals with medically unexplained symptoms. The clinical complexity of these individuals often makes medical decision making extremely challenging. A lack of medical diagnosis and clarity in these instances can lead to unnecessary tests, procedures and lengthy admissions detrimentally impacting upon patient flow. Identifying these patients, providing specialist assessment and then co-ordinating appropriate care across all agencies involved is anticipated to reduce unnecessary attendances in this cohort.

Aim and goals

The CQUIN has been designed to encourage collaboration between providers across the care pathway – both acute and mental health providers. It is anticipated that there will be increased collaborative working across care providers (primary care, police, ambulance, substance misuse, social care and voluntary sector).

The aim is to provide a cohort of patients, who have been identified as regularly attending the A and E department, with an individually tailored care plan. These plans will ensure that the necessary social, medical and psychological support and interventions are provided in a well-co-ordinated manner, which in turn will reduce unnecessary attendances to the Emergency Department.

A baseline has been taken in the first quarter of the year and the aim for end of year 1 is to have reduced attendances by the identified cohort by 20%. Year 1 (17/18) will focus on improving the understanding of the complex needs of the cohort of patients and also on improving the quality of the coding of primary and secondary mental health needs in A and E.

Year 2 will seek to maintain the 20% reduction achieved in 17/18. The aim to reduce overall mental health attendances to A&E by 10% has been removed. Instead there is now an aim to identify a new cohort of frequent attenders who could benefit from psychosocial interventions (NHS England April 2018). This cohort will include at least 25-30 people, it need not be the most frequent attenders to A&E and will focus on groups of people who experience particular inequalities in accessing services (Annex A CQUIN Indicator Specification 2017/18-2018/19)

What did we do to improve our performance?

Performance was improved through a number of strategies. This included:

- Monthly identification of the relevant cohort of patients via the EDIS system
- Regular liaison with partner organisations
- Development of multi-agency care plans. This work was predominantly led by the Clinical Health Psychology Department and was patient focused and patient inclusive
- Improved coding of patients via the EDIS upgrade
- Regular review against target for the group of cohort patients

How we monitored and reported progress

Progress has been monitored on a quarterly basis and has been reported via the CQUIN system.

Outcome

CQUIN Performance for 17/18 shows that there has been a 48% reduction in attendance for the identified cohort of patients.

Priority 4

ADVICE AND GUIDANCE

Why do we need to improve?

The demand for outpatient appointments keeps growing. Advice and Guidance from a consultant to a GP may help to prevent a patient having to attend the hospital. Advice and guidance is where a GP asks a consultant specialist a question regarding a patient through e-Referral. If the consultant believes the patient still needs to be seen the advice request can be converted to a referral.

Advice and Guidance may include:

- Virtual review of test results (ECG, blood tests) and advice on next steps required.
- Supply of a suggested treatment or management plan to the GP (which may include carrying out further investigations in Primary Care).
- Direct booking of diagnostic tests (e.g. Endoscopy).
- Advice on the appropriate clinic referral (reducing re-directed appointments).

Aim and goals

Prevent unnecessary hospital attendances and provide the patient with timely, appropriate care.

What did we do to improve our performance?

The CQUIN standard was to ensure that Advice and Guidance services were operational for specialties covering at least 35% of total GP referrals.

How we monitored and reported progress

Requests for advice and guidance are actioned daily. An email is sent to the owning clinician to request

input. If a response is not received within 24 hours a reminder is sent. Responses are recorded in e-Referral. A spreadsheet has been maintained of all requests received and responses provided. A quarterly update is provided to the Clinical Commissioning Group.

Outcome

We provided advice and guidance for all specialties. There have been challenges in turning around our responses within 48 hours, especially in those specialties where the Trust relies on a visiting consultant.

Priority 5

NHS E-REFERRAL

Why do we need to improve?

National requirement for all providers to publish all first outpatient appointment slots available on NHS e-Referral Service (e-RS) by 31st March 2018.

Aim and goals

All services first outpatient appointments for consultant-led services to be published on e-RS.

What did we do to improve our performance?

The Trust published more of its services in e-RS. Introduced a referral assessment service (RAS) for some specialties so that referrals can be reviewed before being accepted.
How we monitored and reported progress

All referrals are received by our referral booking team (RBT). Any referral not received via e-RS has been advised to commissioners for feedback to the relevant GP practice.

Outcome

All new GP referrals for consultant-led care (with the exception of exclusions e.g. those referrals where treatment is within 24 hours) are booked in e-RS.

Priority 6

PROACTIVE AND SAFE DISCHARGE

Why do we need to improve?

There is considerable evidence for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has a serious impact across health and care systems, reducing the ability of emergency departments to respond to people's needs, and increasing costs to local health economies.

Unnecessary delay in discharging older patients from hospital is a systemic problem with a rising trend - between 2013 and 2015 recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million bed days . For older people in particular, we know that longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs.

Local A&E Delivery Boards were asked in 2016/17 to implement key initiatives to address some of the major underlying issues causing delayed discharges. This CQUIN builds upon the 2016/17 A&E Plan and focuses on discharge-specific activity to support systems to streamline discharge pathways, embed and strengthen the discharge to assess* pathway to maximum effect, and to understand capacity within community services to

support improved discharge.

This is a two year CQUIN that works across local health economies that aims to improve discharge for patients across all wards within hospitals.

***Definition of discharge to assess:**

This refers to where people who are clinically optimised and do not require an acute hospital bed, but may still require care services, are provided with short term, funded support to be discharged to their own home (where possible) or another community setting. This is where assessment for longer -term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. Commonly used terms for this are: 'discharge to assess', 'home first', 'safely home', 'step down'[2].

[1] National Audit Office, (2016) Discharging Older Patients from Hospital
[2] Quick Guide: Discharge to assess www.nhs.uk/quickguide

Aim and goals

The desired outcomes will be an improvement in patient outcomes, an improvement in patient flow and a reduction in delayed discharges (and thus reduction in associated costs).

Year 1 17/18

Part a	Actions to map existing discharge pathways, roll-out new protocols, collect baseline/ trajectories
Part b	Emergency Care Data Set (ECDS) *(Type 1 or 2 A&E providers to have demonstrable and credible planning by the end of Quarter 1, in order to commence timely submission of data from 1st October 2017).*
Part c	Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17). Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rates.

Year 2 18/19

Part a	Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 7.5% points from 2017/18. Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate.
Part b	Completion and timely submission of data by provider in line with the collection requirements. See milestone section for detail of the requirements.

What did we do to improve our performance?

Part a
The Trust worked jointly with Norfolk Community Health & Care Trust and West Norfolk Clinical Commissioning Group to review existing pathways. For example:-

- Access to virtual Ward
- Acute ICC Role – Discharge Support
- Discharge Planning
- RAT (Rapid Access)

- NFS (Norfolk First Support Assessment & Reablement Service)
- Community Beds Referral
- Wheelchair Service
- Intermediate Care Beds

In addition to reviewing the above pathways, the team also attended a number or workshops to map out the pathway for 'unplanned admissions'. The team were jointly responsible for rolling out any new / improved pathways.

The Baseline data for year 1 was set using the data from Q3 and Q4 2016/17. The target for year 1 was to achieve either a 2.5% point increase on that baseline or to reach 47.5% for Q3 and Q4 2017/18 for discharges to usual place of residence.

Analysis of this data has been on-going and has been shared with the relevant personnel, both internally and externally, with regards to all discharges of patients over the age of 65+ so that appropriate steps can be put in place to ensure that patients are discharged in a timely manner to their usual place of residence, where medically appropriate to do so.

The baseline for Q3 / Q4 2016/17 is 45.49% and therefore our Target for year 1 = 47.5%

Although this was only introduced as a CQUIN in April 2017, the discharging of appropriate, medically fit patients has always been a priority for the Trust. Unfortunately due to the local demographic of an ageing population and the high acuity of our patients this remains a very challenging process for the Trust.

The Trust continues to work closely with the Commissioners and with Community Services to ensure patients are discharged in a timely manner to an appropriate destination.

Part b
The Trust had two upgrades planned to the Emergency Department EDIS system to facilitate the final software change which would have supported the required collection of data from 1st October 2017. Our supplier, DCX had given assurance that the software would be available in September 2017.

The Trust provided the Commissioners with a report/email regarding the delays to implementation of the ECDS and requested this deliverable be moved to Q4. However, ECDS was not in place in the required timeframe and the Trust failed to achieve the Q3 deliverable.

Part c
Unfortunately the performance during Q3 and Q4 17/18 has not shown the required improved against the baseline and therefore this element of the CQUIN has not been achieved. The performance within this CQUIN has remained very consistent throughout the year. The Trust has raised its concerns with NHS England/ NHS Improvement regarding whether this was actually an appropriate CQUIN for trusts and whether the goals were realistic. The achievement of these targets required collaboration between acute and community providers.

The CQUIN has been removed for 2018/19 by NHS England.

How we monitored and reported progress

All elements of the CQUIN were reviewed and monitored monthly and quarterly in the form of information sharing of actual discharge performance data and meetings with all parties, both internal and external.

Quarterly reports were submitted to the Commissioners for assessment as part of the CQUIN process.

Outcome

The Trust achieved the requirements for both Q1 and Q2 but due to the delay in the implementation of the ECDS, Q3 was not achieved and resulted in a loss of income of approximately £18k.

Although the performance in Q3 and Q4 17/18 did not reach the desired targets, the final outcome of this quarter is still to be determined by the Commissioners and NHS England but could result in a loss of income of approximately £139k.

Priority 7

STP (SUSTAINABILITY AND TRANSFORMATION PLANS)

Why do we need to improve?

The NHS as a whole is stretched financially and is continually trying to implement better ways of working to improve patient care and stream line processes to ensure value for money. Local health economies have been encouraged to prioritise engagement between Providers and Commissioners to work together to achieve financial balance across the whole health economy by developing Sustainability and Transformation Plans.

Effective organisations cannot implement the Five Year Forward View and deliver the required productivity savings and care redesign in silos. Only through a system-wide set of innovations will the NHS be sure of being able to deliver the right care, in the right place, with optimal value.

Each STP becomes the route map for how the local NHS and its partners convert the Five Year Forward View into reality, within the Spending Review envelope. It provides the basis for operational planning and contracting.

This has meant developing new relationships with patients and communities, looking at the totality of health and care when identifying solutions, using social care and wider services to support improved productivity and quality as well as improving people's wellbeing.

Aim and goals

The Board of Directors was required to approve the plan agreed through STP governance to contribute to STP transformation initiatives and demonstrate to the STP governance, arrangements how it is supporting and engaging in the local STP initiatives. This included Memorandums of Understanding, Governance structures to demonstrate engagement with key stakeholders, patients and the public.

What did we do to improve our performance?

The Trust has been fully engaged with the Sustainability and Transformation Partnership as required by the CQUIN. This has involved representing the hospital and our patients at many events, both clinical and non-clinical to help set the future direction of health care services across Norfolk. The Trust is leading on a number of work streams such as Estates and procurement and has played an active role in all other areas. The Trust has been actively involved, participated in decision-making, demonstrated delivery of Provider specific actions aligned and worked collaboratively with other organisations towards the aims and objectives of the STP.

How we monitored and reported progress

The Trust was required to provide evidence of engagement with the Norfolk and Waveney STP, patients and the public in the form of minutes or other confirmation of regular attendance and participation at the STP Executive Board, the STP Programme/Delivery Board and other relevant meetings.

Outcome

This engagement has been recognised by the CCG and wider STP and has awarded full achievement for this CQUIN.

CQUINS - SPECIALIST CONTRACT

Priority 8

MEDICINES OPTIMISATION

Why do we need to improve?

Optimising the use and management of medicines is a significant and realisable opportunity for the NHS. The Carter Review highlighted that unwarranted variation in use and management of medicines costs the NHS at least £0.8billion per year that could be re-invested to support sustainable service delivery. This CQUIN was designed to support Trusts and commissioners to realise this benefit through a series of modules that improve productivity and performance related to medicines. The expectation being that the targets and metrics will unify hospital pharmacy transformation programme (HPTP) plans and commissioning intentions to determine national best practice and effective remedial interventions.

Aim and goals

This CQUIN scheme aims to support the procedural and cultural changes required fully to optimize use of medicines commissioned by specialized services. The following priority areas for implementation have been identified nationally by clinical leaders, commissioners, Trusts, the Carter Review and the National Audit Office, namely:

- Faster adoption of best value medicines with a particular focus on the uptake of best value generics, biologics and CMU frameworks as they become available;
- Significantly improved drugs data quality to include dm+d code and all other mandatory fields in the drugs MDS and outcome registries such as SACT, as well as to meet the requirements of the ePharmacy and Define agendas;
- The consistent application of lowest cost dispensing channels.

What did we do to improve our performance?

- All relevant drugs were identified in advance of the availability of generics or biosimilars to ensure that switches could be made within the required timescale.
- Dm+d software was procured and installed for JAC; MDS submissions to NHSE were reviewed to achieve required standards for data submissions; the IVIG database (Intravenous Immunoglobulin) was reviewed and data added within required timescales; SACT data (Systemic Anti-Cancer Therapy) were reviewed and compared to NHSE-invoiced details to achieve compliance.
- Where appropriate for safe patient care, supply of medicines via homecare has been used to achieve VAT-efficient supply; the viability of creating a wholly-owned subsidiary is being considered.

How we monitored and reported progress

All required parameters were monitored via JAC (pharmacy stock control system), IVIG and SACT databases and reported as required by NHSE quarterly.

Outcome

Q1: 100% achievement
Q2: 100% achievement
Q3: 100% achievement
Q4: awaiting submission and feedback from NHSE

Priority 9

DENTAL DASHBOARD

Why do we need to improve?

A Dental Quality Dashboard has been developed nationally in order to capture information to facilitate planning for the new dental pathways. Submission of the dashboard will lead to increased intelligence about activity at a local, regional and national level to support pathway development in line with NHS England's published Commissioning Guides for Commissioning Dental Services.

What did we do to improve performance?

All required information was identified and the data recorded on a monthly basis for the dental specialties provided within the Trust.

How we monitored and reported on progress

All the information on the specified activity was captured on a Quality Dashboard and submitted on a quarterly basis to the Clinical Commissioning Group.

Outcome

The Trust was fully compliant with populating the Dental Quality Dashboard for 2017/18.

Priority 10

BREAST SCREENING

Why do we need to improve?

This local CQUIN was developed to ensure the sustainability of the breast cancer screening programme across Norfolk through the development of a clinical network between the three acute trusts (The Queen Elizabeth Hospital, James Paget University Hospital and the Norfolk and Norwich University Hospital) and to aid business continuity and service development.

Aims and Goals

- Updated Terms of Reference to be agreed by all 3 Trusts;
- Interval cancer review group for bi-annual review of interval cancers;
- Evidence that the third interval cancer review group has been conducted demonstrating outcome of actions;
- Evidence of network wide training plan;
- Evidence of continued network meetings;
- Enabling consistent achievement of key performance indicators and quality and performance standards in breast screening.

What did we do to improve performance?

- James Paget University Hospital to lead, named individual agreed;
- Interval cancer review group for bi-annual review of interval cancers, first 2 have been held and attended by all 3 trusts;
- Agreed plans from the three trusts were submitted for the development of a clinical network and this included the new terms of reference;
- Quarterly meetings of the 3 trusts;
- Three trusts agreed network objectives and action plan submitted;

- Training plan developed and submitted.

How we monitored and reported progress?

All three trusts have met up on a regular basis to agree aims and objectives and to determine progress.

Outcome

The Trust has participated fully in the development of the network and has met all the requirements of the CQUIN.

Priority 11

ARMED FORCES

Why do we need to improve?

The Armed Forces Covenant is now included within the NHS Constitution. The Trust Board Armed Forces Champion plays a pivotal role in ensuring the Armed Forces Covenant is applied in clinical practice and across all access pathways. The principle of no disadvantage is understood and upheld in terms of clinical need.

Extract of The Armed Forces Covenant, 'Today and Tomorrow':

The Armed Forces Community should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area they live. They should retain their relative position on any NHS waiting list, if moved around the UK due to the service person being posted.

Veterans receive their healthcare from the NHS, and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need. Those injured in the Service, whether physically or mentally, should be cared for in a way which reflects the Nation's moral obligation to them whilst respecting the individual's wishes. For those with concerns about their mental health, where symptoms may not present for some time after leaving Service, they should be able to access services with health professionals who have an understanding of the Armed Forces culture.

What did we do to improve performance?

The Queen Elizabeth Hospital in conjunction with both the Norfolk and Norwich University Hospitals NHS Foundation Trust and the James Paget University Hospital NHS Foundation Trust collaborated in producing a patient access policy for Norfolk. Provision is made for the armed forces to ensure personnel are not disadvantaged when moving between areas as part of their military commitment.

A Trust awareness communication was sent out on Remembrance Day for the second consecutive year, to remind all of our staff of our obligations within a healthcare setting of caring for military personnel past and present.

The Trust has joined the programme Step into Health which aims to offer current and former military personnel the opportunity to embark on a second fulfilling career for the benefit of others, in working within hospital.

Outcome

Further training and communications are planned to ensure that we keep our obligations to military personnel at the forefront of our care commitments.

2017/18/19 - COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

National & Regional CQUINs 2017/19 (ACUTE CONTRACT)

Goal No.	Description of Goal	Indicator Name	National or Regional Indicator	Indicator Weighing of contract Total value 2.5	
				17/18	18/19
1a	Improvement of Health and Wellbeing of NHS Staff	Improving staff health & well-being	National	0.25	0.3
1b	Healthy Food for NHS Staff, Visitors and Patients				
1c	Improving the Uptake of Flu Vaccinations for Front Line Staff within Providers				
2a	Timely Identification of Sepsis in Emergency Departments and Acute Inpatient settings	Reducing the impact of Serious Infections (Antimicrobial Resistance & Sepsis)	National	0.25	0.3
2b	Timely Treatment for Sepsis in Emergency Departments and Acute Inpatient settings				
2c	Antibiotic Review				
2d	Reduction in Antibiotic Consumption per 1,000 Admissions				
4	Year 1: • Reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who could benefit from mental health & psychosocial interventions. Year 2: • Sustain reduction in year 1 • Reduce total number of attendances to A&E in Q4 by 10% for all people with primary mental health needs	Improving services for people with Mental Health needs who present in A&E	National	0.25	0.3
6	Offering Advice & Guidance (75% of GP referrals are made to elective outpatient specialties which provide access to A&G services by Q4 18/19)	Advice & Guidance	National	0.25	0.3
7	GP referrals to consultant led 1st o/p services only. All providers to publish ALL such services and make ALL their First O/P apt slots available on NHS e-Referral Service by 31st March 2018	YEAR 1 ONLY NHS e-Referrals	National	0.25	N/A

8	Overall aim is to increase the proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission for patients aged 65+.	Supporting proactive & Safe Discharge REMOVED Y2	National	0.25	N/A
9	Reinforcing the critical role Providers have in developing and implementing local STPs	Sustainability & Transformation Plans	National	0.5	1.0
10	If a provider delivers its agreed organisational control total in 2016/17, the CQUIN will be paid at the beginning of 2017/18 to the provider, who will be required to hold it as a reserve until release for investment is authorised (see below). If the provider's agreed 2016/17 control total is not achieved, the 0.5% risk reserve will be held by its commissioners until release is authorised.	Risk Reserve REMOVED Y2	National	0.5	N/A
9a	Tobacco Screening - % unique patients screened	YEAR 2 ONLY Preventing ill health by risky behaviours – Alcohol & Tobacco	National	N/A	0.3
9b	Tobacco brief advice - % of unique patients given brief advice				
9c	Tobacco referral and medication offer - % of unique patients who are smokers and offered referral to stop service and medication				
9d	Alcohol Screening - % of unique patients who are screened for drinking risk levels				
9e	Alcohol brief advice - % of unique patients who drink alcohol above lower-risk levels and given advice or referral				
				2.5	**2.5**

National & Regional CQUINs 2017/19
(SPECIALIST CONTRACT – including Public Health and Armed Forces)

Goal No.	Description of Goal	Indicator name	National or Regional Indicator	Indicator Weighting of contract Total value
1	The expectation is that the targets and metrics will unify hospital pharmacy transformation programme (HPTP) plans and commissioning intentions to determine national best practice and effective remedial interventions	Hospital Pharmacy Transformation and Medicines Optimisation	Regional	2.0
				2%
1	Submission of fully populated Dental Quality Dashboard Quarterly	Dental quality Dashboard	Regional	1.93
2	Breast Cancer Screening – Clinical Network for: NNUH / JPH & QEH	Breast Screening	Regional	0.57
				2.5%
1	Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community	Armed Forces Health	Regional	2.5
				2.5%

TRUST PERFORMANCE AGAINST THE 2017/18 RISK ASSESSMENT FRAMEWORK

Description	Target	Performance	Achieved Y/N
18 weeks (admitted / non-admitted)			
Admitted	90.0%	76.41%	No longer national target
Non-admitted	95.0%	85.75%	No longer national target
Incomplete pathways	92.0%	86.57%	N
Cancer			
2ww	93.0%	96.70%	Y
Breast symptoms 2ww	93.0%	97.97%	Y
31 day – Diagnosis to first treatment	96.0%	98.67%	Y
Subsequent treatments (31 day) – Drug treatments	98.0%	99.58%	Y
Subsequent treatments (31 day) - Surgery	94.0%	95.91%	Y
62 day – Waits for first treatment (urgent GP referral)	85.0%	83.23%	N
62 day – Waits for first treatment (NHS Cancer Screening referral)	90.0%	98.51%	Y
A&E			
Patients seen in < 4 hrs	95%	85.52%	N
Clostridium Difficile			
Total number of cases YTD	52	48	Y
VTE			
	97.24%	97.05%	
SHMI			
	<1	0.9797	
Risk of or actual failure to deliver commissioner requested service – Homebirth service is now re-instated			

Annex 1 – Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Norfolk Health Overview and Scrutiny Committee

The Norfolk Health Overview and Scrutiny Committee has decided not to comment on any of the Norfolk provider Trusts' Quality Accounts and would like to stress that this should in no way be taken as a negative comment. The Committee has taken the view that it is appropriate for Healthwatch Norfolk to consider the Quality Accounts and comment accordingly.

Healthwatch Norfolk

West Norfolk Clinical Commissioning Group

The Trust's Governors have been invited to review the draft Quality Report for 2016/17:

Annex 2 – Statement of Directors' responsibilities for the quality report

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

Guidance has been issued to NHS Foundation Board of Directors on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Board of Directors should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18;
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2017 to March 2018
  - Papers relating to Quality reported to the Board over the period April 2017 to March 2018
  - feedback from commissioners dated xxxx
  - feedback from Norfolk Health Overview and Scrutiny Committee dated 14 May 2018
  - feedback from governors dated xxxx
  - feedback from local Healthwatch organisations dated xxxx
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 07.06.2017
  - national inpatient patient survey 31/05/2017
  - national staff survey 06/03/18
  - the head of internal audit's annual opinion over the Trust's control environment dated 02/2018
  - CQC quality update monthly
- The quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information in the quality report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

Edward Libbey - Trust Chair
Date: 22/5/2018

Jon Green – Chief Executive
Date: 22/5/2018

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Financial Report

2017/18

Contents

Foreword to the Accounts

THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATION TRUST

These accounts for the year ended 31 March 2018, have been prepared by the Board of Directors of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 to the National Health Service Act 2006.

Jon Green – Chief Executive
Date: 22/5/2018

Independent auditor's report

to the Council of Governors of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

. REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income and Expenditure, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and Trust's income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview	
Materiality: Trust financial statements as a whole	£1.9m (2016-17:£1.7m) 1% (2016-17: 1%) of total operating income

Risks of material misstatement		vs 2016-17
Recurring risks	Going Concern	◄►
	Valuation of land and buildings	◄►
	Recognition of NHS and non-NHS income	◄►

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows (unchanged from 2016-17):

All of these key audit matters relate to the Trust.

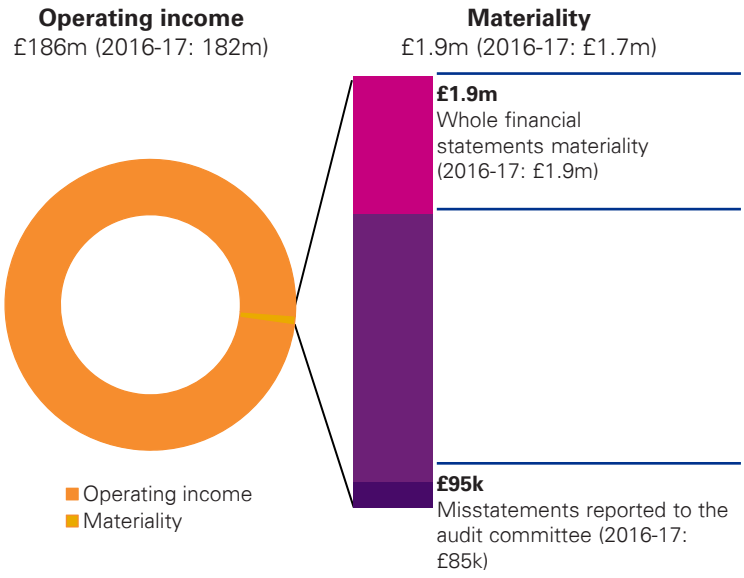
	The risk	Our response
Going Concern *Refer to page 191 (accounting policy)*	**Going concern and financial resilience** The Trust is reliant on ongoing support from the Department of Health to sustain its financial position and continue to be able to provide health care provision. Under guidance from the Department of Health the Financial accounts should continue to be prepared on a Going Concern basis as long as the Trust has a licence to provide services and does not expect this to be withdrawn or intend to apply to revoke that licence	**Our procedures included:** — **Financial plans:** We obtained the Trust's financial plans submitted to NHSi for 2018/19 and 2019/20 and we reviewed correspondence with NHSi in relation to the financial plans. — **Future income and support**: We obtained copies of signed contracts from the Trusts largest commissioners for 2018-20 and agreed these to the financial plans. We considered recent correspondence with NHSi to understand the agreed process for approval of future funding and borrowing requirements. — **Presentation:** we reviewed the disclosures in the financial statements to ensure they were appropriate
Land and buildings (£68 million; 2016-17: £71 million) *Refer to pages 17 to 18 (accounting policy) and page 31 (financial disclosures).*	**Subjective valuation:** Land and buildings are required to be held at fair value. The Trust's main land and buildings relate to a hospital built at Gayton Road, King's Lynn. As hospital buildings are specialised assets and there is not an active market for them they are valued on the basis of the cost to replace them with an equivalent asset. The appropriate valuation of land and buildings relies on: the expertise of the valuer and the accuracy of the records provided to the valuer to prepare the valuation; There is a risk that land and buildings values are materially misstated, therefore our work focused on whether the basis of valuation as at 31 March 2018 was appropriate.	Our procedures included: — **Sector experience:** We reviewed management's methodology for assessing whether land and buildings assets on the fixed asset register require impairment as a result of loss of value in use or deterioration in condition. — **Review of the Trust's valuer:** We assessed the scope, qualifications and experience of the valuer and the overall methodology of the valuation performed to identify whether the approach was in line with industry practice and the valuer was appropriately experienced and qualified to undertake the valuation ; — **Benchmarking assumptions:** We compared the Trust's assumptions to externally derived data by comparing to other available indices to determine whether they are indicative of local market conditions; — **Asset records:** We will review the valuation of any additions to land and buildings made during the year to ensure they have been appropriately revalued to fair value and that an appropriate valuation basis has been applied.

	The risk	Our response
NHS and non- NHS income Income: £186 million (£182 million; 2016/17) *Refer to pages x to x (accounting policy) and page x (financial disclosures).*	**Recognition of NHS and non-NHS income:** The Trust earned £186 million of operating income in 2017/18, of which £168 million was patient income from NHS bodies. The two largest sources are NHS England (£15 million) and Clinical Commissioning Groups (£151 million). There is a risk providers recognise income to which they are not entitled and that cannot be supported by actual activity levels undertaken during the year. Insufficient provision may be made for potential fines levied by commissioners, especially where agreement has not been reached during the year Included in the £186 million of operating income is £18 million of other operating income (income earned from activities other than delivering patient care). The largest items for the Trust are education and training (£6 million) and non-patient care services to other bodies (£7 million). There is a risk that the Trust recognises income to which it is not entitled. An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances.	Our procedures included: — **Agreement of balances:** obtaining the outcome of the agreement of balances exercise with other NHS bodies. Where there were mismatches over £95,000 we sought explanations and supporting evidence to verify the Trust's entitlement to the receivable; — **Contract agreement:** We obtained copies of the signed contracts in place for the largest CCG commissioners and NHS England. For a sample of contracts, we reconciled the income per the contract to the actual income recognised in the year and agreed variances to source documentation; — **Income testing:** We agreed a sample of items relating to other activities income back to source documentation and agreed their treatment; — **Bad debt provision:** We assessed the Trust's assumptions behind the provision against available data on historic payment performance of counterparties and our own knowledge of recent bad debts affecting the NHS sector.

3. Our application of materiality and an overview of the scope of our audit

Materiality for Trust financial statements as a whole was set at £1.9 million (2016/17: £1.7 million), determined with reference to a benchmark of operating income (of which it represents approximately 1% (2016/17: 1%)). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £95k (2016/17: £85k), in addition to other identified misstatements that warranted reporting on qualitative grounds.



4. Material uncertainty on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements.

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of disclosures made in Note 1 ("Going concern") of the financial statements concerning the ability of the Trust to continue as a going concern.

The Trust has incurred a significant deficit of £20 million for the year ended 31 March 2018. In addition, the Trust has submitted a 2018/19 revised financial plan to NHS Improvement with a planned deficit of £9.9 million. The plan includes a cost improvement programme of £8.0 million (4% of costs); and £9.3 million of this is income generation through increased clinical income. Based on the plan, the Trust will also need a significant injection of loan support of £18.3 million (£8.4 million capital and £9.9 million revenue) over the course of 2018/19 in order to meet its liabilities and continue to provide healthcare services. The extent and nature of the financial support from the Department of Health, including whether the support will be forthcoming and sufficient, is currently uncertain, as are any terms and conditions associated with the funding.

These conditions together with other matters explained in Note 1 ("Going concern") of the financial statements, indicate the existence of a material uncertainty which may cast significant doubt over the Trust's ability to continue as a going concern. The financial statements do not include any adjustments that would result if the Trust was unable to continue as a going concern.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page [A], the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention

to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

Our conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is qualified

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Qualified conclusion

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

The Trust's outturn position for 2017/18 is a deficit of £20 million. The £20 million pre-impairment deficit represents an £8m deterioration against budget of £16.6 million deficit. The Trust has received cash support of £17 million from the Department of Health and Social Care to support working capital and fund capital injection payments.

The shortfall against budget was due to a decline in income as a result of capacity and cost saving challenges. These issues are evidence of weaknesses in arrangements for sustainable delivery of the Trust's strategic priorities.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out below together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Financial sustainability	The NAO Code of Audit Practice requires us to consider 'sustainable resource deployment'. The ongoing financial position and its reliance on support from the NHSi exposes the Trust to operational and financial challenges in terms of financial sustainability.	Our work included: • Reviewing the Trust's performance against its agreed target year-end outturn and CIP target at year-end; • Reviewing management's forecasts to determine whether an improvement in run rate is expected to be achieved in the short term and, if so, whether the underlying assumptions are reasonable; • Consideration of the extent to which CIP achievement was recurring or non-recurring; and • Reviewing correspondence with NHS Improvement where they confirmed support through providing further funding. **Our findings on this risk area:** • The Trust has incurred a deficit of £20m million before impairments to property, plant and equipment against an initial budget of £16.6 million deficit; • The Trust has prepared a two year financial strategy setting out its plans and initiatives to improve its financial position. • The trust is reliant on further cash support from NHS Improvement in order to meet its liabilities and continue to provide healthcare services

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

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

Chartered Accountants
Botanic House
100 Hills Road
Cambridge
CB2 1AR

25 May 2018

Statement of Comprehensive Income and Expenditure

		2017/18	2016/17
	Note	£000	£000
Operating income from patient care activities	3	168,020	165,911
Other operating income	3.4	18,385	16,131
Operating expenses	4, 6	(204,909)	(203,715)
Operating deficit from continuing operations		**(18,504)**	**(21,673)**
Finance income	9.1	17	14
Finance expenses	9.2	(1,454)	(1,205)
PDC dividends payable		-	(502)
Net finance costs		**(1,437)**	**(1,693)**
Other losses	9.4	(72)	(69)
Deficit for the year from continuing operations		**(20,013)**	**(23,435)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	24	-	244
Total comprehensive expense for the period		**(20,013)**	**(23,191)**
Note to Statement of Comprehensive Income and Expenditure			
Total comprehensive expense for the year		(20,013)	(23,191)
Add back			
In year impairments		-	5,008
Loss on asset disposals		72	69
Donated assets depreciation		290	314
Less:			
Revaluations		-	(244)
Donated income		(92)	(113)
Trust Control Total Deficit		(19,743)	(18,157)

All income and expenditure is derived from continuing operations.

The notes on pages X to X form part of these accounts.

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	10	605	327
Property, plant and equipment	11	85,180	87,878
Trade and other receivables	14	998	1,022
Total non-current assets		**86,783**	**89,227**
Current assets			
Inventories	13	2,191	2,366
Trade and other receivables	14	9,887	8,757
Cash and cash equivalents	15	5,633	3,914
Total current assets		**17,711**	**15,037**
Current liabilities			
Trade and other payables	16	(24,252)	(21,528)
Borrowings	18	(1,393)	(1,385)
Provisions	20	(194)	(235)
Other liabilities	17	(301)	(238)
Total current liabilities		**(26,140)**	**(23,386)**
Total assets less current liabilities		**78,354**	**80,878**
Non-current liabilities			
Borrowings	18	(82,443)	(65,082)
Provisions	20	(321)	(347)
Other liabilities	17	(538)	(543)
Total non-current liabilities		**(83,302)**	**(65,972)**
Total assets employed		**(4,948)**	**(14,906)**
Financed by			
Public dividend capital		52,319	52,160
Revaluation reserve		11,614	11,614
Income and expenditure reserve		(68,881)	(48,868)
Total taxpayers' equity		**(4,948)**	**14,906**

The financial statements on pages X to X were approved by the Board on and signed on its behalf by:

Jon Green – Chief Executive
Date: 22/5/2018

Statement of Changes in Equity

For the year ended 31 March 2018	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**52,160**	**11,614**	**(48,868)**	**14,906**
Deficit for the year	-	-	(20,013)	**(20,013)**
Public dividend capital received	159	0	0	**159**
Taxpayers' equity at 31 March 2018	**52,319**	**11,614**	**68,881**	**(4,948)**

For the year ended 31 March 2017	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**52,160**	**16,802**	**(30,865)**	**38,097**
Deficit for the year	-	-	(23,435)	**(23,435)**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(5,008)	5,008	**-**
Other transfers between reserves	-	(424)	424	**-**
Revaluations	-	244	-	**244**
Taxpayers' equity at 31 March 2017	**52,160**	**11,614**	**(48,868)**	**14,906**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating deficit		(18,504)	(21,673)
Non-cash income and expense:			
Depreciation and amortisation	4.1	6,389	5,860
Net impairments	5	-	5,008
Income recognised in respect of capital donations	3.4	(92)	(6)
(Increase) / decrease in receivables and other assets		(1,386)	(1,393)
(Increase) / decrease in inventories		175	(65)
Increase / (decrease) in payables and other liabilities		3,714	1,446
Increase / (decrease) in provisions		(67)	57
Net cash used in operating activities		**(9,784)**	**(10,766)**
Cash flows from investing activities			
Interest received		17	14
Purchase of intangible assets		(357)	(294)
Purchase of property, plant, equipment and investment property		(4,597)	(8,725)
Sales of property, plant, equipment and investment property		33	156
Net cash used in investing activities		**(4,904)**	**(8,849)**
Cash flows from financing activities			
Public dividend capital received		159	-
Movement on loans from the Department of Health and Social Care		17,452	23,929
Capital element of finance lease rental payments		(89)	(74)
Interest paid on finance lease liabilities		(10)	(18)
Other interest paid		(1,398)	(1,186)
PDC dividend (paid) / refunded		280	(782)
Net cash used in financing activities		**16,394**	**21,869**
Increase in cash and cash equivalents		**1,719**	**2,254**
Cash and cash equivalents at 1 April - brought forward		**3,914**	**1,660**
Cash and cash equivalents at 31 March	15.1	**5,633**	**3,914**

Where relevant prior year analysis has been adjusted to be on a consistent basis with the current year.

NOTES TO THE ACCOUNTS

Financial Performance

As per prior years the Trust is expecting to incur a deficit during the next 12 months and as a result will require additional external funding from the Department of Health and Social Care. The Regulator is expected to assess the Trust's Annual plan for 2018/19 and confirm the level of cash support (capital and revenue) that will be available to the Trust for the year. To enable the continuation of services, the Trust is expecting to continue to take out loans on a monthly basis.

International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management intends, or has no alternative but, to apply to the Secretary of State for the Trust's dissolution without the transfer of its services to another entity.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust's Board of Directors has carefully considered the principle of 'Going Concern' and the Directors have concluded that the on-going risk around cash flow support represents a material uncertainty that casts significant doubt upon the Trust's ability to continue as a going concern.

Nevertheless after making enquiries, and considering the reality of the uncertainty materialising, the Directors have a reasonable expectation that the Trust will have access to adequate cash resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts.

Looking Forward to 2018/19 and Beyond

The Trust's financial plan for 2018/19 has been approved by the Board following discussion with the Regulator and a comprehensive planning process. Cost savings of £8.0m (4%) have been included in the plan along with investments to maintain and enhance patient care.

The financial plan for 2018/19 includes the receipt of Provider Sustainability Funding as the Trust is planning to deliver the control total deficit and archive operational trajectories for the four hour Emergency Access target.

Eastern Counties Newspapers, 1980. The Queen Elizabeth Hospital on Gayton Road cost £17 million.

Summary

During the next twelve months, the Trust will continue to enhance the standard of patient care and services and the Trust's financial plans have identified the requirement for significant additional external funding from the Department of Health and Social Care of £19.7m.

The Trust is planning to receive the additional funding via Department of Health and Social Care loans which are drawn on a monthly basis.

However, the circumstances outlined above represent a material uncertainty that casts significant doubt upon the Trust's ability to continue as a going concern. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

Note 1
Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

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

Note 1.2 Critical judgements in applying accounting policies

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

The Trust's management have made the following critical judgments in applying the Trust's accounting policies:

Valuation of Land and Buildings

The most significant estimate within the accounts is the value of land and building. The interim valuation for 2016/17 was performed by professional Chartered Surveyors Boshier and Company on the basis of market value as at 1 April 2016. Boshier and Company have extensive knowledge of the physical estate and market factors, are independent to the Trust and certified by the Royal Institute of Chartered Surveyors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

Untaken annual leave

Under Trust policy with respect to annual leave, staff are not allowed to carry over any holiday days into the following financial year, this is change in policy from 2016/17. The Trust does have a financial liability for any annual leave earned by staff but not taken as at 31st March 2018 in respect of those staff who are on maternity leave, long-term sickness leave or suspended. The estimated costs of untaken annual leave as at 31st March 2018 was £322,770, (31st March 2017 £662,980).

Provisions

Assumptions around the timing of cash flows relating to provisions are based on information from the NHS

Pensions Agency and internal opinion in the Trust.

Non-Consolidation of Charitable Funds

IFRS10 requires production of consolidated accounts where there is a parent/subsidiary relationship. IFRS10 defines a subsidiary as "an entity... that is controlled by another entity. Control is the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities." The Trust is Corporate Trustee of the Charitable Fund and meets the definition of control.

Materiality is an overriding consideration in preparation of the accounts. The International Accounting Standards Board (IASB) states that "Information is material if its omission or misstatement could influence the economic decisions of users taken on the basis of the financial statements".

The net assets of the Charitable Fund amount to about 4% of the Trust net assets. Charitable fund income is about 0.3% of Trust income. The Directors therefore consider that the significant amount of work which would be necessary to consolidate the accounts of the Charitable Fund with those of the Trust is not justified on the grounds of materiality.

Note 1.2.1 Key sources of estimation and uncertainty

The preparation of the financial information in conformity with IFRS requires management to make judgements, estimates and assumptions that affect the application of policies and the reported amounts of income and expenses and of assets and liabilities. The estimates and assumptions are based on historical experience and other factors that are believed to be reasonable under all the circumstances. Actual results may vary from these estimates. The estimates and assumptions are reviewed on an on-going basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods. The estimates and judgements that have had a significant effect on the amounts recognised in the financial statements are outlined below.

Note 1.2.2 Income estimates

In measuring income for the year, management has taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year. Included in the income figure is an estimate for partial spells, i.e. patients undergoing treatment that is only partially complete at twelve midnight on 31 March. The number of partial spells for each specialty is taken and multiplied by the average specialty price and adjusted for the proportion of the spell which belongs to the current year.

Note 1.2.4 Expense accruals

In estimating expenses that have not yet been charged for, management have made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted.

Note 1.2.5 Provisions

In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rate as stated, as appropriate. Management have also taken into account all available information for disputes and possible outcomes.

Note 1.3 Income

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

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

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.4 Expenditure on employee benefits

Note 1.4.1 Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Note 1.4.2 Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.
Employers' pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:

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

or

- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates,

are anticipated to have simultaneous disposal dates and are under single managerial control;

or

- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Note 1.6.2 Measurement

Valuation

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

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of valuation less any subsequent accumulated depreciation and impairment losses.
Revaluations are performed every 5 years and reviewed with sufficient regularity in between to ensure carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

The Trust conducted an interim valuation of land and buildings as at 1 April 2016. The valuation was performed by Boshier and Company Chartered Surveyors.

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

Note 1.6.3 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Note 1.6.4 Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction contract are not depreciated until the asset is brought into use.

Note 1.6.5 Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Note 1.6.6 Transferring revaluation surplus to retained earnings

The depreciable amount of a revalued asset is based upon its revalued amount, not its cost. The depreciation charge for each period is recognised as an expense in the profit and loss.

However, the revaluation surplus may be transferred directly to retained earnings as the surplus is realised. Realisation of the surplus may occur through the use (and depreciation) of the asset or upon its disposal.

Where the Trust disposes of the asset, the whole of the revaluation reserve is transferred. Other than this no transfer of any part of the revaluation reserve will take place.

Note 1.6.7 Impairments

In accordance with the DH GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.6.8 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:

    - management are committed to a plan to sell the asset
    - an active programme has begun to find a buyer and complete the sale
    - the asset is being actively marketed at a reasonable price
    - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.9 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7 Intangible assets

Note 1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Note 1.7.2 Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Note 1.7.3 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Note 1.7.4 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8 Revenue government and other grants

Government grants are grants from Government bodies other than income from Care Commissioning Groups or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

Note 1.10 Financial instruments and financial liabilities

Note 1.10.1 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), or that are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above/below.

Note 1.10.2 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.10.3 Classification and measurement

Financial assets are categorised as either available for sale, at fair value through income and expenditure, loans and receivables or held to maturity.

Note 1.10.4 Financial assets and financial liabilities at 'fair value through income and expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Note 1.10.5 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Note 1.10.6 Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Note 1.10.7 Determination of fair value

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Note 1.10.8 Impairment of financial assets

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Note 1.11 Leases

Note 1.11.1 Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Note 1.11.2 Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Note 1.11.3 Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.12 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Note 1.12.1 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed in note 19.1 but it is not recognised in the Trust's accounts.

Note 1.12.2 Non-clinical risk pooling

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

Note 1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital used by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.14 Value Added Tax

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

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

Note 1.15 Corporation Tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly in relation to specified activities of a Foundation Trust (s519 (3) to (8) ICTA 1988). None of the Trust's activities in the period are subject to corporation tax liability.

Note 1.16 Foreign Exchange

The functional and presentational currencies of the trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Note 1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.20 Accounting standards that have been issued but have not yet been adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2017/18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers –– Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting

periods beginning on or after 1 January 2018.

Note 2 Segmental Reporting

Under the definitions of operating segments contained within International Financial Reporting Standard 8, the Trust has a single operating segment where the revenues are derived from the provision of healthcare services.

The products and services provided to external customers are identified in notes 3.1 and 3.2 below under the headings "Income from activities analysed by service type" and "Other operating income".

All revenues from external customers are derived from within the UK, and all non-current assets are located in the UK. Revenues from transactions with entities under the control of the UK Government amount to £179.782m (2016/17 - £178.319m), and are reported within the single healthcare segment.

Note 3
Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2017/18	2016/17
	£000	£000
Acute services		
Elective income	28,299	30,004
Non elective income	65,294	56,685
First outpatient income	12,498	20,006
Follow up outpatient income	15,028	12,305
A&E income	8,645	7,469
Other NHS clinical income	37,593	38,229
All services		
Private patient income	72	780
Other clinical income	591	433
Total income from activities	**168,020**	**165,911**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18	2016/17
	£000	£000
NHS England	14,918	14,777
Clinical commissioning groups	150,485	149,816
Other NHS providers	10	-
Non-NHS: private patients	72	780
Non-NHS: overseas patients (chargeable to patient)	56	51
NHS injury scheme	539	433
Non NHS: other	1,730	54
Total income from activities	**168,020**	**165,911**
Of which:		
Related to continuing operations	168,020	165,911

Note 3.3 Overseas visitors (relating to patient charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	56	51
Cash payments received in-year	56	-

Note 3.4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	697	587
Education and training	6,219	5,376
Receipt of capital grants and donations	92	113
Non-patient care services to other bodies	6,997	1,048
Sustainability and transformation fund income	1,405	-
Rental revenue from operating leases	-	5
Other income **	2,975	9,002
Total other operating income	**18,385**	**16,131**
Of which:		
Related to continuing operations	18,385	16,131

** Analysis of other operating income : Other

	2017/18	2016/17
	£000	£000
Car Parking Income	1,350	1,338
Catering	603	528
Pharmacy Sales	56	59
Property rental (not leasee income)	172	29
Staff accommodation rental	-	224
Estates recharges	-	85
Staff contribution to employee benefit schemes	-	17
Clinical excellence awards	214	212
Grossing up consortium arrangements	-	3,195
Other income generation schemes	793	-
Other income not already covered	(213)	3,315
	2,975	9,002

Note 3.4 Sustainability and transformation fund income

STF - incentive scheme - general distribution	1,405	-

Note 3.5 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017/18	2016/17
	£000	£000
Income from services designated as commissioner requested services	161,156	162,067
Income from services not designated as commissioner requested services	6,864	3,844
Total	**168,020**	**165,911**

Note 4 Operating expenses

Note 4.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,713	4,192
Purchase of healthcare from non-NHS and non-DHSC bodies	794	2,220
Staff and executive directors costs (Note 6.1)	142,559	134,759
Remuneration of non-executive directors	120	123
Supplies and services - clinical (excluding drug costs)	15,019	15,021
Supplies and services - general	2,890	2,797
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	15,922	16,998
Consultancy costs	282	465
Establishment	1,473	1,592
Premises	5,912	5,761
Transport (including patient travel)	1,157	948
Depreciation on property, plant and equipment	6,310	5,850
Amortisation on intangible assets	79	10
Net impairments	-	5,008
Increase / (decrease) in provision for impairment receivables	61	(19)
Increase / (decrease) in other provisions	-	78
Change in provisions discount rate(s)	5	34
Audit fees payable to the external auditor		
audit services - statutory audit	55	55
other auditor remuneration (external auditor only)	11	75
Internal audit costs	122	124
Clinical negligence	4,885	3,709
Insurance	96	112
Education and training	445	587
Rentals under operating leases	545	479
Car parking & security	73	260
Hospitality	33	45
Losses, ex gratia & special payments	25	20
Other services, eg external payroll	105	109
Other	1,218	2,303
Total	**204,909**	**203,715**
Of which:		
Related to continuing operations	204,909	203,715

Note 4.2 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
Taxation compliance services	-	17
Other non-audit services not falling within items 2 to 7 above	-	49
Total	-	66

Note 4.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2016/17: £1m).

Note 5 Impairment of Assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage to normal operations	-	5,008
Total net impairments charged to operating surplus / deficit	-	**5,008**
Impairments charged to the revaluation reserve	-	**-**
Total net impairments	-	**5,008**

Note 6 Employee benefits

Note 6.1 Employee benefits

	2017/18	2016/17
	Total	Total
	£000	£000
Salary and wages	105,503	99,873
Social security costs	9,880	9,319
Apprenticeship levy	505	-
Employer's contributions to NHS pensions	11,639	11,088
Termination benefits	-	41
Temporary staff (including agency)	15,032	14,438
Total gross staff costs	**142,559**	**134,759**

Note 6.2 Retirements due to ill-health

During 2017/18 there were 2 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £121k (£84k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7 Pension Costs

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

for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

Note 8 Operating Leases

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust as a lessee		
This note discloses costs and commitments incurred in lease agreements where The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is the lessee.		
	2017/18	**2016/17**
	£000	**£000**
Operating lease expense		
Minimum lease payments	545	479
Total	**545**	**479**
	31 March 2018	**31 March 2017**
	£000	**£000**
Future minimum lease payments due:		
- not later than one year;	373	561
- later than one year and not later than five years;	3	376
Total	**376**	**937**

Note 9 Finance

Note 9.1 Finance income

Finance income represents interest received on assets and investments in the period

	2017/18	2016/17
	£000	£000
Interest on bank accounts	17	14
Total	**17**	**14**

Note 9.2 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Media	1,444	1,186
Finance leases	10	18
Total interest expense	**1,454**	**1,204**
Unwinding of discount on provisions	-	1
Other finance costs	-	-
Total finance costs	**1,454**	**1,205**

Note 9.3 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

No interest was incurred in either 2017/18 nor 2016/17 in respect of late payment of commercial debts.

Note 9.4 Other losses

	2017/18	2016/17
	£000	£000
Losses on disposal of assets	(72)	(69)
Total losses on disposal of assets	**(72)**	**(69)**

Note 10 Intangible Assets

Note 10.1 Intangible assets - 2017/18

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**573**	**573**
Additions	357	**357**
Gross cost at 31 March 2018	**930**	**930**
Amortisation at 1 April 2017 - brought forward	**246**	**246**
Provided during the year	79	**79**
Amortisation at 31 March 2018	**325**	**325**
Net book value at 31 March 2018	**605**	**605**
Net book value at 1 April 2017	**327**	**327**

Note 10.2 Intangible assets - 2016/17

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2016	**279**	**279**
Additions	294	**294**
Valuation / gross cost at 31 March 2017	**573**	**573**
Amortisation at 1 April 2016	**236**	**236**
Provided during the year	10	**10**
Amortisation at 31 March 2017	**246**	**246**
Net book value at 31 March 2017	**327**	**327**
Net book value at 1 April 2016	**43**	**43**

Note 11 Property, plant and equipment

Note 11.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**4,610**	**64,628**	**4,406**	**29,229**	**430**	**18,107**	**678**	**122,088**
Additions	-	-	3,609	103	-	5	-	**3,717**
Reclassifications	-	1,957	(5,554)	2,390	-	1,207	-	**-**
Disposals/derecognition	-	-	-	(853)	-	-	-	**(853)**
Valuation/gross cost at 31 March 2018	**4,610**	**66,585**	**2,461**	**30,869**	**430**	**19,319**	**678**	**124,952**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**2,410**	**-**	**18,719**	**408**	**12,174**	**499**	**34,210**
Provided during the year	-	3,085	-	1,842	8	1,351	24	**6,310**
Disposals/derecognition	-	-	-	(748)	-	-	-	**(748)**
Accumulated depreciation at 31 March 2018	**-**	**5,495**	**-**	**19,813**	**416**	**13,525**	**523**	**39,772**
Net book value at 31 March 2018	**4,610**	**61,090**	**2,461**	**11,056**	**14**	**5,794**	**155**	**85,180**
Net book value at 1 April 2017	**4,610**	**62,218**	**4,406**	**10,510**	**22**	**5,933**	**179**	**87,878**

Note 11.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016	**4,366**	**71,525**	**5,075**	**27,344**	**443**	**16,767**	**675**	**126,195**
Additions	-	-	7,807	81	-	9	3	**7,900**
Impairments	-	(10,961)	-	-	-	-	-	**(10,961)**
Revaluations	244	-	-	-	-	-	-	**244**
Reclassifications	-	4,191	(8,476)	2,954	-	1,331	-	**-**
Disposals / derecognition	-	(127)	-	(1,150)	(13)	-	-	**(1,290)**
Valuation/gross cost at 31 March 2017	**4,610**	**64,628**	**4,406**	**29,229**	**430**	**18,107**	**678**	**122,088**
Accumulated depreciation at 1 April 2016	**-**	5,953	-	17,459	409	11,082	475	**35,378**
Provided during the year	-	2,410	-	2,312	12	1,092	24	**5,850**
Impairments	-	(5,953)	-	-	-	-	-	**(5,953)**
Disposals / derecognition	-	-	-	(1,052)	(13)	-	-	**(1,065)**
Accumulated depreciation at 31 March 2017	**-**	**2,410**	**-**	**18,719**	**408**	**12,174**	**499**	**34,210**
Net book value at 31 March 2017	**4,610**	**62,218**	**4,406**	**10,510**	**22**	**5,933**	**179**	**87,878**
Net book value at 1 April 2016	**4,366**	**65,572**	**5,075**	**9,885**	**34**	**5,685**	**200**	**90,817**

Note 11.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	4,610	57,050	2,461	10,548	14	5,785	139	**80,607**
Finance leased	-	-	-	19	-	-	-	**19**
Owned - donated	-	4,040	-	489	-	9	16	**4,554**
NBV total at 31 March 2018	**4,610**	**61,090**	**2,461**	**11,056**	**14**	**5,794**	**155**	**85,180**

Note 11.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	4,610	57,986	4,406	9,846	22	5,928	161	**82,959**
Finance leased	-	-	-	159	-	-	-	**159**
Owned - donated	-	4,232	-	505	-	5	18	**4,760**
NBV total at 31 March 2017	**4,610**	**62,218**	**4,406**	**10,510**	**22**	**5,933**	**179**	**87,878**

Note 11.5 Economic life of purchased intangible assets

	Min life	Max life
	Years	Years
Software	5	5

Note 11.6 Economic life of property, plant and equipment

	Min life	Max life
	Years	Years
Buildings excluding dwellings	15	80
Plant and machinery	5	15
Transport equipment	7	7
Information technology	5	8
Furniture and fittings	5	15

Note 12 Donations of property, plant and equipment

	2017/18
	£000
Medical equipment	26
Specialist furniture	61
Software	5
	92

Note 13 Inventories

	31 March 2018	31 March 2017
	£000	£000
Drugs	861	800
Consumables	1,239	1,475
Energy	91	91
Total inventories	**2,191**	**2,366**
of which:		

Inventories recognised in expenses for the year were £29,226k (2016/17: £29,893k). Write-down of inventories recognised as expenses for the year were nil (2016/17: nil).

Note 14 Trade Receivables

Note 14.1 Trade receivables and other receivables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade receivables	4,922	3,671
Accrued income	3,443	2,767
Provision for impaired receivables	(1,011)	(939)
Prepayments (non-PFI)	1,481	1,388
PDF dividend receivable	-	280
VAT receivable	346	716
Other receivables	706	874
Total current trade and other receivables	**9.887**	**8,757**
Non-current		
Other receivables	998	1,022
Total non-current trade and other receivables	**998**	**1,022**
Of which receivables from NHS and DHSC group bodies:		
Current	7,506	6,707

Note 14.2 Provision for impairment of receivables

	31 March 2018	31 March 2017
	£000	£000
At 1 April	**939**	**958**
Increase/(decrease) in provision	61	(19)
Amounts utilised	11	-
At 31 March	**1,011**	**939**

Note 14.3 Credit quality of financial assets

	31 March 2018	31 March 2017
	Trade and other receivables	Trade and other receivables
	£000	£000
Ageing of impaired financial assets		
0 - 30 days	-	-
30 - 60 days	-	-
60 - 90 days	-	-
90 - 180 days	640	784
Over 180 days	1,012	1,069
Total	**1,652**	**1,853**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	2,579	1,174
30 - 60 days	(288)	600
60 - 90 days	236	404
90 - 180 days	640	743
Over 180 days	1,012	634
Total	**4,179**	**3,555**

Note 15 Cash and cash equivalents

Note 15.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**3,914**	**1,660**
Net change in year	1,719	2,254
At 31 March	**5,633**	**3,914**
Broken down into;		
Cash at commercial banks and in hand	82	47
Cash with the Government Banking Service	5,551	3,867
Total cash and equivalents as in SoFP	**5,633**	**3,914**

Note 15.2 Third party assets held by the trust

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

The Trust held £46 of patients monies as at 31 March 2018 (£320 31 March 2017).

Note 16 Trade and other payables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	7,136	8,522
Capital payables	617	1,589
Accruals	12,090	7,357
Social security costs	1,421	1,397
Other taxes payable	1,305	1,263
Accrued interest on loans	107	67
Other payables	1,576	1,333
Total current trade and other payables	**24,252**	**21,528**
Of which payables from NHS and DHSC group bodies:		
Current	6,961	2,484

Note 17 Other liabilities

	31 March 2018	31 March 2017
	£000	£000
Current		
Deferred income	301	238
Total other current liabilities	**301**	**238**
Non-current		
Deferred income	538	543
Total other non-current liabilities	**538**	**543**

Note 18 Borrowings

Note 18.1 Borrowings

	31 March 2018	31 March 2017
	£000	£000
Current		
Loans from the Department of Health and Social Care	1,303	1,303
Obligations under finance leases	90	82
Total current borrowings	**1,393**	**1,385**
Non-current		
Loans from the Department of Health and Social Care	82,443	64,992
Obligations under finance leases	-	90
Total other non-current borrowings	**82,443**	**65,082**

Note 18.2 Analysis of loans with Department of Health

The Trust has 16 loans outstanding with the Department of Health, the details of which are contained in the table below.

	Loan Value	Term	Expiring
	£000	(years)	
Normal Capital Investment Loan	750	10	2020/21
Normal Capital Investment Loan	1,475	10	2021/22
Interim Capital Loan	800	15	2029/30
Interim Revenue Loan	16,800	5	2019/20
Revolving working capital facilities	17,630	5	2019/20
Interim Revenue loan	15,625	5	2020/21
Interim Capital Loan	5,668	13	2028/29
Interim Revenue loan	1,000	3	2019/20
Interim Revenue loan	2,468	3	2019/20
Interim Revenue loan	2,775	3	2019/20
Interim Revenue loan	1,540	3	2020/21
Interim Revenue loan	1,615	3	2020/21
Interim Revenue loan	1,546	3	2020/21
Interim Revenue loan	3,485	3	2020/21
Interim Revenue loan	5,443	3	2020/21
Interim Revenue loan	5,126	3	2020/21
Total loans at 31 March 2018	**83,746**		

Note 19 Finance leases

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust as a lessee

	31 March 2018	31 March 2017
	£000	£000
Gross lease liabilities	**90**	**172**
of which liabilities are due:		
- not later than one year;	90	82
- later than one year and not later than five years;	-	90
Net lease liabilities	**90**	**172**
of which payable:		
- not later than one year;	90	82
- later than one year and not later than five years;	-	90

Note 20 Provisions for liabilities and charges

Note 20.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Other	Total
	£000	£000	£000
At 1 April 2017	**112**	**470**	**582**
Change in the discount rate	1	4	5
Arising during the year	-	52	52
Utilised during the year	(13)	(85)	(98)
Reversed unused	(10)	(16)	(26)
At 31 March 2018	**90**	**425**	**515**
Expected timing of cash flows:			
- not later than one year;	13	181	194
- later than one year and not later than five years;	49	86	135
- later than five years	28	158	186
Total	**90**	**425**	**515**

Note 20.2 Clinical negligence liabilities

At 31 March 2018, £76.924k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (31 March 2017: £47,240k).

Note 21 Contractual capital commitments

	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	1,088	484
Total	**1,088**	**484**

Note 22 Financial instruments

Note 22.1 Carrying values of financial assets

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	8,231	**8,321**
Cash and cash equivalents at bank and in hand	5,633	**5,633**
Total at 31 March 2018	**13,864**	**13,864**
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	6,642	**6,642**
Cash and cash equivalents at bank and in hand	3,914	**3,914**
Total at 31 March 2017	**10,556**	**10,556**

Note 22.2 Carrying values of financial liabilities

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	83,746	**83,746**
Obligations under finance leases	90	**90**
Trade and other payables excluding non financial liabilities	20,611	**16,822**
Total at 31 March 2018	**104,447**	**104,447**
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	66,295	**66,295**
Obligations under finance leases	172	**172**
Trade and other payables excluding non financial liabilities	14,093	**14,093**
Total at 31 March 2017	**80,560**	**80,560**

Note 22.3 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	22,004	15,478
In more than one year but not more than two years	41,976	1,393
In more than two years but not more than five years	36,911	59,723
In more than five years	3,556	3,966
Total	**104,447**	**80,560**

Note 23 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	2	-	14	3
Fruitless payments	30	14	14	49
Bad debts and claims abandoned	346	4	355	6
Total losses	**378**	**18**	**383**	**58**
Special payments				
Compensation under court order or legally binding arbitration award	3	9	3	12
Ex-gratia payments	35	64	31	43
Special severance payments	-	-	11	50
Total special payments	**38**	**73**	**45**	**105**
Total losses and special payments	**416**	**91**	**428**	**163**

Note 24 Revaluation reserve

	31 March 2018			31 March 2017
	Land	Buildings	Total	
	£000	£000	£000	£000
Revaluation reserve at April 1st	2,331	9,283	11,614	16,802
Impairments	-	-	-	(5,008)
Revaluations	-	-	-	244
Transfers to income & expenditure reserves	-	-	-	(424)
Revaluation Reserve at March 31st	**2,331**	**9,283**	**11,614**	**11,614**

Note 25 Related parties

	Receivables		Payables	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Other NHS Bodies	7,506	6,427	6,804	2,484
Other Government bodies including local authorities	378	775	2,784	1,492
Department of Health and Social Care	-	280	-	-
Charitable Funds	6	41	-	-
Total	**7,890**	**7,523**	**9,588**	**3,976**

	Income		Expenditure	
	2018	2017	2018	2017
	£000	£000	£000	£000
Other NHS Bodies	179,676	178,233	12,353	9,862
Other Government bodies including local authorities	106	84	22,869	2,100
Department of Health	-	-	-	1,186
Charitable Funds	452	472	-	-
Total	**180,234**	**178,789**	**35,222**	**13,148**

List of Related Parties:

- Department of Health and Social Care
- HM Revenue & Customs
- Care Quality Commission
- NHS Business Service Authority
- NHS Pension Scheme
- NHS England
- NHS Commissioning Board
- NHS Blood & Transplant
- NHS North Norfolk CCG
- NHS South Norfolk CCG
- NHS West Norfolk CCG
- NHS Norwich CCG
- NHS Cambridgeshire & Peterborough CCG
- NHS Lincolnshire East CCG
- NHS South Lincolnshire CCG
- NHS West Suffolk CCG
- NHS Litigation Authority
- Health Education England
- Cambridgeshire University Hospital NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- Cambridge & Peterborough NHS Foundation Trust
- Norfolk and Norwich University NHS Foundation Trust
- North West Anglian NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Kings Lynn and West Norfolk Borough Council
- 2016/17 only - Dr I Hosein (Husband of the CEO and working on contract as the interim Associated

Medical Director)

The Trust received revenue and capital payments amounting to £452,131 (£471,988 2016/17), as disclosed above, from The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust Charitable Fund, the Trustees for which make up the Trust Board. A copy of The Queen Elizabeth King's Lynn NHS Trust Charitable Fund Accounts can be obtained on request (01553 613981).

The Trust conducted transactions with other Health Authorities and NHS bodies, which individually are not regarded as material, during the normal course of the Trust's activities.

Note 26 Financial risk management

International Financial Reporting Standard 7 and International Accounting Standard 32 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Foundation Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

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

Currency Risk

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

Interest rate risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity Risk

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

NHS

70 YEARS OF THE NHS 1948 - 2018

The Queen Elizabeth Hospital King's Lynn

NHS Foundation Trust