Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals
NHS Foundation Trust

Annual Report and Accounts 2016-17

Norfolk and Norwich University Hospitals NHS Foundation Trust

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

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Performance Report

Mark Davies, Chief Executive (left) and John Fry Chairman.

Chairman's Statement

Looking back over the last year, I feel we have achieved a great deal and our staff should be very proud of their work here and the fantastic support they give to our patients.

Patients treated in our hospitals consistently say that our teams are welcoming, caring and helpful. This is a great testament to the caring nature and resilience of our staff and volunteers, given the pressure of meeting the huge increase in demand which we have seen in recent years.

It is great to see our employee numbers rise as we invest in services and help new people have a career in our hospitals.

In particular our link with the University of East Anglia continues to develop, and is hugely successful in delivering highly motivated and skilled employees who are making our services a success. Training is vitally important and we aim to upskill our employees throughout their working lives.

We also have a growing and exciting programme of research which brings great benefits for patients and helps us to attract the very best clinicians to work here. These advancements in learning enable us to be at the forefront of innovation and new developments.

We are leaders in day case surgery. For patients to be able to come into hospital, have their procedure, and still be home the same day is really beneficial. As we expand our scope to include additional treatments, more of our patients are able to benefit from this streamlined approach.

We have also made other service improvements in the last 12 months which have put us in a better position for the future, such as starting the ward refurbishment programme, increasing elective care and a series of improvements in the Emergency Department. All this is against a backdrop of higher workloads, capacity constraints and tight finances. We are not alone as many Trusts across the country struggle to make their finances fit an ever increasing demand for care from an ageing population.

One of the more difficult aspects of the past year was going into financial special measures, because we would not agree to a financial target which we viewed as detrimental to our patients. Whilst this process put an additional load onto our management there have been some positive aspects to the process. We have taken a thorough look at all aspects of our business to deliver the best value for money for the taxpayer. Thankfully the hard work of all our teams has paid off and we came out of financial special measures in February 2017. Overall, we are in a better place than 12 months ago with more stability in our leadership team, a divisional management structure in place and positive plans for expansion to meet the growing demand for our care. We have also been able to demonstrate leading levels of efficiency, highlighted by the Carter review of trust finances across the country.

I would like to express my sincere gratitude to the staff for their tireless efforts and for creating such a reassuring environment for patients. People come to us in need of kindness and at very difficult times in their lives. It is thanks to our staff that they receive the excellent care and support that they need.

John Fry
Chairman

Chief Executive's Statement

This annual report reflects my first full year after becoming substantive Chief Executive in October 2015. One of my first priorities was to improve clinical leadership and clinical accountability across the Trust. We have a very committed and caring workforce and with the new divisional management teams in place, staff are better able to influence the way in which services are delivered.

Pressure on services

The last year has been one of the most pressurised times that the Trust, and indeed the NHS, has experienced. For example, attendances in A&E in December 2016 were 18% higher compared to two years' ago. It is this pressure that has presented us with challenges with some key access targets, notably in respect of the emergency four hour waiting time standard, cancer 31 day referral to surgery and 62 day referral to treatment targets and 18 week referral to treatment times.

Our services are working in new ways to assess, admit and treat our Emergency Department patients and the good news is that the 'conversion' rate of those patients being admitted has fallen. That means that we have more patients coming through the front door and far fewer patients being admitted which helps our patient flow. Developments are underway for the redesign of emergency pathways in the Emergency Assessment Unit for Surgery (EAUS), which aims to reduce the time a patient has to wait for a decision to be made about their care. This service is being run on Easton ward alongside the more traditional Emergency Assessment Unit for Surgery. AEC offers patients same-day assessments and aims to offer same day-treatment too which gives patients quicker access to treatment and helps avoid an unnecessary stay in hospital. Since the introduction of the pilot in February 2016, it has been shown that around 60% of patients that attend EAUS are diagnosed and/or treated on the same day.

Performance

One of the most significant improvements in our performance is our work for those patients who were in hospital for more than 14 days. This has been a great success as previously we have seen these numbers at around 300 patients and now we are down to between 160 and 200 patients which is a great improvement and it has had a significant impact and helped our patients return home sooner.

Other examples of where we are becoming more efficient is with the introduction of the Red2Green campaign which makes sure that every day is a day of added value for patients in our care. The initiative is about reducing unnecessary delays in our processes and sharing with patients what the plan is to help get them home.

We do well on our performance on cancer targets for our patients and this is a prime objective for us. We are the seventh biggest cancer unit in the country and we treat cancer patients as our priority, for example our two week wait performance is one of the best in the country. Where we have more difficulty is with our 62 and 31 day subsequent surgery targets because of the more complex pathways and extensive surgery that modern cancer treatments involve.

Against the background of growing demand, such as an 11% increase in two week wait referrals, we are still performing better than last year.

Building capacity

Demand is rising across the whole NHS putting pressure on services. One of the constraints which is a huge challenge as our number of patients continues to increase is a lack of capacity. We have seen a significant increase in demand and this has been acknowledged by our commissioners and regulators.

We are already doing everything we can to deal with the demand including the use of temporary facilities on site, introducing three session days and looking at increasing the number of services which run for seven days per week, to keep pace with demand. This can only be for the short or medium term; we need, and are, planning longer term solutions to help solve the pressures on our capacity.

That is why we are rapidly developing plans to increase capacity on site – the hospital is too small to cope with the huge demands on our services. So we plan to build an Ambulatory Care and Diagnostic Centre (ACAD) and develop our services for interventional radiology, cardiac catheter labs and critical care.

We will also be expanding our endoscopy services in Summer 2018 when a new unit opens at the Quadram Institute, a pioneering new facility for food and health research under construction on Norwich Research Park.

Workforce

I am deeply conscious of the pressures our 7,500 employees have faced during 2016/17. That they have met these challenges with such determination and continued to strive so hard in the interests of our patients is a great credit to an excellent team of caring and dedicated professionals across our hospitals.

As a vibrant and growing organisation, with many centres of excellence, we need a skilled and expanding workforce. We are appointing ten senior clinical/academic posts with the University of East Anglia which is an important step in the Trust's academic mission. We are also gaining 20 more new additional senior registrar/junior doctor posts from Health Education England (HEE).

There has also been significant investment in additional staff with 200 appointed during the year. We achieved a massive reduction in reliance on using agencies through careful management and changes in the staff bank and have reviewed recruitment mechanisms to streamline the joining process for our own staff and bank-only staff. We should not underestimate the value of our 670 volunteers and the difference they make to the experience of our patients.

Partnerships

There are four main workstreams in the Norfolk and Waveney Sustainability and Transformation Plan: mental health, acute care, demand management, primary, community and social care, plus the enabling work on information management and technology looking at how we link hospitals together and also with primary care.

We are also making progress with the acute hospitals group and how we work together with the James Paget University Hospital and the Queen Elizabeth Hospital.

Research and Innovation

Research and innovation are a key part of our mission and we maintain close links with the University of East Anglia. Together we are capable of leading the world in innovative techniques and last year an NNUH patient became the first woman in the world with an artificial pancreas to manage her diabetes to give birth naturally.

We are also one of the hospitals in the UK which is taking part in the 100,000 Genomes Project, a world-leading DNA project which aims to sequence 100,000 complete sets of DNA from around 70,000 NHS patients. NNUH will be recruiting 625 patients who have cancer of the colon, kidney, testes and ovary over the next three years. We currently run more than 300 research studies each year and this is expected to rise once our Clinical Research and Trials Unit moves to the Quadram Institute together with our expanded endoscopy services.

We are leaders in day surgery with nearly 90,000 day procedures carried out each

year. An exciting development in our Day Procedure Unit is the addition of laparoscopic hysterectomies, laser prostatectomy, tonsillectomies and the innovative new Urolift procedures to the range of treatments offered by the unit. There is also a benefit for other areas across the hospital as these innovations reduce demand for overnight beds on wards and help patients to get home more quickly.

Finance

We are operating in a tough financial climate and ended the year with a deficit of £25m. During the year, we spent a number of months in Financial Special Measures which came to an end in February 2017 thanks to the great teamwork by all staff to save £25m.

This was achieved in a number of ways including significant reductions (about 50%) in our agency and locum spend and improvements in income. There are many challenges ahead as we change, innovate and develop new capacity to meet demand and provide our patients with the best possible care.

We have fantastic staff whose compassionate care and drive for improvement fuels our work each day. I am confident that we are in a strong position to move forward and build on the hard work of the last 12 months. I am very pleased to be the CEO of this excellent hospital.

Mark Davies
Chief Executive

Overview of Performance

Welcome to our 2016/17 annual report which describes our achievements during the year, covering our service improvements, finances and performance in key areas. Our Quality Account provides a more in-depth report on how we are continuously improving quality, safety and patient experience in our hospitals.

Purpose of the overview section

This overview section gives a short summary of the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Purpose and Activities

The Norfolk and Norwich University Hospital is a 1,200 bed teaching hospital with state-of-the-art facilities for modern patient care. We work closely with the University of East Anglia's Faculty of Medicine and Health Sciences to train health professionals and undertake clinical research. Cromer Hospital on the North Norfolk coast is also a very important facility for us providing high volumes of care to the relatively isolated, predominantly older population of North Norfolk.

Our staff of more than 7,500 care for and support patients who are referred to us by around 100 local GP practices and from other acute hospitals and from GPs around the country. Our team of 670 dedicated and active volunteers is involved in providing support to patients and staff across both the N&N and Cromer Hospital.

We have a range of more specialist services such as cancer care and radiotherapy, orthopaedics, plastic surgery, ophthalmology, rheumatology, children's medicine and surgery, and specialist care for sick and premature babies.

We have world class facilities, highly skilled staff and low infection rates. Our patients rate us highly on quality of care and having friendly, approachable staff.

Brief History

We were authorised as an NHS Foundation Trust on 1st May 2008 in accordance with the National Health Service Act 2006. The NHS Foundation Trust succeeded the NHS Trust formed in 1994.

We are one of the busiest teaching hospitals in England, serving a population of over 900,000. We are located on the southern boundary of Norwich, and our nearest neighbouring acute hospitals are the James Paget University Hospital (JPUH) which is situated 30 miles to the east in Gorleston-on-Sea and the Queen Elizabeth Hospital (QEH), which is situated 40 miles to the north west in Kings Lynn.

We have developed strategic relationships with both of these hospitals over recent years, most recently through partnering together to form the Eastern Pathology Alliance (EPA), with NNUH as the network host laboratory. We have over many years built clinical networks with the majority of clinical specialities at the James Paget Hospital.

Amongst local providers there is a recognition of the need to explore closer collaborative working across clinical networks to ensure that the highest possible quality of care is available for local people. As a result we are working with the other Trusts, plus other partner organisations, through the Sustainability and Transformation Plan.

Key Issues and Risks

The demand for healthcare is at an unprecedented level. We are one of the busiest hospitals in the country in terms of numbers of patients treated, and emergency admissions account for a particularly high proportion of our overall occupied bed days. This is due in part to our patient demographic; the ageing population in Norfolk is reflected in the size of our older people's admission numbers, which are significantly higher than the national average.

The twin issues of increased emergency demand and an increase in complex discharges to other healthcare and social care providers have affected our ability to meet targets and put huge pressure on staff and services.

At the same time, we have faced significant financial pressures with the impact of tariff reductions, pay and pension increases, price inflation and other cost pressures mean that we have significant savings to make in common with all NHS Trusts.

We know from the review into NHS efficiency carried out by Lord Carter, that we are one of the most efficient teaching hospitals in the country. From a cost point of view, the review found that when compared with other same treatments at other hospitals, we are giving excellent value for money. Despite our efforts our deficit position at the end of 2016/17 was £25m. For more information on finances see page 35.

Strategy

Our strategy agreed in 2016 remains in place to guide developments at the Trust. In summary there are five key objectives:

Our Objectives

- We will be a provider of high quality healthcare to our local population
- We will be the centre for complex and specialist medicine for Norfolk and the Anglia region
- We will be a recognised centre for excellence in research, education and innovation
- We will be a leader in the redesign and delivery of health and social care services in Norfolk

The strategy to meet these objectives:

- Develop a new ambulatory care day facility to expand capacity for outpatient, diagnostic and day surgery services (known as ACAD)
- Introduce an Electronic Patient Record across the organisation
- Develop services at Cromer Hospital
- Support the Divisions to eliminate waste and duplication
- Support a 24 hour seven days a week acute hospital service
- Maintain and strengthen our tertiary (region wide) specialist services
- Become a recognised centre of excellence for stroke, heart attack and cancer services; develop these services and the supporting clinical services such as interventional services, diagnostics and critical care
- Strengthen our partnership and role in the Norwich Research Park
- Collaborate with our acute hospital partners to help ensure clinical services remain or become sustainable
- Develop our work with primary and social care to help improve how we look after patients with long-term conditions and reduce the increase in emergency admissions

Although the impact of Financial Special Measures has delayed development of some of our goals, work is underway to build strong business cases to help increase capacity at the Trust. This remains the key challenge facing the Trust.

In addition to this the Trust is playing an active part in the Norfolk and Waveney Sustainability and Transformation Plan (STP). The Trust leads a number of workstreams looking at how the health and social care system can meet current and future demands within the resources available.

Leadership appointments

Peter Chapman, Consultant Orthopaedic Hand Surgeon, was appointed to the role of permanent Medical Director in June 2016. Mr Chapman had been the interim Medical Director since April 2015.

James Norman was appointed as Chief Finance Officer commencing in post in January 2017.

State of the art robotic surgery for patients with prostate cancer

A new £1 million robot is being used to carry out prostate cancer surgery at NNUH.

Robotic assisted prostatectomy is a type of keyhole (laparoscopic) surgery which is used to remove the prostate. The robot has four arms which are controlled by a surgeon sitting at a console in the operating theatre. One arm holds a camera and the others hold surgical instruments, such as scissors or graspers. The surgeon can see the operating area through the console which gives a magnified 3D view.

Going Concern Statement

After making enquiries, the directors have a reasonable expectation that the Norfolk and Norwich University Hospitals NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trust continues to adopt the going concern basis in preparing the accounts.

Our expectation is informed by the anticipated continuation of the provision of service in the future, as evidenced by inclusion of financial provision for that service in published documents. Contracts for Service, being the NHS Standard Contract 2017/18 have been signed with the Trust's main Commissioners.

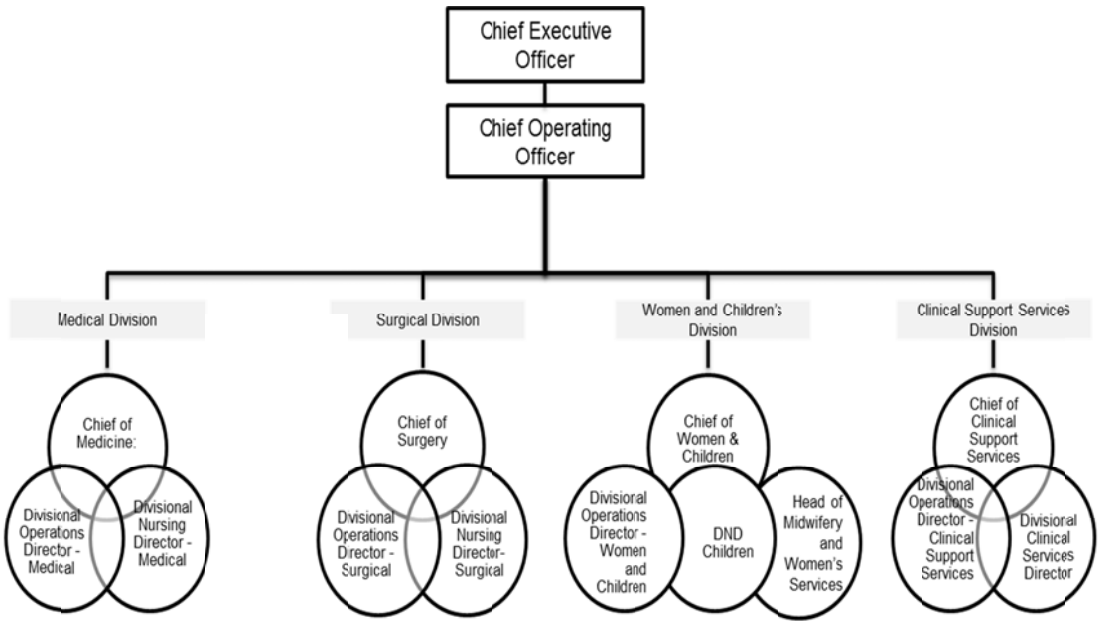
Performance Analysis

How We Measure Performance

A new clinical leadership model was introduced from 1st April 2016 to address the operational performance challenges we face.

Four divisions were established (Medicine, Surgery, Women and Children's Services, and Clinical Support) with a Chief of Division role in each who is the overall lead for the division, with all roles within the division ultimately reporting to them. The Chief is accountable for the performance of the division. Each division also has a Divisional Operations Director whose primary role is to direct and control operations to deliver the division's business plan including recruitment and training of staff, management of service line budgets and ensuring service quality. There is also a Divisional Nursing/Clinical Services Director whose role is to direct and control divisional clinical staff including maintaining patient safety and ensuring front-line teams are appropriately motivated and trained.

The Chiefs of Division report to the Chief Operating Officer and are part of the Management Board with the Executive Directors. The Management Board is responsible for the operation and performance of the Trust, reporting to the Trust Board. The divisional structures are show below:

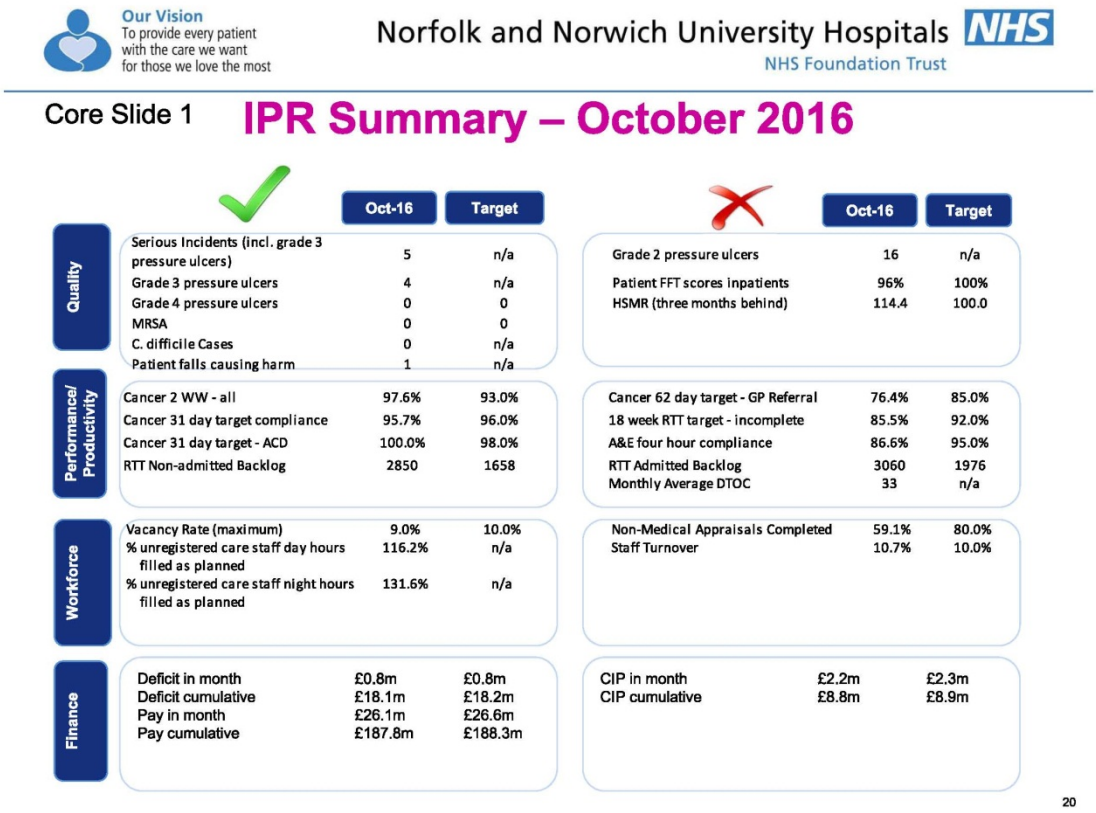


Integrated Performance Analysis

A 75-page monthly integrated performance report is produced by the Trust which provides details of how the Trust is performing on key targets such as infection control, cancer waiting time targets, the A&E target, and the 18 week RTT target, plus finance and staffing issues.

It is shared widely with the Trust Board, Management Board, the Council of Governors and with the staff through the monthly Viewpoint sessions. The aim is to keep everyone informed on how the Trust is performing and describe our progress towards meeting targets or introducing new quality initiatives.

Example of a summary slide from the integrated performance report:



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Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Core Slide 1

IPR Summary – October 2016

		Oct-16	Target
Quality	Serious Incidents (incl. grade 3 pressure ulcers)	5	n/a
	Grade 3 pressure ulcers	4	n/a
	Grade 4 pressure ulcers	0	0
	MRSA	0	0
	C. difficile Cases	0	n/a
	Patient falls causing harm	1	n/a
Performance/ Productivity	Cancer 2 WW - all	97.6%	93.0%
	Cancer 31 day target compliance	95.7%	96.0%
	Cancer 31 day target - ACD	100.0%	98.0%
	RTT Non-admitted Backlog	2850	1658
Workforce	Vacancy Rate (maximum)	9.0%	10.0%
	% unregistered care staff day hours filled as planned	116.2%	n/a
	% unregistered care staff night hours filled as planned	131.6%	n/a
Finance	Deficit in month	£0.8m	£0.8m
	Deficit cumulative	£18.1m	£18.2m
	Pay in month	£26.1m	£26.6m
	Pay cumulative	£187.8m	£188.3m

	Oct-16	Target
Grade 2 pressure ulcers	16	n/a
Patient FFT scores inpatients	96%	100%
HSMR (three months behind)	114.4	100.0
Cancer 62 day target - GP Referral	76.4%	85.0%
18 week RTT target - incomplete	85.5%	92.0%
A&E four hour compliance	86.6%	95.0%
RTT Admitted Backlog	3060	1976
Monthly Average DTOC	33	n/a
Non-Medical Appraisals Completed	59.1%	80.0%
Staff Turnover	10.7%	10.0%
CIP in month	£2.2m	£2.3m
CIP cumulative	£8.8m	£8.9m

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During the year, we have been meeting with our regulator NHS Improvement to review our performance and have focused on the Trust's improvement plans, financial position and long term strategy.

Long term trend analysis

Over the last ten years the NNUH has experienced significant growth in the demand for its services. Around a year ago the Trust Board agreed that providing additional capacity for treating patients was crucial if the hospital was going to continue to provide excellent care for its local population and the wider East Anglian region.

There are two main schemes under development, plus the development of the Quadram Institute which when completed in 2018 will house the largest endoscopy unit in Europe. The first involves extending part of the hospital building to accommodate additional space for interventional radiology and cardiology.

These involve state of the art of minimally invasive procedures that, because of their specialist nature, are not available at smaller hospitals and can offer improved outcomes for patients suffering from a variety of conditions. This scheme is currently being developed and is likely to be considered by the Trust Board in the Spring.

The second major development is the ACAD (Ambulatory Care and Diagnostics Centre). This would be a new building located adjacent to the hospital which would provide more space for outpatients, scanning and day case procedures. The case for this will take longer to develop and the Trust Board will be considering this in more detail in the summer.

The Trust has more demand than it is currently able to deal with and this is recognised by NHS England. These additional facilities – together with recruitment of staff to work in them – will help correct this imbalance. However, like all complex projects they take time to design and appraise and also will involve significant investment. We are currently developing a business case and this scheme will move forward during 2017/18.

Patient Care

Quality of care

The Care Quality Commission (CQC) last inspected our Trust in November 2015 and published their report in March 2016. The report highlighted the caring nature of the service provided by our staff across the Trust. No part of our service was judged to be inadequate and the overall rating of 'requires improvement' was in line with our own self-assessment.

We continue to review and evaluate our compliance with all CQC regulations on an on-going basis and maintain an action plan developed to specifically address recommendations within our March 2016 inspection report. We received a re-inspection by the CQC during April 2017 and we are awaiting a further report. For more information of the quality of care, see the quality report on page 123.

Respect, dignity and safeguarding

A core element of our services is respect for dignity, protection of vulnerable patients and of human rights. This is reflected in the strengthening of our specialist Learning Difficulties and Safeguarding team during 2016. Through a series of Trust policies and protocols, awareness raising, input on the wards and through staff training the dignity and autonomy of patients is enhanced. This is illustrated, for example, in relation to the deprivation of liberty safeguards, reporting of female genital mutilation, protection against domestic abuse and facilitated decision making for patients with dementia. Regular reports on these issues are received and reviewed through the Trust's Caring and Patient Experience Governance Sub-Board

NNUH Radiology Team

NNUH Radiology department receives ISAS accreditation

The NNUH Radiology department is celebrating renewing a national accreditation for a further four years for their services offered to patients.

The Imaging Service Accreditation Scheme (ISAS) is a patient-focused assessment and accreditation programme designed to help diagnostic imaging services ensure their patients receive high quality services.

The accreditation has been awarded to the NNUH Radiology team for their excellent patient-centred service that they provide. The accreditation standards are endorsed by the Royal College of Radiologists and the Society and College of Radiographers, and overseen by an independent body UKAS (UK Accreditation Service).

Development and Performance

Expansion of Ambulatory Emergency Care

We experienced a very busy year in the Emergency Department and, in common with many acute trusts across the country, we did not meet the national target of 95 per cent of patients waiting less than four hours in A&E from arrival to admission or discharge, achieving 85.9% for the year.

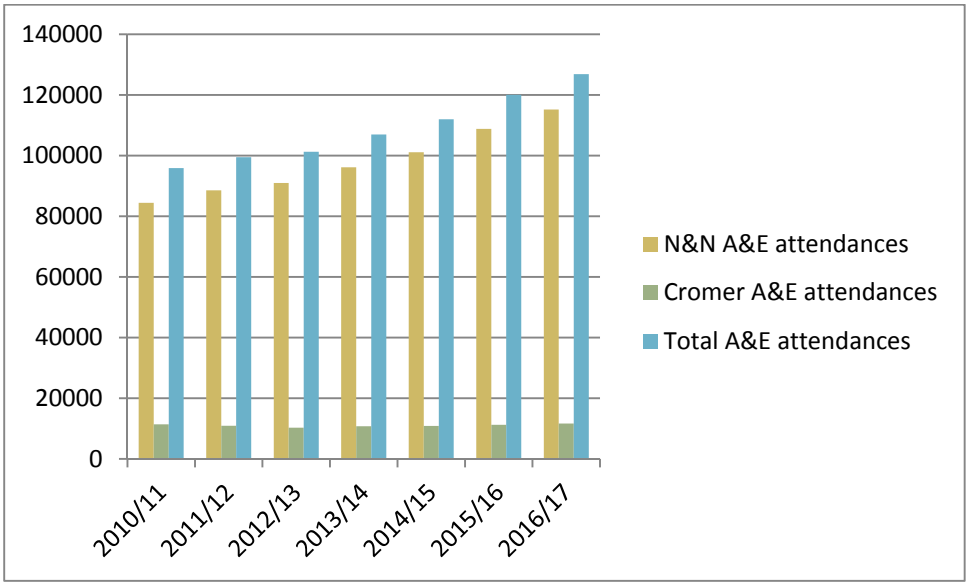
There are a number of steps we have taken to improve performance and the most significant is the expansion of the Ambulatory Emergency Care (AEC) service. This service has enhanced patient experience and helped to reduce the number of patients requiring admission to hospital by around 5%.

Ambulatory Emergency Care is offered to patients who require further investigations, procedures or treatment following a referral from their GP or from A&E. The service offers same-day emergency care and reduces unnecessary admissions into hospital.

NNUH started this service in 2014; however since July 2016 the service has significantly expanded with the introduction of nine new treatment areas and a quiet room for patients and families.

The AEC team have been guided by the national AEC Network, a national programme that enables healthcare teams to rapidly expand their ambulatory emergency care services. Plans are in place to expand the AEC service further.

Emergency Department performance



Attendances at A&E at the N&N rose from 108,831 in 2015/16 to 115,118 in 2016/17. At Cromer Hospital there were 11,233 attendances in 2015/16, compared to 11,676 in 2016/17. Altogether, attendances increased from 120,064 in 2015/16 to 126,864 in 2016/17.

Red to Green

We have been taking part in the national Red2Green campaign which aims to make sure that every day is a day of added value for patients in our care. The initiative is about reducing unnecessary delays in our processes and sharing with patients what the plan is to help get them home. Evidence shows that ten days in hospital for a patient aged over 80 leads to the equivalent of 10 years ageing in the muscles.

We will be measuring our services for improvement and a key factor for success will be to identify and address our most common reasons for delay. The first five exemplar wards started rolling out Red2Green in February 2017.

Improvements in Discharge

In April 2016 the Trust appointed a senior Matron to manage the integrated discharge team. Over the last year we have increased this team significantly to support safe and timely discharges throughout the organisation. This has included a number of initiatives which have now been successfully implemented or with plans to implement over the next few coming months.

We launched a discharge HUB in May 2016 that acts as a central point of contact for all wards and staff to access support with discharge planning. In the next few months we plan to relocate into a discharge suite which will be a further positive step towards the integration of health and social care. This move will enable the discharge team, continuing healthcare team, social services and community teams to all work in the same space to encourage more collaborative, joined up working across our health systems.

In March 2017, we have successfully launched the discharge to assess pathway. This enables us to support discharges for those likely to receive ongoing health funding within 72 hours. Previously this assessment process was a long and lengthy process often causing significant delays in discharge from the hospital. We aim to continue to develop this pathway further over the next few months.

In April 2017, The Trust will welcome a company called CHS, to work alongside the discharge team and social services in supporting those patients who are deemed "self funding" these are patients that have had a social care assessment and are deemed not eligible for funding. Often these patients felt under supported and isolated when having to make difficult decisions surrounding their ongoing care needs.

This company will work collaboratively with NNUH teams in supporting safe and timely discharges of this client group which will reduce any unnecessary waits and will be far more supportive for this patient group. We have increased the nursing team for the integrated discharge team. This enables us to support board rounds daily, identify complex discharge issues earlier and implement plans faster. It also enables us to support the role of Red 2 Green on the wards and with some support with the new clinical utilisation review tool.

A significant amount of work has been completed over the last 12 months in reducing our stranded patient metrics. A stranded patient is any patient who has been in hospital for longer than 14 days. This number in April 2016 was around 350 patients, with an intense focus on this and persistent reviews we have successfully managed to reduce this number to around 200 patients. We aim to reduce this further to 170 by the end of April 2017.

There has been a CQUIN assigned to discharge which has shown significant improvements in:

- Booking transport 24 hours in advance
- Improving compliance with estimated discharge dates giving site Ops a clearer understanding of capacity planning
- Numbers of patients being supported via the discharge HUB we have seen a significant increase.
- Reduction in length of stay

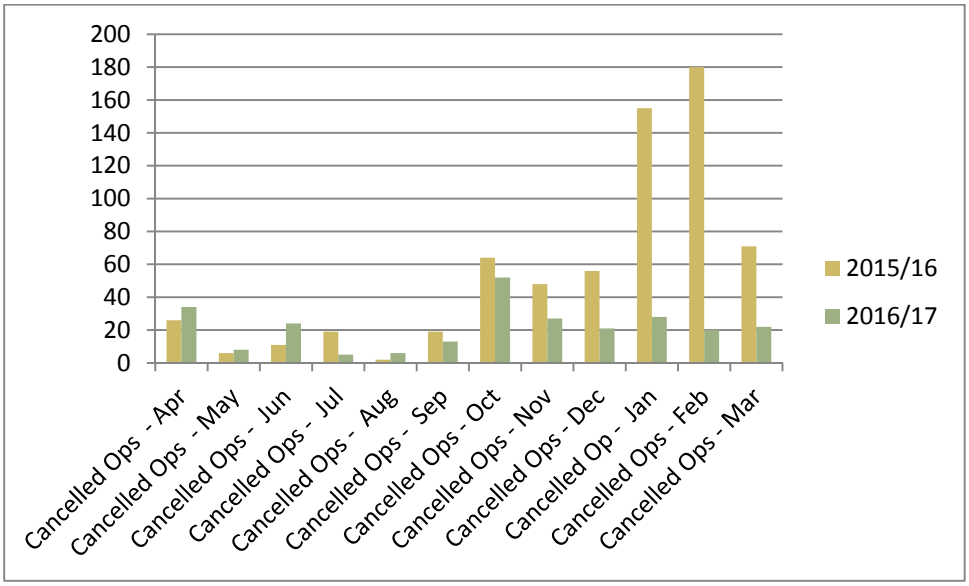
We have achieved a significant amount of this CQUIN which has been financially beneficial to the Trust. Finally we aim to implement "single point referral" this year, which will mean one referral will be required to support a discharge rather than multiple referrals saving significant nursing time on wards. The aim of this is to get the right person there, first time, to ensure a timely and safe discharge.

Patient Flow

Significant progress in patient flow provided us with an opportunity to both reduce nurse agency staff costs through temporary bed closures, and restart our ward refurbishment programme. At the same time, we have ring fenced our Day Procedure Unit to increase day surgery activity.

From August to November 2016 three wards were closed temporarily and they were reopened when over 80 newly qualified nurses joined us from the University of East Anglia. A £2.5 million ward refurbishment programme was also carried out on Mattishall Ward which has become the decant ward for the rolling programme of ward refurbishments. Henderson Unit, which provided reablement for patients, was closed in October 2016 as part of our financial savings plan. It followed improvements in discharge arrangements which enabled us to maintain patient flow.

The overall improvement in patient flow has enabled us to bring down the number of cancelled operations due to bed shortages. In 2015/16, there were 180 operations cancelled for this reason, compared to 20 in February 2016/17.



This graph shows cancelled operations due to bed shortages and the improvement from 2015/16 to 2016/17.

NNUH secures funding for enhanced levels of maternity care

NNUH was awarded more than £80,000 of government funding to invest in the maternity department to help mothers and babies.

The hospital put in a successful bid to the Department of Health's Maternity Innovation Fund and the Maternity Safety Training Fund to provide additional training for staff.

The Maternity Innovation Funding will go towards a new piece of simulation technology called 'CTGi' which replicates a baby's heart rate pattern during labour. This piece of training technology will be used within clinical areas for both the midwifery and medical teams and supplement more traditional class room tutorials and e-learning programs.

Medical Day Unit

Since opening in December 2016, Gunthorpe Medical Day Unit (GMDU) has already received very positive feedback from patients who have undergone elective procedures, such as pleural aspiration and ascitic drainage, without the need for hospital admission. We now see day patients who previously would have been admitted to a ward or come in via the Emergency Department, so this is going a long way to reduce hospital admissions.

The development has also paved the way for the introduction of a new day case pleural service led by the respiratory team and a new radial lounge for the cardiology team. The radial lounge for patients who are having an angiogram, so instead of patients going into beds, they are being treated as elective ambulatory patients in a specialised area.

It also offers patients a more responsive service so that they can contact us when they need a procedure and we can see them more quickly. The hope now is to expand the range of procedures offered in the day unit, and develop new skills within the nursing team.

The unit is freeing up beds for the front door on those medical wards where patients would have previously been sent. Now they are coming straight to Gunthorpe, having their procedure and going home.

Performance against key health targets

Referral to Treatment waiting times

We have seen a significant rise in demand in recent years which has outstripped our capacity. Over the last five years, two week wait referrals for cancer have risen 10% year on year, with RTT demand also rising by 2.8% annually and emergency admissions going up by 3.7% each year.

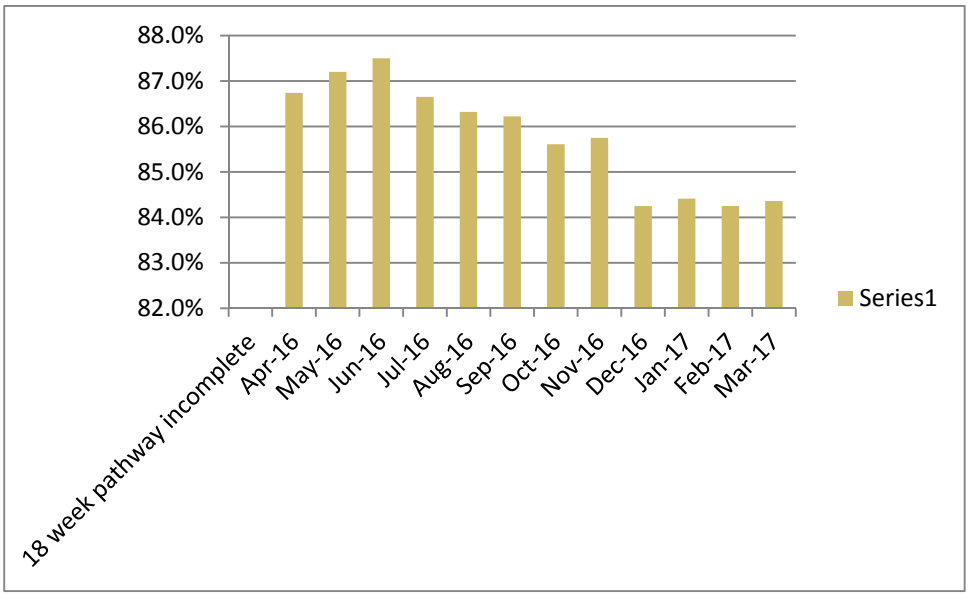
Detailed work has been carried out with commissioners and regulatory bodies to look at waiting list data which has confirmed that the data quality and governance processes at NNUH are robust. There is a significant gap (circa 10,000 patients) between our current waiting list and one that would be sustainable. The result is that additional capacity is required for Norfolk patients to be seen in a timely manner.

A number of steps have been taken to create temporary capacity, such as additional clinicians, temporary facilities and a range of productivity improvements. We are also working closely with commissioners who are seeking to manage demand and use alternative providers. Despite these efforts, the Trust remains overheated with longer waits for patients and pressure on staff. The key specialties with very long waits are ENT, General Surgery, and Gynaecology where we have specific plans in place to address the capacity issues.

We are working with partner agencies in a System Delivery Board which has been set up to address the capacity issue across the local healthcare system.

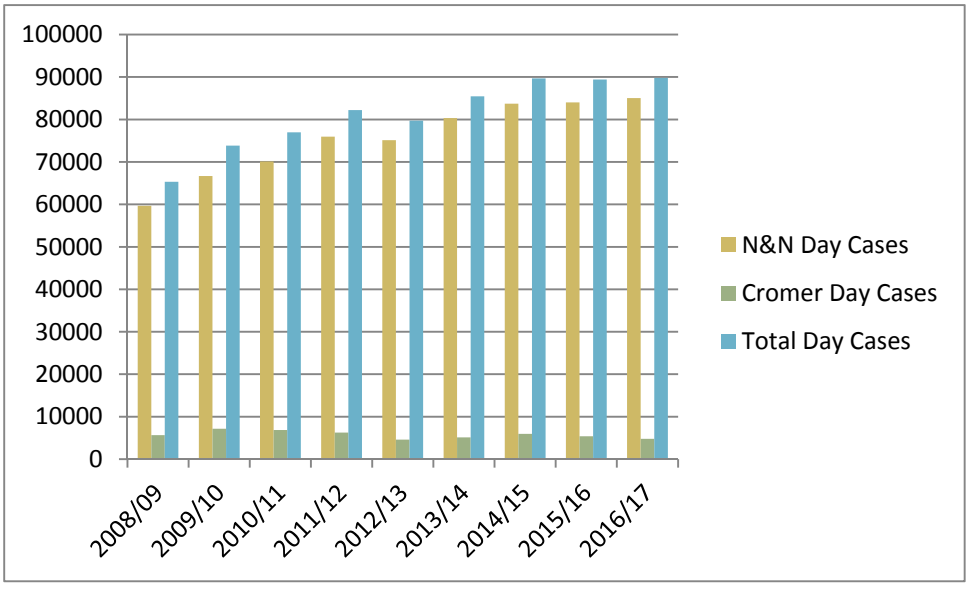
In terms of the Trust's plans, the expansion in capacity will take the form of an Ambulatory Care and Diagnostics Centre (ACAD). This facility will provide outpatient services, day-case theatres and diagnostic procedures. These plans are being developed at pace and regular update are being given at the Trust Board's meetings held in public.

Trust total % of patients on an incomplete RTT pathway (92% target). Through the year, performance has gone from 86.7% to 84.6%.

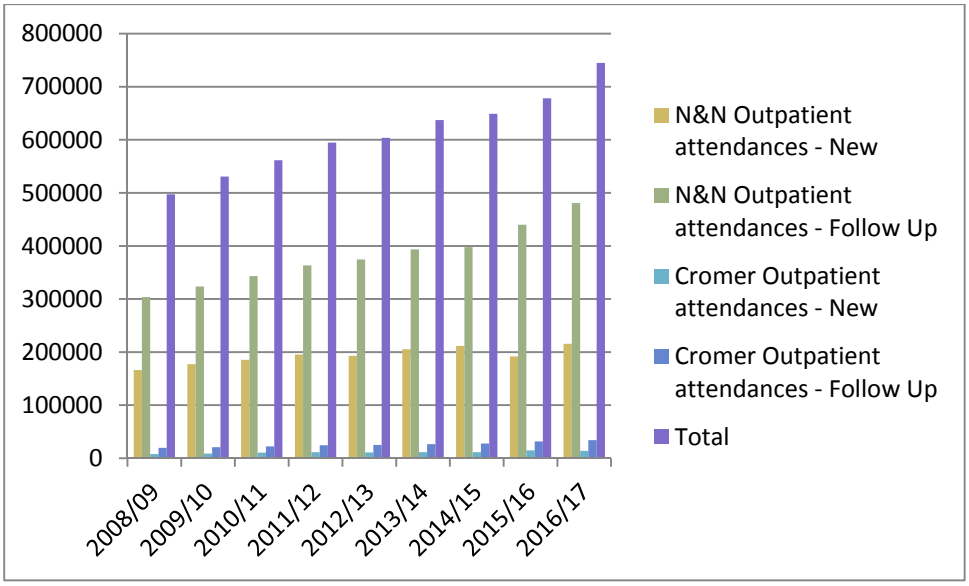


Day Cases

In 2016/17, there were 85,029 day cases at NNUH, 4,773 at Cromer Hospital with a total of 89,801, compared to 84,014 in 2015/16.



Outpatient Services

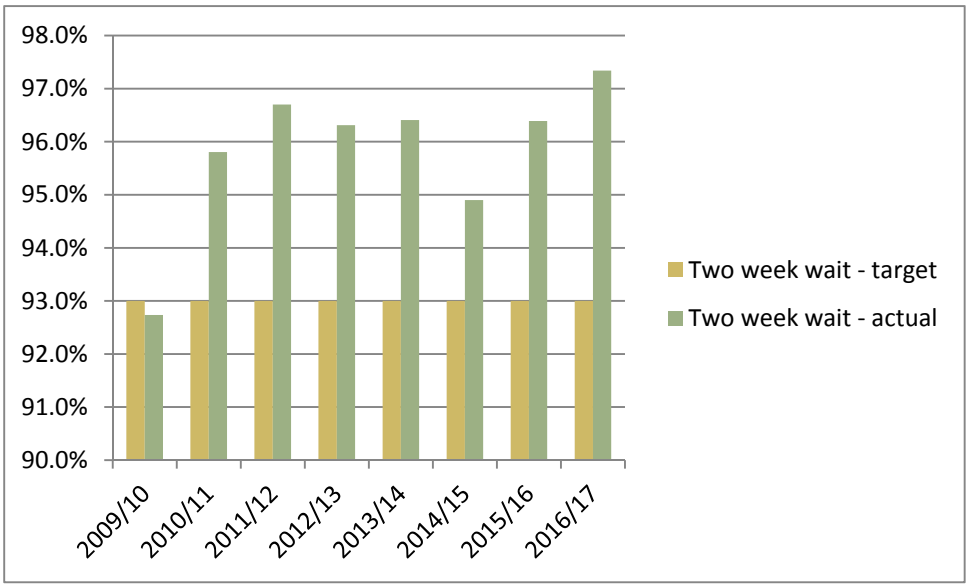


Overall there were 229,545 new outpatient attendances in 2016/17, compared to 206,740 in 2015/16 with 515,305 follow ups in 2016/17 compared to 471,635 in 2015/16.

At the N&N hospital in 2016/17 there were 215,662 new outpatient attendances which compared to 191,721 in 2015/16. The N&N saw 481,122 follow ups in 2016/17 compared to 440,047 in 2016/17. At Cromer Hospital we saw 13,883 new outpatients in 2016/17 compared to 14,749 in 2015/16 and 34,183 follow up appointments in 2016/17 compared to 31,588 in 2015/16.

Cancer

For two week waits, we exceeded the target by achieving 97.3% (target is 93%). This was despite an increase in referrals of nearly 9% which now number over 2,000 a month.

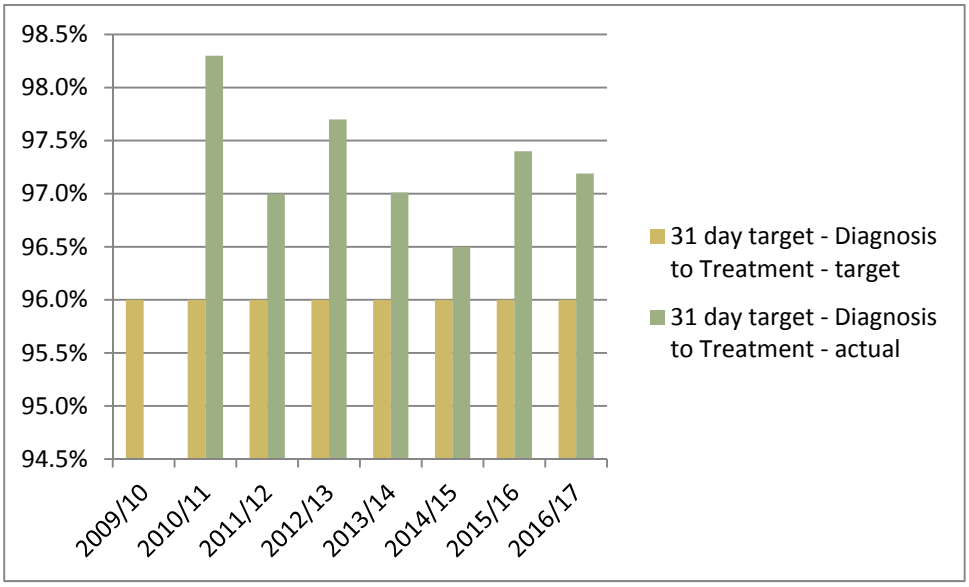


NNUH to launch improved 'finger food menu' initiative for patients

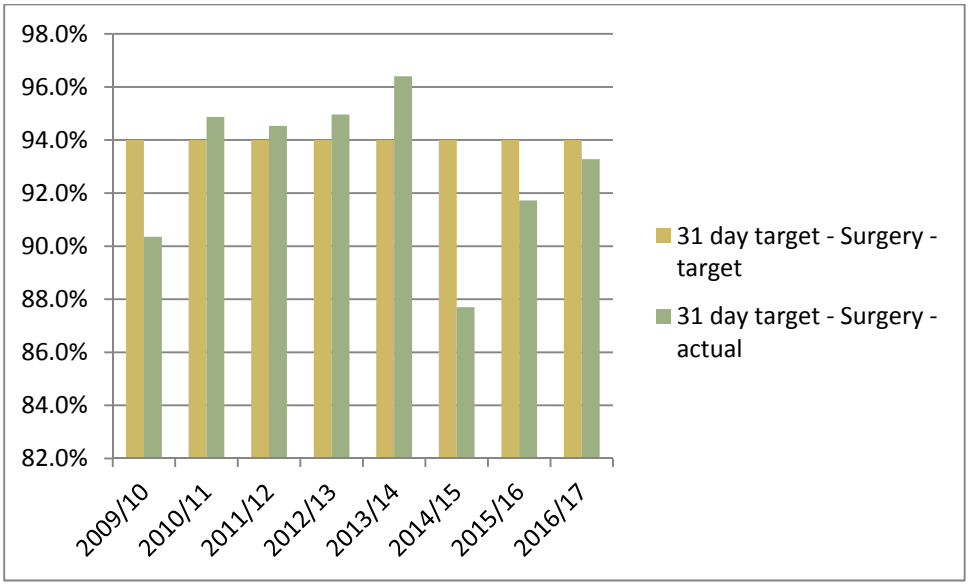
NNUH has launched an improved 'finger food menu' during Dementia Awareness Week to aid patients including those with dementia. Research has shown that a finger food menu for patients with dementia could help with enjoyment of food and drink, improve nutritional intake, help maintain independence and avoid co-ordination problems with cutlery.

The trial was launched by an internal focus group, for Nutrition and Hydration for People with Dementia, on two of the hospitals Older Peoples Medicines Wards, Holt and Knapton. The trial was so successful it will now be rolled out across all wards within the hospital. Staff commented that they liked the format and options available to the patients whilst patients enjoyed the variety they were able to choose from and eating in a way that suits them.

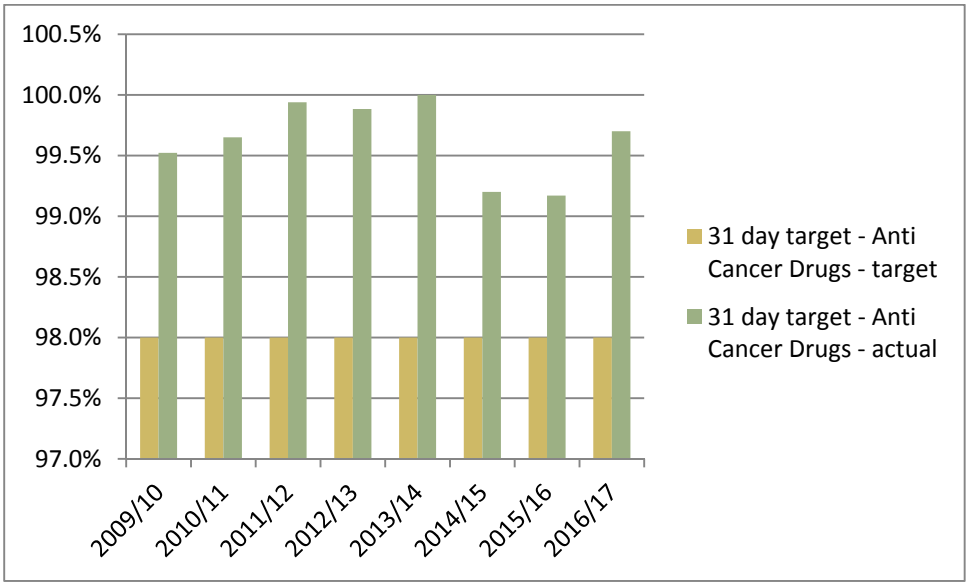
For the 31 day target for diagnosis to treatment, we achieved 97.2% which is above the target of 96%.



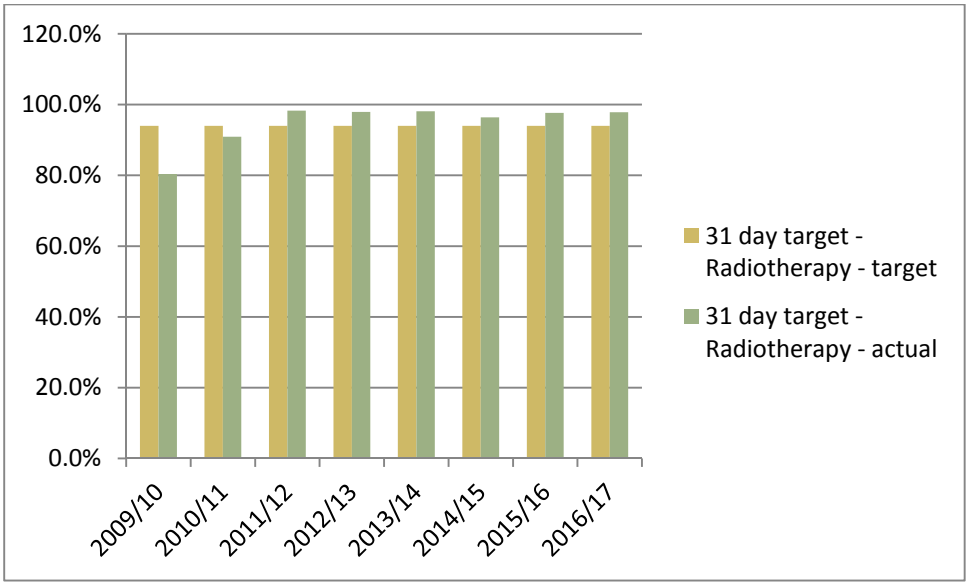
For 2016/17, we achieved 93.3% against the target of 94% for the 31 day target for surgery. Although NNUH did not meet the target of 94% performance has improved since the previous year, with it being achieved in 5 of the 12 months.



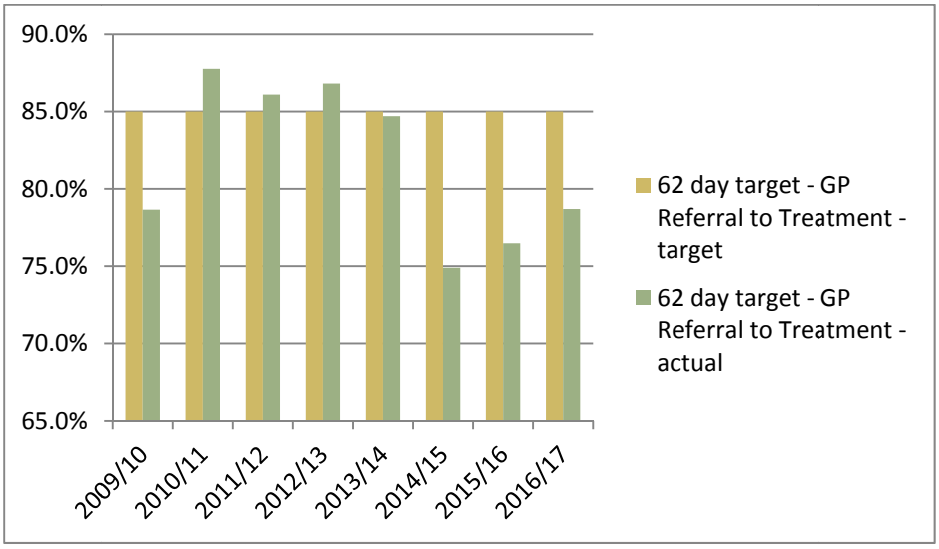
There are two surgical areas where high demand has made it difficult to meet the target consistently every month. Demand has exceeding capacity in Plastic Surgery for wider excision procedures and we are employing another consultant to boost our capacity. In Urology, we are also increasing capacity to meet the 31 day target.



For the 31 day target for anti-cancer drugs, we achieved 99.7% against a target of 98%.



For the 31 day target for radiotherapy, we achieved 97.8% against the target of 94%.

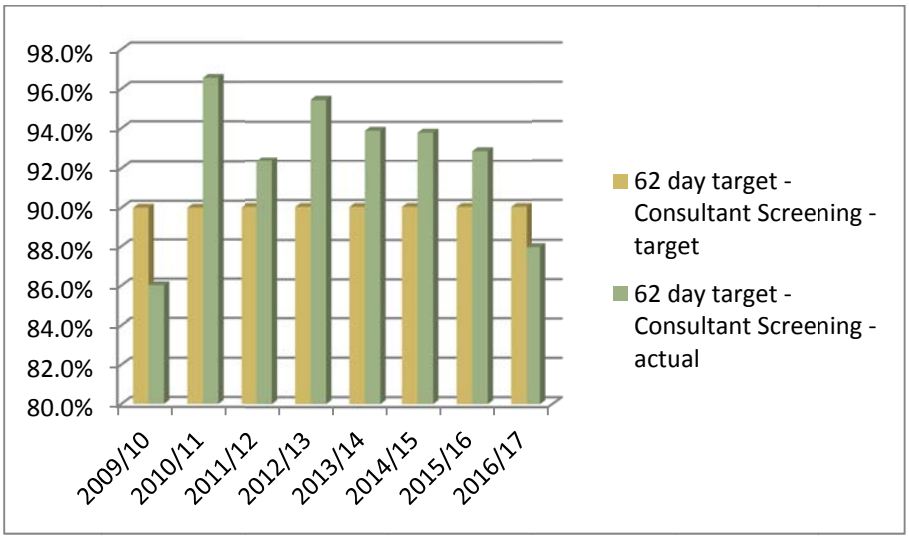


The 62 day target for GP referral to treatment was not achieved with 72.12% achieved against the target of 85%.

Performance against this standard has improved over the previous year and the target has been met in six out of 12 months. NNUH, like many other Trusts nationally, is continuing to see an increase in the number of referrals and requires more capacity in diagnostics, outpatient services and surgery. We expect to meet the target fully in 2017/18.

Cancer pathways have become more complex in recent years, with additional diagnostic and treatment techniques now available that ensure that patients survival is increased, complications are reduced and as many people as possible can enjoy disease free lives as is possible. These techniques are hugely resource intensive (for example all day surgery) which has added to the pressures of delivering the 62 day pathway.

NNUH is due to open its expanded chemotherapy day unit in April 2017 which will increase capacity from 14 chairs to 24, this will reduce waiting times for treatment and provide a better patient and staff environment.

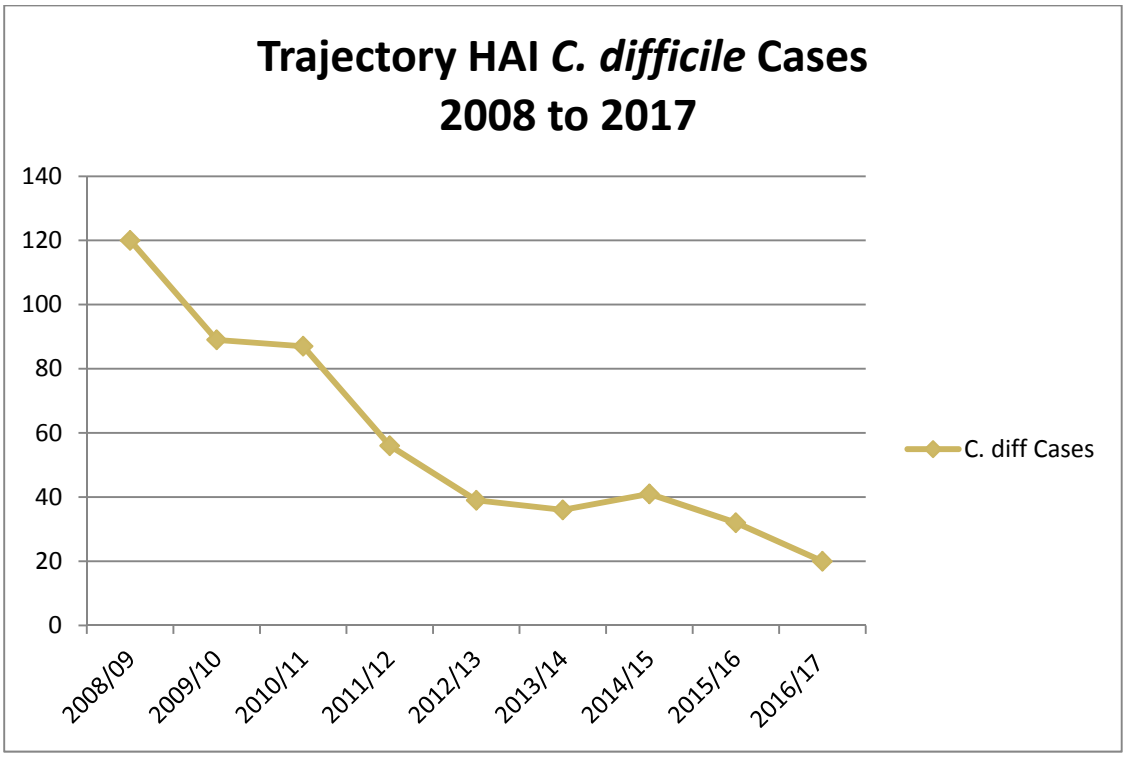


The 62 day target for consultant screening was not achieved with 85.9% against a target of 90%.

Healthcare Acquired Infections

MRSA bacteraemia: The DH ceiling set for the hospital was zero. The trust met this objective, there was no hospital acquired MRSA bacteraemia in 2016/17

Clostridium difficile:



Further improvements were made this year and the targets met as has been the case over previous years. For 2016/17, the DH ceiling set for NNUH was 49 hospital acquired (HAI) *Clostridium difficile* cases. There were 42 HAI cases in total of which 22 were counted against trajectory i.e. involved lapses in care and 20 were unavoidable i.e. no lapse in care. By comparison, in 2015/16 the DH ceiling was also 49 hospital acquired cases, there were 56 HAI cases in total of which 32 (57%) were counted as trajectory and 24 (43%) were unavoidable.

Norfolk hospital and science partnership cures patients of debilitating gut infection

Dr Ngozi Elumogo in the laboratory

A new treatment programme for Clostridium difficile (C.diff) was announced during International Infection Prevention Awareness Week 17-21 October.

In the last year, the lives of 20 patients diagnosed with C. diff, a bacterium that infects the gut, have been transformed by NNUH by the use of Faecal Microbiota Transplant (FMT). Following national guidance from NICE, the hospital started a pilot scheme in August 2015 in partnership with the Institute of Food Research. This treatment has had a 90% success rate.

Our Financial Performance

In August 2016, it was announced by NHS Improvement (NHS I), our regulator, that five Trusts including NNUH were being placed in financial special measures. This was because like most of the NHS we were in deficit and also because we did not accept the control total set by NHSI. A control total represents additional savings targets on top of the tough savings targets we had already agreed in our financial improvement plan.

We were brought out of Financial Special Measures in February 2017 after working hard to bring down our deficit from £32m to £25m. A Programme Management Office was set up to track and monitor financial improvement plans, with oversight from the Financial Improvement Programme Board. This approach enabled the Trust to demonstrate financial improvement from all the actions taken by the different teams across the Trust. There was also support for the operational divisions from a Turnaround Director and Price Waterhouse Coopers to develop skills and identify additional financial improvements and innovations.

Our turnover is £564 million, and our actual deficit for this financial year is £25 million, consistent with the plan agreed with our regulators.

Financial Improvement

Our financial improvement plan required us to deliver £24.6m of recurrent savings, representing 4.4% of turnover. We have successfully achieved this in year, with a particular focus on reducing premium pay costs and working hard on productivity and associated improvements. This has been underpinned by an enhanced governance and delivery programme with inbuilt quality and safety safeguards.

Cash management

Our expectation for the year was that we would need to borrow £20m of cash to enable us to meet our liabilities as they fell due. We have focused on cash management in order to ensure that our cash is used most effectively and have been successful in both reducing the amount we have had to borrow from the DH and also in the timing of that borrowing which has allowed us to secure a more favourable interest charge rate. Our end of year borrowing was £16m.

Capital Expenditure

We invested £6,885k in new and replacement capital assets during the year (2014/15: £8,257k).

Charitable Funding

We are fortunate to be supported by the Norfolk and Norwich University Hospital Charity, The Friends of Norfolk and Norwich Hospital Charity and The Friends of Cromer Hospitals. In addition we are again fortunate to receive support from many external charities and organisations. In 2016/17 we benefited from £0.2m of donated assets.

Longer term:
We recognize the need to return to a sustainable recurrent financial position, and building on the improvements achieved in 2016/17 we have developed an operational plan for 2017/18 which shows a return to a small surplus. The plan is sensibly based but will be tough to achieve. It requires savings of 5% of planned turnover with a continued reduction in premium pay and emphasis on productivity, and a relentless focus on patient safety and care.

Financial Accounts 2016/17
The full accounts are attached at the end of this document.

Overseas operations
We do not have any overseas operations.

Social and Community Report

We aim to be at the heart of the local community serving a large population in a rural area. We touch the lives of many people as patients, visitors, members, fundraisers, volunteers and employees. Local people can get involved in a number of ways, principally through our large membership scheme, but also through our ward assurance audit programme, patient panel or as a volunteer.

Patient feedback is vital to help us improve the care we provide and we collect the views of patients in several ways outlined on the following pages:

Patient Feedback

How we gather patient feedback across our Hospitals and the insight it gives to us includes In-patient, Out-patient and emergency areas. All additional 'free-text' comments are reviewed and themed, helping us to understand patients' views and to make service improvements.

Feedback is invited through a variety of methods including card systems, telephone and touch-screens. We are actively exploring the potential to extend this to text messaging as a more convenient method for some of our patients.

The efficacy of changes we have made as a result of the Friends and Family Test, such as reducing noise and disturbance at night by providing earplugs to patients who would like them, is reviewed through our Quality Assurance Audit programme

Insight

We have continued to ask a small number of additional questions in our inpatient surveys, to assess whether patients feel that all the staff caring for them, and that they introduce themselves properly. The results have been very encouraging at more than 97% and patients' responses by individual ward area are reviewed so that we can effect improvements at individual area levels.

Monthly patient feedback reports at ward level are available to matrons to share with ward staff and the reports are discussed at the monthly Patient Experience Working Group, providing transparency and enabling them to take action to remedy issues and share best practice.

The Board is updated every month on the key issues highlighted by patients, and actions taken to resolve them. Our matrons have been using the information from these surveys to work with our ward teams to improve the care we provide and our Friends and Family Test score from inpatients is consistently been above 97%

Quality Assurance Audits

Our Quality Assurance Audit programme involves unannounced inspections by teams across the hospitals' departments most days of the week. Comprising a minimum of two senior nurses and an independent external representative from the community when particular standards are reviewed, the teams visit a department and inspect the standards of care provided to patients in that setting including cleanliness, assistance with meals, privacy & dignity, involvement in care planning and records. During this year we have re-designed the administration of the programme. This was to enable more areas to be included, all standards to be reviewed and to ensure timely remedial actions and reassessment of areas where a need for improvement is identified.

Our independent external representatives are mainly from local voluntary and community groups such as Age UK, the Older People's Forum, tutors from the university and patient groups and are primarily responsible for talking with patients and families and listening to their feedback. At the end of each audit all members of the team share their findings with the ward they have visited with any action points for improvement.

One of the strengths of this Quality Assurance Audit programme is that it provides an opportunity for peer reviews and the sharing of good practice. The results are shared with all relevant clinical and managerial staff and are reported monthly to the Trust Board. Feedback from patients is actively sought, especially by our external audit team members and we use this to help inform on-going improvements in the services we provide.

To explain and detail initiatives and changes we have implemented as a result of these audits, we hold periodic bespoke update events for our external audit team members. Examples of changes made include better signposting for carers and families when they wish to communicate with our clinical teams.

Carers' Strategy

A Carers' Strategy is in place to improve engagement with carers and to provide support to carers to maintain their physical and mental wellbeing. It is led by senior healthcare professionals and reports its work and initiatives to our Caring and Patient Experience Assurance Sub-board which is chaired by the Director of Nursing.

Patient Information Forum

We have a Patient Information Forum, which is responsible for ensuring a consistent standard in the design and production of high quality information leaflets for patients. All patient information leaflets submitted to the forum are reviewed by a multidisciplinary team to ensure that they are jargon free, accessible, accurate and appropriate for the intended audience. Our Virtual Patients' Panel members or service users are invited to review newly-developed patient information leaflets prior to their approval, to report on the clarity of the information presented.

NNUH Patients benefit from Generous Legacy

Delphine Fulcher

Gastroenterology patients at NNUH are benefitting from a generous £54,000 bequest to the hospital charity from a Norfolk woman.

The money left by Delphine Fulcher from Mundesley has been used to buy two machines that will help doctors investigating disorders of the gullet and to see the inside of bile ducts at the busiest endoscopy unit in the country.

Delphine's partner Michael Webb said "Delphine was passionate about helping others and wanted the money to go to local services."

Consultant Hepatologist Simon Rushbrook explained that more than £33,000 was spent on an oesophageal mamoneter "This will allow us to understand and diagnose disorders of the gut as well as diagnosing the nature of oesophageal reflux."

Volunteer work to improve the Patients' Experience

We currently have more than 670 volunteers and work with a wide variety of external voluntary groups to support us and enhance the experience of our patients.

Our volunteers are placed throughout Norfolk and cover services over seven hospital sites and also in the community.

Volunteers have been specially trained to support appropriate patients at mealtimes, to provide companionship and dementia support volunteers have been introduced to work alongside the dementia support workers on OPM wards. In addition to this some specialist roles have also been established such as reading aloud, breast feeding support and music therapy.

A regular team of volunteers support our school of medicine assisting them with registering students and providing refreshments on exam days.

Fundraising volunteers have been assigned to our fundraising manager and assist her with all kinds of fundraising events and activities. Bleep buddies carry bleeps and can be contacted by staff hospital-wide. They are mainly used by secretaries, administration staff, receptionists and the volunteers' office for ad hoc errand running, note collecting, patient escorting and wheelchair pushing duties.

In addition, a team of volunteers carry out audits and surveys gathering patient experience data from our inpatients on iPads. They also collect card surveys from our outpatient clinics and conduct telephone surveys with patients the day after discharge.

The community "Settle in Service" has proved a great success. Our 'Settle-in' volunteers meet patients as they return home and carry out some simple checks around the home. Duties include making a cup of tea, unpacking patient's bags, checking the central heating is working and ensuring there are some basic grocery supplies such as bread and milk in the cupboards. Volunteers can also arrange for patients to be helped or referred to other services where necessary who are able to offer on-going support after discharge.

As part of our volunteer training programme ALL new volunteers are now trained as dementia friends.

New roles currently being established are:

Palliative Care

Palliative care volunteers to help support patients and their families towards the end of life. For patients (and those important to them) who have been admitted to our hospital and are estimated to be within the last term of their lives volunteers will provide:

- A befriending and companionship service for the patient
- A respite break for the family
- Run small errands within the hospital shops, restaurant and café
- Assist with hobbies if appropriate and available eg. Board games, reading, playing cards etc.

Volunteers will be able to offer compassionate and empathetic support to patients and those important to them who may be experiencing complex or difficult emotions and who may be feeling emotionally vulnerable.

Learning Disabilities

Volunteers will be placed with the LD liaison team to help support patients with a recognised learning disability. Duties may include:

- Meeting patients from transport, orienting to hospital environment, supporting with return transport
- Supporting patients who may be waiting for appointments
- Supporting patients' understanding of information given to them
- Visiting inpatients on the ward to provide social interaction, reassurance and to support activities. May include supporting patients to access different parts of the hospital (i.e. shop/café) if this is clinically safe and approved by ward
- Supporting patients with eating and drinking (these patients will *not* have identified complexities in this area such as dysphagia)
- Handing out LD patient satisfaction surveys
- Supporting the LD team with resources / sharing resources with wards
- Support with stalls and awareness raising

Older Peoples Medicine

A new Older People's Medicine project will provide a specialised team of volunteers to offer mealtime support, therapeutic massage and activities such as memory box and reminiscence exercises. Volunteers will be based within all areas of older people's medicine and will also offer support in the emergency department, where they will meet, befriend, reassure and accompany patients to further investigations for the duration of their visit.

Young People

We are working with various departments at City College Norwich as part of their "Marketplace" programme… a networking group that offers work advice and experience to their younger students. We are working to provide not only health and social care volunteering placements, but also administrative, reception and support service opportunities to students who are unsure of their career path. We will be additionally supporting students who have anxiety and/or confidence issues.

Health Overview and Scrutiny Committee

The Health Overview and Scrutiny Committee is part of Norfolk County Council and its role is to scrutinise the local health service, ensuring that patients and the public are properly involved in any changes to services. The committee has examined issues such as ambulance turnaround times at A&E and discharge from hospital, looking at the arrangements in our hospital and others locally.

Nora Long who received an award for 45 years' service with Mark Davies and John Fry

Hospital volunteers give 310 years' service

Thirty seven volunteers at NNUH have just received awards in recognition of their long service, including one volunteer who has achieved 45 years' service.

The awards were presented by NNUH Chairman John Fry and Chief Executive Mark Davies at the Volunteers' Christmas Party held at the hospital. Twenty one volunteers received five-year long service awards, thirteen volunteers received ten-year long service awards and two volunteers received 15 year service awards. Altogether the volunteers have given 310 years' service to the hospital.

Healthwatch

Healthwatch was set up in April 2013 following new legislation covering public engagement with the NHS. Healthwatch England is the national consumer champion in health and care. It has significant statutory powers to ensure the voice of the patient is strengthened and heard by those who commission, deliver and regulate health and social care services. Healthwatch members have been part of our quality assurance audit process and Healthwatch members have also assisted in gathering feedback from patients.

Membership scheme

As an NHS Foundation Trust, we have a membership scheme with over 16,000 public members. Members receive a copy of our magazine The Pulse and they are invited to talks on health topics and events such as our open day and fete. Members also give their views on health priorities and other issues. More information about membership is given in the Council of Governors' section of the Director's report on page 47.

The Fundraising Connection

Norfolk and Norwich University Hospitals NHS Foundation Trust is the Trust's registered charity. Our objective is to improve the health and wellbeing of NHS patients who use the services of the Trust's hospitals.

We make grants to pay for equipment, facilities or amenities which enhance and supplement what the Trust provides with its NHS funds. This year we raised £2.303m largely through the generosity and tireless efforts of donors and supporters in the local community as well as the Trust's own staff.

During the year, the charity spent £1.1m on charitable activities across the two hospital sites.

This expenditure included the purchase of: digital endoscopes, ultrasound scan trainer, corneal tomography machine, digital spyglass scope, simulation recording system, haemofiltration machines, bladder scanners, memory day room for patients with dementia, hysteroscopes and flexible video cystoscopes.

The Charity's general fundraising for its wards and departments benefited from outstanding support from donors and fundraisers in the local community — typically patients and their families, friends and colleagues. In addition online sponsorship and giving showed promising growth and we have used social media to highlight activity and to thank supporters.

We have a varied calendar of fundraising events on site from Summer and Christmas Fairs to an annual Bike ride and increasingly staff and the public use these events to raise money for their favourite ward or department. We are grateful to the support from corporate partners, community organisations other charities including Friends of NNUH and Friends of Cromer & District Hospitals.

Environmental responsibility

The Trust is conscious of its potential impact on the environment and is seeking to mitigate this through the promotion of cycling, waste recycling and its Carbon Reduction Plans.

Complaints handling

We have a long-established process for investigating, managing and learning from formal complaints about the services of the Trust.

In order to ensure that complaints are used to learn lessons and prompt service improvements for patients, every complaint is reported to the relevant divisional/departmental manager and clinical director so that any necessary actions can be taken. Monthly reports are then reviewed by our Caring and Patient Experience Governance Sub-Board, with summaries provided to the Management Board and Board of Directors.

For more information, go to page 178 of the quality report.

Stakeholder Relations

The Quadram Institute – This new world leading centre for food and health research will bring together the Institute of Food Research, the Norfolk and Norwich University Hospitals' regional gastrointestinal endoscopy facility and aspects of the University of East Anglia's Norwich Medical School and the Faculty of Science.

This new centre for food and health research to be located at the heart of the Norwich Research Park, one of Europe's largest single-site concentrations of research in food, health and environmental sciences. The new £81.6m Quadram Institute is expected to open in 2018.

Being part of the development of the Quadram Institute will help us to double our capacity for bowel screening which is needed due to population changes and the need to screen a broader age range of patients.

Approval of the Performance Report

I confirm my approval of the Performance Report:

Mark Davies
Chief Executive **Date: 26 /05/2017**

Accountability Report

Directors' Report

Board of Directors

The Board of Directors has overall responsibility for the operational management of the Trust and is charged by statute with ultimate responsibility for the Trust's corporate affairs in both strategic and operational terms. It is responsible for the design and implementation of agreed priorities, objectives and the overall strategy of the Trust.

The composition of the Board of Directors is specified in our Constitution to have a majority of independent Non-Executive Director members. The Board comprises six Executive Directors and seven independent Non-Executive Directors (including the Chairman).

In accordance with the Trust's Constitution, the Non-Executive Directors are appointed by the Council of Governors, typically for a three-year term of office and they usually serve two such three-year terms unless otherwise determined by the Council of Governors. One of the Non-Executive Directors is nominated by the University of East Anglia.

The Foundation Trust Code of Governance recommends that NHS Foundation Trusts should identify one of its Non-Executive Directors as Senior Independent Director (SID). The Board has identified Mr Tim How as Senior Independent Director.

The Board meets in public every other month and otherwise as required and in accordance with Standing Orders. The Board Agendas are formulated to ensure that time is devoted to strategic, operational and financial matters and there is a strong focus on the quality and safety of clinical services for patients. The Board has approved a Scheme of Delegation of authority and a Schedule of Matters Reserved for decision by the Board. The Trust's Constitution sets out a process for resolution of any conflict between the Board and Council of Governors in the unlikely event that the Chairman cannot achieve such resolution.

Who is on the Board of Directors?

Executive Directors

Chief Executive

Mark Davies was appointed as Interim Chief Executive of the Trust in August 2015 and as Chief Executive from November 2015. Mark has over 20 years' experience as chief executive of NHS hospital trusts, including Hammersmith Hospitals and St Mary's Hospital Paddington. He was CEO of the first Academic Medical Centre in the UK, Imperial College Healthcare NHS Trust. Immediately prior to joining the Trust Mark was Improvement Director at Monitor, the independent regulator of foundation trusts. Mark leads the executive team responsible for the overall leadership of our hospitals. He represents the Trust on the Boards of Norwich Research Park and the Quadram Institute.

Medical Director

Peter Chapman is responsible for providing professional strategic medical advice to the Board and leadership on clinical quality and safety and clinical research. Peter is a Consultant Orthopaedic Surgeon specialising in hand and wrist surgery and he was appointed as Interim Medical Director from April 2015 and as Medical Director in July 2016. Peter chairs our Clinical Safety Sub-Board and Clinical Effectiveness Sub-Board.

Director of Nursing

Emma McKay was appointed Director of Nursing in November 2012. Emma is a registered General Nurse (RGN) and is responsible for nursing leadership in the Trust and for providing professional nursing guidance to the Board. Emma is the executive lead on patient experience, infection prevention and control and safeguarding. Emma chairs our Caring and Patient Experience Sub-Board.

Chief Finance Officer

James Norman was appointed as our Chief Finance Officer in January 2017. Previously James was Deputy Group Finance Director at Network Rail and has more than 15 years' experience working in finance within the construction, utilities and transportation sectors. James is responsible for overseeing the financial systems and processes of the Trust.

Director of Workforce

Jeremy Over was appointed as Director of Workforce from October 2014 and is an experienced HR Director. Jeremy is responsible for our staff learning and development and Human Resources functions including recruitment, payroll and workplace health, safety and well-being. Jeremy chairs our Workforce Sub-Board and Non-Clinical Safety Sub-Board.

Chief Operating Officer

Richard Parker was appointed as Interim Chief Operating Officer in March 2015 and then as substantive Chief Operating Officer and a member of the Board from January 2016. As Chief Operating Officer Richard is responsible for the operational performance of the Trust, in addition to capital planning and estates management. Richard chairs our Divisional Performance Committee.

Non-Executive Directors

Chairman

John Fry was appointed Chairman of the Foundation Trust in May 2013. In April 2016 John was reappointed by the Council of Governors for a second three year term. John, was chief executive of regional media group Johnston Press from 2009 to 2012, and before that was chief executive of Archant, a private company which publishes newspapers and magazines across the UK including the Eastern Daily Press and Evening News. John is Chairman of both the Board of Directors and of the Council of Governors and the Board's Nominations and Remuneration Committee. He is a member of the Board's Finance and Investments Committee.

Tim How was appointed Non-Executive Director in August 2013. In April 2016 Tim was reappointed by the Council of Governors for a second three year term. Tim is Chairman of Roys (Wroxham) Ltd, and Non-Executive Director of Dixons Carphone Plc and of Henderson Group Plc. Tim is a member of the Nominations and Remuneration Committee, Charitable Funds Committee and Chairman of the Finance and Investments Committee. Tim is the Senior Independent Director for the Trust.

Mark Jeffries is a solicitor, formerly senior partner and now consultant at the national law firm Mills & Reeve LLP. Mark is Non-Executive Director of R G Carter Holdings Ltd and N W Brown Group Ltd. He was a trustee of the Norfolk Community Foundation from 2006-11. Mark was appointed as a Non-Executive Director in November 2011 and reappointed by the Council of Governors for a further three years from November 2014. Mark is a member of the Nominations and Remuneration Committee, Audit Committee and Chairman of the Quality and Safety Committee.

Dr Geraldine O'Sullivan was appointed as a Non-Executive Director from 1 November 2016. Geraldine is a Consultant Psychiatrist, who was previously the Executive Director of Quality and Medical Leadership, and before that Co-Medical Director, of Hertfordshire Partnership University NHS Foundation Trust. Geraldine is a Member and Fellow of the Royal College of Psychiatrists. Geraldine is a member of the Quality and Safety Committee, Audit Committee and Charitable Funds Committee at NNUH.

Professor David Richardson is Pro-Vice Chancellor of the University of East Anglia. David was appointed as Non-Executive Director from September 2014. David is a Microbiologist with particular research interests in the biochemistry of environmentally and medically important bacteria. David is a member of the New Anglia LEP Board and the Norwich Research Partners LLP. He is also a member of the Health Education East of England Board. David is a member of our Finance and Investments Committee.

Angela Robson is a chartered accountant who has worked at JP Morgan and Goldman Sachs and is now Deputy Vice-Chancellor of Norwich University of the Arts. Angela is a Trustee of the Theatre Royal and a Director of the Diocesan Board of Finance. Angela was appointed as a Non-Executive Director for a three year term in November 2011 and reappointed by the Council of Governors for a further three years from November 2014. Angela is Chair of the Audit Committee and is a member of the Nominations and Remuneration Committee.

Sally Smith QC is an eminent Barrister and was appointed as a Non-Executive Director of the Trust from 1 September 2015. Sally has served on ethics committees with organisations including the Medical Research Council, the Royal College of Physicians and St Thomas' Hospital in London. Sally is a member of our Quality and Safety Committee and of the Nominations and Remuneration Committee.

Changes during the Year

There were a number of changes to the Board during the year:

- At the end of his second term Matthew Fleming left the Board in September 2016, having been a Non-Executive Director of the Trust since 2011; and
- Sheila Budd returned to her previous role of Deputy Director of Finance, having been Acting Finance Director for the period between September 2015 and December 2016.

Division of responsibilities
There is a clear division of responsibilities between the Chairman and Chief Executive. The Chairman is responsible for:

- providing leadership to the Board of Directors and the Trust;
- facilitating the contribution of the Non-Executive Directors to the success of the Trust in the delivery of high-quality healthcare;
- ensuring effective communication with the Council of Governors;
- the annual evaluation of the performance of the Board and its committees and implementing any action required following such evaluation.

The Chief Executive is responsible for:

- working with the Chairman to ensure the development of strategy that is supported by the Board as a whole;
- overseeing operational implementation of the strategic objectives of the Trust;
- creating a framework of values and objectives to ensure the delivery of key targets, and allocating decision-making responsibilities accordingly;
- ensuring effective communication with employees and taking a leading role, with the Chairman, in building relationships with key external partners and agencies.

Independence of Non-Executive Directors
The Non-Executive Directors bring wide and varied experience to the Board. They also play a crucial role via the assurance committees of the Board.

There is full disclosure of all Directors' interests in the Register of Directors' Interests. The Register is held by the Board Secretary and is publicly available on our website (www.nnuh.nhs.uk).

Any actual or potential conflicts of interest are dealt with in accordance with procedures set out in the Standing Orders for the Board of Directors. The Chairman has not declared any significant commitments that are considered material to his capacity to carry out his role. The Board considers that the Chairman and the Non-Executive Directors satisfy the independence criteria set out in the Foundation Trust Code of Governance.

The Board has considered Professor Richardson's role as Vice Chancellor of the University of East Anglia, which has a material business relationship with the NHS Foundation Trust, and whether this could affect or appear to affect his independence as a Non-Executive Director. The Board noted that Professor Richardson's role with the University does not require a direct operational relationship with the Trust and, when this is viewed in conjunction with the safeguards against conflicts of interests as set out in the Board's Standing Orders, the Board considers that Professor Richardson satisfies the criteria for 'independence'.

In accordance with Regulations overseen by the Care Quality Commission, Foundation Trusts are required to ensure that all directors meet the requirements of the 'fit and proper persons test' and do not meet any of the criteria that would exclude them from holding such a directorship.

The Trust has ensured compliance with this requirement through use of a 'toolkit' issued by NHS Employers, NHS Confederation and NHS Providers following consultation with the CQC. Annual checks are conducted and the Board can accordingly confirm that all its director level appointments meet the 'fit and proper persons test'.

The Board's Committees

The Board makes a distinction between management responsibility (led by the Chief Executive) and independent assurance responsibility (led by the Non-Executive Directors).

There are four committees of the Board – Audit, Nominations and Remuneration, Quality and Safety and Finance and Investments. Terms of Reference allocate specific assurance responsibilities between the committees.

Audit Committee:

The Committee consists of Non-Executive Directors only. The Committee is chaired by Angela Robson with Mark Jeffries and Geraldine O'Sullivan completing the membership. As required by the Foundation Trust Code of Governance the external and internal auditors are normally in attendance at Committee meetings. Directors and senior managers also attend as required. The Chair of the Audit Committee meets regularly and separately with the External Auditor and the Head of Internal Audit.

The Committee continuously reviews the structure and effectiveness of our internal controls and risk management arrangements. It also monitors progress to ensure that any remedial action has been or is being taken by management in any areas of identified weakness. It oversees an agreed programme of external and internal audit.

The Trust's external auditors, KPMG LLP, were appointed by the Council of Governors for a three year term from 2016/17 following a formal tender process and in accordance with recommendation from the Audit Committee. The fees for the external audit are set out in note 6 of the financial statements.

Auditor Independence and Non-Audit Services

The Audit Committee reviews and monitors the external auditor's independence and objectivity and considerations of avoiding conflicts of interests formed a specific consideration taken into account in appointing the external auditors. The Trust has a policy by which any non-audit services provided by the external auditor are approved. In addition to undertaking the external audit of financial statements and assurance work on the Quality Report, KPMG LLP during 2016/17 KPMG has provided the following non-audit services:

- specialist advice in relation to a radiotherapy managed service contract; and
- advice concerning appropriate recovery of VAT.

KPMG LLP is also the external auditor of Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Funds of which the Trust Board of Directors is the Corporate Trustee. The fees in respect of this engagement in 2016/17 were Charitable funds audit fee is £4,850 and Hospital fee is £65,150 (excluding VAT).

The Chair of the Audit Committee confirms the independence of the external auditors to the Council of Governors at its meeting where the Annual Report and Accounts was presented and also reports any exceptional issues to the Governors during the course of the year.

Statement as to disclosure of the auditors

The Executive and Non-Executive Directors who held office at the date of the approval of the Directors' report confirm that, so far as they are aware, there is no relevant audit information of which KPMG LLP (the Trust's external auditor) is not aware. They also confirm that they each have taken all reasonable steps in order to make themselves aware of any relevant audit information and to establish that KPMG LLP knows about that information.

Code of Governance

The Norfolk and Norwich University Hospitals 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.

Main Activities of the Audit Committee during the Year Ended 31 March 2017

The Audit Committee met on 4 occasions during the year ended 31 March 2017.

The focus of the Committee was on:

- governance, risk management and internal control;
- internal audit;
- external audit;
- other assurance functions;
- financial reporting.

The Chair of the Audit Committee meets regularly and separately with the External Auditor and the Head of Internal Audit.

During the course of the year the Audit Committee received audit reports from the internal auditors, RSM, in accordance with an agreed Audit Plan and including regular reports on follow-up of recommendations from previous audits. The Audit Plan for 2016/17 included audits relating to financial control, nursing revalidation, additional sessions for consultant doctors, risk management, staff recruitment, information governance and processes for staff appraisal.

The Committee received regular reports from the Local Counter Fraud Service including reviews with regard to processes in place to prevent, deter and detect invoice fraud. The Committee has also reviewed the Trust's Speak-Up procedures for staff to raise concerns, and plans for strengthening systems for risk management in the Trust.

In March 2016 the Committee reviewed and agreed the External Audit Annual Plan for the 2015/16 audit. The financial performance of the Trust for 2015/16 was reviewed by the Auditors during April and May 2016 and presented to the Committee in May 2016. In accordance with this established annual cycle, financial performance for 2016/17 is subject to external audit review during April and May, for review of the Accounts by the Committee in May 2017.

Nominations and Remuneration Committee:
During 2016/17 the Board reviewed its Committee structure and decided to combine its previously separate Nominations Committee and Remuneration Committee. The combined Nominations and Remuneration Committee has a membership consisting of Non-Executive Directors and the Chief Executive. It is Chaired by John Fry. The other members of the Committee are Mark Jeffries, Tim How, Angela Robson and Sally Smith QC. The Secretary to the Committee is the Board Secretary.

The Committee has duties and responsibilities that are detailed in agreed Terms of Reference, reflecting the provisions of the FT Code of Governance. It meets as required and usually no less than once a year. During 2016/17 the Committee has met on two occasions. In accordance with its Terms of Reference, the Committee has reviewed the size, structure and composition of the Board of Directors. The Committee decided to make no recommendations for change to the Council of Governors.

In the case of Executive Director vacancies, the Committee is responsible for identifying suitable candidates to fill vacancies as they arise. During the period of this report the Committee oversaw the process for appointment of Mr Norman as our Chief Finance Officer and approved the Terms and Conditions of appointment. This appointment was achieved with the assistance of recruitment agents, following a national recruitment search.

The Committee considers levels of remuneration for executive directors and other senior posts that come within the Committee's remit, by reference to other organisations and NHS Foundation Trusts in particular. During 2016/17, following consideration of national benchmarking data and national NHS pay-awards, the Committee reviewed and approved revision to remuneration for the executive directors, as reported in the Remuneration Report.

In the case of Non-Executive Director vacancies, the Committee is responsible for advising the Council of Governors on the relevant qualities and attributes required to supplement those already on the Board. The Committee has reviewed the schedule of Non-Executive terms of office and has made appropriate recommendation to the Governors accordingly, in relation to vacancies expected to arise during 2017/18.

Quality and Safety Committee:
The Quality and Safety Committee of the Board was established in October 2015 to provide additional capacity for Non-Executive led scrutiny and assurance to the Board concerning quality and safety matters. The Committee has a membership of 7, including three Non-Executive Directors, Chief Executive, Chief Operating Officer, Director of Nursing and Medical Director. The Committee routinely meets 6 times a year.

Matters considered by the Committee during 2016/17 have included the operation of the Trust's clinical governance systems and processes under the new divisional structure. A significant area of focus of the Committee has also been on the Quality Impact Assessment (QIA) process established in the Trust to ensure that appropriate safeguards are in place to protect quality and safety whilst making financial savings and productivity improvements. The Committee has also scrutinised quality and safety related issues including development of a Safety Improvement Plan, reform of our Quality Assurance Audit system, establishment of a Risk Committee, review of mortality and improving palliative care and our procedures for learning from incidents.

Finance and Investments Committee:
The Finance and Investments Committee of the Board was established in October 2015 to provide additional capacity for Non-Executive led scrutiny and assurance to the Board concerning finance and investments. The Committee has a membership of 6, including three Non-Executive Directors, Chief Executive, Chief Operating Officer and Director of Finance.

Matters considered by the Committee during 2016/17 have included significant focus on the Trust's response to Financial Special Measures, and development of productivity and efficiency initiatives. The Committee has also reviewed the Trust's financial plans for the forthcoming year, cash management, and planned capital investments. The Committee provided scrutiny to our financial planning and governance processes during the year, culminating in the Trust's release from Financial Special Measures in March 2017.

Attendance at meetings of the Board of Directors
The Board meets in public bi-monthly and otherwise as required and in accordance with Standing Orders. During this year the Board of Directors met in public on 6 occasions and in private on a further 5 occasions. Attendance at meetings of the Board and its Committees was as below:

Name of Director	Number of Attendances
Mr John Fry	11
Mrs Sheila Budd[1]	8
Mr Peter Chapman	11
Mr Mark Davies	11
Mr Matthew Fleming[2]	5
Mr Tim How	8
Mr Mark Jeffries	11
Mrs Emma McKay	11
Mr James Norman[3]	3
Dr Geraldine O'Sullivan[4]	6
Mr Jeremy Over	11
Mr Richard Parker	11
Prof David Richardson	5
Mrs Angela Robson	10
Miss Sally Smith QC	11

[1] Mrs Budd stood down as Acting Director of Finance in December 2016.
[2] Mr Fleming stepped down from the Board in October 2016.
[3] Mr Norman was appointed as Chief Finance Officer in January 2017.
[4] Dr O'Sullivan was appointed as Non-Executive Director in October 2016.

In addition, the Board held additional Extraordinary Board Meetings on 4 occasions during 2016/17, notably in relation to managing the process of Financial Special Measures.

Attendance at meetings of the Audit Committee

The Audit Committee meets quarterly and met on 4 occasions during the year.

	20 May 2016	21 September 2016	15 December 2016	15 March 2017
Mrs Angela Robson (Chair of Committee)	✓	✓	✓	✓
Mr Matthew Fleming (Non-Executive Director)	✓	X		
Mr Mark Jeffries (Non-Executive Director)	✓	✓	X	✓
Dr Geraldine O'Sullivan (Non-Executive Director)			✓	✓

Nominations & Remuneration Committee

	23 December 2016	24 February 2017
Mr John Fry (Chairman and Chair of Committee)	✓	✓
Mr Mark Davies (Chief Executive)	✓	✓
Mr Tim How (Non-Executive Director)	✓	✓
Mr Mark Jeffries (Non-Executive Director)	✓	✓
Mrs Angela Robson (Non-Executive Director)	✓	✓
Miss Sally Smith QC (Non-Executive Director)	✓	X

Quality and Safety Committee – meeting and attendance

The Quality and Safety Committee routinely meets bi-monthly and met on 6 occasions during the year.

	12 April 2016	15 June 2016	8 September 2016	11 October 2016	6 December 2016	22 February 2017
Mr Mark Jeffries (Chair of Committee and Non-Executive Director)	✓	✓	✓	✓	✓	✓
Mr Peter Chapman (Medical Director)	✓	✓	✓	✓	✓	✓
Mr Mark Davies (Chief Executive)	✓	✓	✓	✓	✓	X
Mrs Emma McKay (Director of Nursing)	✓	✓	✓	X	✓	✓
Dr Geraldine O'Sullivan (Non-Executive Director)					✓	X
Mr Richard Parker (Chief Operating Officer)	X	✓	✓	✓	✓	✓
Miss S Smith QC (Non-Executive Director)	✓	✓	✓	✓	X	✓

Finance and Investments Committee – meeting and attendance

The Finance and Investments Committee routinely meets quarterly and otherwise as required. The Committee met on seven occasions during the year as follows:

	7 April 2016	22 June 2016	9 September 2016	23 September 2016	14 December 2016	10 January 2017	16 March 2017
Mr Tim How (Chair of Committee and Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓
Mrs Sheila Budd (Acting Director of Finance)	✓	✓	✓	✓	✓		
Mr Mark Davies (Chief Executive)	✓	✓	✓	✓	✓	✓	X
Mr John Fry (Chairman)	✓	✓	✓	✓	✓	✓	✓
Mr James Norman (Chief Finance Officer)						✓	✓
Mr Richard Parker (Chief Operating Officer)	✓	✓	✓	✓	✓	✓	✓
Professor David Richardson (Non-Executive Director)	X	✓	X	✓	X	X	✓

Board performance

The Board of Directors oversees performance through receipt and scrutiny of a monthly Integrated Performance Report (IPR). The IPR includes standard quality and safety metrics, details of operational performance against relevant national targets and updates on workforce issues and the financial position. The action being taken to reduce identified high level risks is also detailed. The IPR incorporates issues and areas of note/concern highlighted by the governance sub-boards and Management Board

The meetings of the Board of Directors are managed to ensure that actions are followed up and the Board's reporting requirements are adhered to.

During the course of the year, the Board reviewed its capacity, and that of the management team, to address the current and future challenges facing the Trust. During 2016/17 Mr Norman was appointed as Chief Finance Officer, strengthening our finance team.

In accordance with its established practice, the Board carried out an annual review of its performance and that of its Committees and Chairman through a process facilitated by the Board Secretary to gather the views of all Board members.

Following this collective self-assessment, and the actions to enhance Board and management capacity outlined above, the Board confirms the following in relation to its roles, structure and capacity:

- the Board maintains its Register of Interests which is publicly available on the Trust's website. Mr Jeffries has declared his role as Non-Executive Director with R G Carter (Holdings) Ltd and accordingly takes no part in discussion or decision of matters that may relate to the relationship between this party and the Trust. Otherwise the Board can confirm that there are no material conflicts of interest in the Board
- the Board is satisfied that its Directors are appropriately qualified to discharge their functions
- the Board is satisfied as to its own balance, completeness and appropriateness to the requirements of the Foundation Trust
- the Board's revised Committee and governance structure is appropriate and its progress and efficacy is regularly reviewed.
- the Board considers that it has an appropriate balance of expertise and experience and it has access to specialist advice, as required.

During the year, performance evaluation of the executive directors has been undertaken by the non-executive directors and Chief Executive. The Chair of the Audit Committee is a Non-Executive Director with recent and relevant financial experience.

The Norfolk and Norwich University Hospitals 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.

NNUH's world-first in baby safety research

Neonatologists at NNUH were the first in the world to publish research showing the thermal safety of scanning newborn babies with high powered 3T magnetic resonance imaging (MRI) scanners.

This research was done when the NNUH took part in the national MARBLE study which investigated the benefits of using the more detailed 3T MRI scans for babies.

Newborn babies who have suffered from oxygen starvation at birth receive "cooling" treatment to minimise the risk of brain damage, followed by a standard MRI scan to check the brain health. But the MARBLE study needed to use high powered 3T scanners. The 3T scanners allow specialist scanning techniques that can measure brain chemistry and provide more detailed images of any areas of damage. However, they have magnetic fields twice as strong as those commonly used for babies and nowhere in the world had so far published data to show that it was safe to scan babies using the higher magnetic fields.

Council of Governors

The Council of Governors is chaired by John Fry who, as Chairman of the Trust, acts as a link between the Council and Board of Directors. Directors regularly attend meetings of the Council of Governors and feedback from the Council is a standing agenda item on meetings of the Board of Directors so that the Board is informed of the views of our Members as represented by the Governors.

The Council of Governors is responsible for representing the interests of Foundation Trust members and partner organisations in the governance of the Trust. The Council receives regular reports from the Chief Executive and other Executive Directors on relevant operational and strategic matters. The Council of Governors has a number of specified statutory responsibilities which it has satisfied during the course of the year. In particular the Council has:

- Received the Trust's Annual Report and Accounts
- Approved the appointment of Dr Geraldine O'Sullivan as a Non-Executive Director
- Expressed views for consideration by the Directors in preparing the Trust's strategic plans
- Appointed the Trust's External Auditors (KPMG).

In April 2016 the Council also reappointed Mr John Fry (Chairman) and Mr Tim How (Non-Executive Director) each for a second three year term of office and with effect from 1 May 2016 and 1 August 2016 respectively.

The term of office for Governors is three years and the appointment of both staff and public Governors is by election by the members. These elections are held once a year and are administered on our behalf by the UK Engage and in accordance with the election rules set out in our Constitution.

As at March 2017 the Governors were:

Partner Governors

• Dr Anoop Dhesi	North Norfolk Clinical Commissioning Group
• Cllr Brian Watkins	Norfolk County Council
• Vacant	University of East Anglia

Public Governors

• Erica Betts	Breckland
• Nick Brighouse	South Norfolk
• Brian Cushion	Broadland
• Diane DeBell	Norwich
• Nina Duddleston	Breckland
• Carol Edwards	North Norfolk
• Sarah Ellis	Norwich
• Ines Grote	Great Yarmouth and Waveney
• Keith Jarvis	North Norfolk
• Janet King	Broadland
• John Labouchere	Breckland
• David McNeil	Broadland
• Mary Pandya	Rest of England

- Paul Postle — Norwich
- Jane Scarfe — South Norfolk
- Vacant[1] — King's Lynn and West Norfolk

[1] Election to be held during 2017.

Staff Governors

- Ed Aldus — Clinical Support
- Mr Neil Burgess — Medical and Dental
- Sue Burt — Nursing and Midwifery
- Terry Davies — Contractors and Volunteers
- Sheila Ginty — Nursing and Midwifery
- Vikki Worman — Admin and Clerical

Changes during the year:

The following Governors stood down from the Council in 2016/17 after many years of service to the NHS:

- Pam Ford, Norwich
- Terry Nye, Broadland

A copy of the Register of Interests declared by the Governors can be found on our website at www.nnuh.nhs.uk.

Performance of the Council of Governors and its Committee

During the year, the Governors have been regularly briefed on a wide range of matters affecting the Trust including:

- Quality standards on our wards
- The development of our strategic plans
- Our performance against national standards
- The impact of Financial Special Measures between August 2016 and February 2017
- Plans for the development of the Quadram Institute; and
- the expansion of the Weybourne Day Unit to increase chemotherapy capacity for patients with cancer
- Creation of new ambulatory care clinics in the Emergency Department – avoiding unnecessary admissions to hospital.

The Governors are involved in a number of groups contributing to the Trust's work in areas such as our work to support carers. They have also been active and valued members of teams conducting quality assurance audits on the hospital wards.

Attendance at formal meetings of the Council of Governors

The Council of Governors held four scheduled meetings in 2016/17. Attendance at Council meetings was as set out below:

	26 April 2016	28 July 2016	25 Oct 2016	31 Jan 2017
Mr Edward Aldus	X	✓	X	X
Ms Erica Betts	✓	✓	✓	✓
Mr Nick Brighouse	X	✓	✓	✓
Mr Neil Burgess	✓	✓	✓	X
Ms Sue Burt	X	✓	✓	✓
Mr Brian Cushion	✓	✓	✓	✓
Mr Terry Davies	✓	✓	✓	✓
Prof Diane DeBell[1]				✓
Dr Anoop Dhesi	X	✓	X	X
Ms Nina Duddleston	✓	✓	✓	✓
Ms Carol Edwards	✓	✓	X	✓
Ms Sarah Ellis[2]				✓
Ms Pamela Ford[3]	X			
Miss Sheila Ginty	✓	✓	✓	✓
Mrs Ines Grote	✓	✓	✓	✓
Mr Keith Jarvis	✓	X	✓	X
Ms Janet King	✓	✓	✓	✓
Mr John Labouchere	✓	✓	✓	✓
Mr David McNeil[4]				✓
Mr Terry Nye	X	✓	✓	

Ms Mary Pandya	X	✓	✓	✓
Mr Paul Postle	✓	✓	✓	✓
Ms Jane Scarfe	✓	✓	✓	✓
Cllr Brian Watkins	✓	✓	✓	✓
Ms Vikki Worman	X	✓	✓	✓

Lead Governor
In accordance with the Foundation Trust Code of Governance, the Council of Governors has nominated one of its members to act as Lead Governor with particular responsibility for providing a channel of communication between the Council and Monitor in appropriate circumstances. In October 2015, the Council elected Mr Terry Davies (Staff Governor for Contractors and Volunteers) as Lead Governor. Public Governor Jane Scarfe was appointed as Deputy Lead Governor to support Mr Davies in April 2016.

Appointments and Remuneration Committee of the Council of Governors
In accordance with Statute, the Council has an Appointments and Remuneration Committee. Membership of the Committee consists of the Chairman of the Trust and four Governors who volunteered for this role.

The work of the Committee is supported by the Board Secretary. As at March 2017, Membership of the Committee is:

- Mr John Fry (Chair)
- Mr Nick Brighouse (Public Governor)
- Mr Terry Davies (Staff Governor)
- Mrs Carol Edwards (Public Governor)
- Mr Keith Jarvis (Public Governor)

The Committee is responsible for making recommendations to the Council of Governors with respect to the appointment or reappointment of Non-Executive Directors. This year the Committee has recommended the appointment of Dr Geraldine O'Sullivan as a Non-Executive Director and the reappointment of Mr John Fry (Chairman) and Mr Tim How (Non-Executive Director).

The Committee is also responsible for overseeing the remuneration of our non-executive directors and making any recommendations for change to the Council. In 2016/17 the Committee has made no recommendation for change.

Our Membership
We have three membership constituencies: Public, Staff and Partners.

- The Public constituency - consists of people over the age of 16 and it includes patients and their carers, as well as the general public. Most are resident within the Local Authority catchment areas of Norfolk and Waveney, although our constituency of 'Rest of England' caters for those living outside this area.

- The Staff constituency – includes employees who have worked for the Trust for at least 12 months. This constituency also includes our volunteers and employees of contractors who work with us, as specified in our Constitution

- Our Partners are represented by Governors drawn from the Clinical Commissioning Groups, local government and the University of East Anglia.

The membership has grown since we achieved Foundation Trust status and an annual recruitment campaign maintains the public membership above the 15,000 minimum set by the Council of Governors. By the end of March 2017 we had 16,499 Public Members.

We have a Membership Strategy for which the objectives in 2016/17 were to:

- continue the communication and involvement programme with members
- hold elections in the following constituencies: Broadland, Norwich, King's Lynn and West Norfolk, plus the nursing and midwifery staff constituency:
- develop strong and representative public membership reflecting the diversity of the population.

	Membership at 2007/08	Membership at 2016/17
Staff	5,000	7,500
Public	5,000	16,499
Total	10,000	23,999

Analysis of membership data reveals that our membership is largely representative of the population we serve, except for younger members (16-21 year olds). Difficulty in developing the membership for this younger age group is a recognised phenomenon for Foundation Trusts and will be considered further by the Council during 2017/18.

Elections

Elections are held on an annual basis to fill any vacancies on the Council. The Trust receives a good level of interest from the local community and staff in filling these vacancies and they are usually contested. We promote elections through mailings to members, media coverage and through the Trust's social media channels.

Communicating and involving our members

We have a programme of internal communication and engagement with staff members which includes a weekly electronic newsletter, staff intranet, in-house magazine (The Pulse), focus groups, surveys and meetings. More detail is given in the Staff Matters section of this annual report.

Public members receive our quarterly magazine, The Pulse. This publication is used to publicise events throughout the year, such as talks, the Annual General Meeting and participation in the Patient Choice Award. During the year members have been invited to a number of talks which have provided opportunities for Governors to meet and talk to members about their experience and to canvas their views and opinions. Members are also asked to respond to surveys periodically.

Governors receive a number of briefings throughout the year, in addition to a regular programme of Q&A sessions with the Chairman, Chief Executive and other directors. These meetings are in addition to the formal meetings and provide opportunity for more detailed discussion about the Trust's services and plans. A number of governors are involved with activities, such as ward/clinic inspections, judging the Trust's staff awards and recruiting new members. New governors are given an induction session and tour of the facilities when they start.

The following is a summary of the events which have involved members and governors:

- A talk on skin cancer took place on 11th May 2016, to coincide with national Sun Awareness Week.
- A talk for the public on blood transfusion was organised for Tuesday 14th June 2016
- Four governors attended the multi-agency briefing on the Norfolk and Waveney Sustainability and Transformation Plan on 7th June 2016.
- Two governors have shadowed matrons to gain an insight into their role and the way our services are run. A further work shadowing opportunity was taken up by one governor with the dietetics team.
- Six governors have helped with judging the staff awards.
- Two governors visited theatres for a tour of the department.
- One governor supported the Somerleyton fundraising event held in September 2016.
- Several governors attended the AGM in September 2016.
- A number of governors also attended the PRIDE values into action events held in October 2016.
- A number of governors attended the tour of the Quadram Building in November 2016.
- Six governors attended the tour of A&E/AMU on 15th December 2016 to see the new admission avoidance clinics.
- Five governors attended the briefing on 17th January 2017 on the palliative care strategy with Palliative Care Consultant Dr Nicola Holtom and Lead Palliative Care Nurse Julie Noble.
- The Summer Fete took place on Saturday 18 June 2016.
- The NNUH annual Bike Ride took place on 11 September

Members can contact the Membership Office by telephone on 01603 287634 or through the website or by e-mail at membership@nnuh.nhs.uk

NNUH leading the way in Tracheostomy care

Erica Everit, Tracheostomy Specialist Practitioner and Shirley Brigham Tracheostomy Support Practitioner

NNUH has been selected for an exciting new quality improvement research project into Tracheostomy care.

The three year project aims to improve the safety and quality of tracheostomy care through collaboration with exemplar sites from across the world. The project is a joint collaboration between the Royal College of Anaesthetists and the Global Tracheostomy Collaborative and is funded by the Health Foundation.

NNUH was one of 15 Trusts nationally who applied to an open invitation and was selected because it is a leader in this field and provides a high quality service focused on the continual improvement of tracheostomy care.

Principle for cost allocation
The Trust is compliant with the cost allocation and charging guidance issued by HM Treasury.

Political and charitable donations
No political or charitable donations have been made by the Trust in 2016/17 financial year or previous year

Quality governance statement
Quality Governance in the Trust is consistent with Monitor's "Quality Governance Framework" and its principles of Strategy, Processes and Structures, Capabilities and Culture, and Measurement.

In particular our quality strategy is based specifically around the domains of safety, effectiveness and a positive patient experience and places organisational wide learning at the heart of what we do. We have a reporting structure which mirrors these three domains and which starts at departmental level against a clear template in order to ensure consistency of measure and reporting against in each of these domains throughout the Trust.

Our twelve Quality Priorities within the three domains have been developed through consultation with our stakeholders and progress and achievements against these for 2015-16 are highlighted in our annual report from page 123 onwards. The report also notes our Quality Priorities for 2016-17 and how assurance against these will be provided by the Quality and Safety Committee and by the Trust Board.

The Trust has participated in national clinical audits and confidential enquiries summarised on page 148 of our annual report and our comparative performance against national quality indicators is summarised on page 153 along with required actions undertaken. Action plans have also been developed for instance in response to our CQC inspection from November 2015, in response to the Morecambe Bay maternity report, and in response to other external inspections such as that from the Royal College of Paediatrics and Child Health.

The Trusts Risk Management strategy is summarised within the Annual Governance Statement on page 107. Risks are stratified ensuring appropriate review at all levels with the highest risks and required actions visible at each Trust Board and reported publicly through the Integrated Performance Report.

Income disclosures required by Section 43(2A) of the NHS Act 2006
During 2016/17 income from the provision of goods and services for the purposes of the health service in England was greater than the income from the provision of goods and services for any other purposes. Accordingly the requirement of the Act has been met. Health service income amounted to £562.2m of the total income of £564.1m (2015/16 £540.1m of total income of £542.2m)

Statement as to disclosure to auditors
So far as the directors are aware there is no relevant audit information of which the Norfolk and Norwich University Hospitals NHS Foundation Trust's auditors are unaware and 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 Trust's auditors are aware of that information.

Significant events since the Statement of Financial Position date
There have been no significant events since the Statement of Financial Position date that require disclosure.

Statement from Directors
Directors consider the annual report and accounts taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

Accounts and Statement of the responsibility of the Accounting Officer
The accounts for the year ended 31/03/2017 can be found at the back of this annual report. The statement of the responsibility of the accounting officer can be found on page 106.

Related party transactions
During the year none of the Board members, Governors or members of the key management staff or parties related to then has undertaken any material transactions with the NHS Foundation trusts. Further details on related parties can be found in note 29 to the accounts.

Better payment practice Code
Disclosures relating to our compliance with the better payment Practice Code can be found in note 11.1 to the Accounts

Interest paid under the Late Payment of Commercial Debts (Interest) Act 1998
Disclosures relating to any interest paid can be found in note 11.2 to the accounts.

Annual Report on remuneration

Major decisions on senior managers' remuneration

Remuneration for the Trust's most senior managers (Executive Directors who are members of the Board of Directors) is determined by the Board of Director's Nominations and Remuneration Committee. The Nominations and Remuneration Committee determined that no amendments to incumbent executives' pay should be made in 2016/17, other than a 1% uplift mirroring the recommendations made by the national pay review bodies in the NHS which were in turn accepted by the government. The acting Medical Director was appointed on a substantive basis on 01 July 2016 and the Chief Finance Officer was appointed on 02 January 2017. The salaries in respect of these appointments were set taking into account benchmark information for comparator NHS teaching hospitals, plus relativity to the Trust's prevailing executive pay structure.

The only non-cash element of senior managers' remuneration packages are pension related benefits accrued under the NHS Pensions Scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme which applies to all NHS staff in the scheme.

The Trust's strategy and business planning process sets key business objectives which in turn inform individual objectives for senior managers. Performance is closely monitored and discussed through both an annual and ongoing appraisal process.

Senior managers are employed on contracts of service and are substantive employees of the Trust. Their contracts are open ended employment contracts which can be terminated by either party with six months' notice. The Trust's normal disciplinary policies apply to senior managers, including the sanction of instant dismissal for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff.

Any substantial changes relating to senior managers remuneration made during the year

No substantial changes to senior managers' remuneration were made during 2016/17, other than a 1% uplift mirroring the recommendations made by the national pay review bodies in the NHS which were in turn accepted by the government.

Signed by Chair of Remuneration Committee on 26th May 2017 Chairman – John Fry

Senior Managers' remuneration policy

Future Policy

The table below summarises each of the components of the remuneration package for senior managers which comprise the senior managers' remuneration policy.

Remuneration component	Applicable to	Jurisdiction	Relevance to Trust's long and short term objectives	Amount payable
Basic salary	All senior managers	Nominations and Remuneration Committee	Recommendations in respect of basic salary are made to the Nominations and Remuneration Committee by the Chief Executive (for executive directors) and the Chairman (for the Chief Executive) on the basis of assessment of performance at annual appraisal, and specifically achievement of agreed personal objectives that reflect the long and short term objectives of the Trust	Any increases are agreed with reference to external benchmarks and advice as required
Pension	All senior managers	Terms of membership as specified by the NHS Pension Scheme administered by the NHS Pensions Agency	N/A	Determined by the NHS Pensions Agency
Clinical Excellence Award Scheme	Medical Director only	Determined by Local Awards Committee in accordance with medical and dental employment contract; not awarded by Nominations and Remuneration Committee	Awards are determined by the Local Awards Committee in accordance with an agreed scheme that recognises clinical excellence across 5 domains. Analysis of the scheme demonstrates a linkage to the Trust's strategic objectives including the leadership and delivery of clinical services, teaching, training and research.	Level 9 award is the maximum that can be awarded locally.

Accompanying notes:

(1) There have been no additions or changes to the components of the remuneration package during 2016/17
(2) There are no significant differences between the remuneration policy for senior managers and the general policy for employees' remuneration
(3) The remuneration policy does not include provision for performance-related bonuses or other such schemes
(4) There is no provision for the recovery of sums paid to directors

Annual Report on remuneration

Service Contracts

The table below summarises, for each senior manager (Directors who are members of the Board of Directors) who has served during the year, the date of their service contract, the unexpired term and details of the notice period.

Name & Title	Date of Contract	Unexpired Term		Notice Period
PM Davies, Chief Executive (appointed 3 August 2015)	14/08/2015	n/a	n/a	6 Months
R Parker, Chief Operating Officer (appointed 1 January 2016)	01/01/2016	n/a	n/a	6 Months
EJ McKay, Director of Nursing	01/12/2012	n/a	n/a	6 Months
JM Over, Director of Workforce	13/10/2014	n/a	n/a	6 Months
PG Chapman, Medical Director (appointed 1 April 2015)	01/04/2015	n/a	n/a	6 Months
S Budd, Acting Director of Finance (14 September 2015 until 2 January 2017)	14/09/2015	n/a	n/a	6 Months
JN Norman, Chief Finance Officer (appointed 2 January 2017)	02/01/2017	n/a	n/a	6 Months
J Fry, Chairman	13/05/2016	12/05/2019	25 months	3 Months
T How, Non-Executive Director	01/08/2016	31/07/2019	28 Months	3 Months
RM Jeffries, Non-Executive Director	01/11/2014	31/10/2017	7 Months	3 Months
A Robson, Non-Executive Director	01/11/2014	31/10/2017	7 Months	3 Months
D Richardson, Non-Executive Director	01/09/2014	31/08/2017	5 Months	3 Months
SE Smith, Non-Executive Director (appointed 1 October 2015)	01/10/2015	30/09/2018	18 Months	3 Months
GH O'Sullivan, Non-Executive Director (appointed 1 November 2016)	01/11/2016	31/10/2019	31 Months	3 Months
M Fleming, Non-Executive Director (until 31 October 2016)	01/11/2013	31/10/2016	n/a	3 Months

The contracts of employment of the Executive Directors are for indefinite terms and are subject to six months' notice by either side. All Executive Directors are subject to periodic appraisal and are accountable to the Board of Directors for performance in those areas to which they provide executive leadership. The contracts of employment of the Non-Executive Directors are for 3 year terms and are subject to three months' notice by either side. There are no provisions within the contracts of employment regarding compensation for early termination for any directors.

The Trust's normal disciplinary policies apply to senior managers. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff

P Chapman was appointed as the substantive Medical Director on 1.7.2016, following a period of acting in the role.

G O'Sullivan was appointed as Non-Executive Director with effect from 1.11.2016.

J Norman was appointed as the Chief Finance Officer with effect from 2.1.2017.

Nominations and Remuneration Committee

The Nominations and Remuneration Committee consists of the Chairman of the Trust and at least two other non-executive directors. The membership currently comprises the Chairman of the Trust, John Fry (Chair of the Committee), Sally Smith, Mark Jeffries and Angela Robson, Geraldine O'Sullivan and Tim How.

The Committee meets as required, and at least once a year. In accordance with Monitor's Code of Governance for Foundation Trusts, the role and policy of the Committee is to monitor the level and structure of remuneration for senior managers, having considered comparative salary levels in other organisations and NHS Foundation Trusts in particular.

The Committee met three times during 2016/17, on 24 June 2016, 23 December 2016 and on 24 February 2017. The meetings were quorate. The work of the Committee included consideration of NHS pay awards over recent years and 'market rate' comparison informed by data from a survey of foundation trusts nationally, coordinated by the Foundation Trust Network (NHS Providers) of which we are a member. In addition the meetings ratified the appointments of the Medical Director and Chief Finance Officer.

No significant awards were made to past Directors during the 12 months ended 31 March 2017.

Where an individual's remuneration is above the level of £142,500 per annum pro rata the Remuneration Committee's policy and practice will be in line with the requirements issued by the Secretary of State on 02 June 2015.

The remuneration and expenses for the Trust Chairman and Non-Executive Directors are determined by the Council of Governors informed by information issued by organisations such as NHS Providers.

Disclosures required by the Health and Social Care Act

There was a total of 7 Executive Directors in office during the year and 8 Non – Executive Directors, including the Chairman. In aggregate the Directors received reimbursement of expenses of £34,105 with claims from 7 directors. In 2015/16, 15 directors had been in office, being 7 executive directors and 8 non-executive directors. In aggregate they received reimbursement of expenses of £15,919 with claims from 6 directors.

No significant awards were made to past Directors during the 12 months ended 31 March 2017.

The Governor role is unpaid. When the Council of Governors was established it was agreed that governors were entitled to claim travel expenses for attending meetings. There were 15 public governors in 2016/17 and three governors claimed £611. (In 2015/16 two governors claiming expenses totalling £486.)

Remuneration – Audited

Name and title	12 months ended 31st March 2017				12 months ended 31st March 2016			
	Salary (bands of £5,000) £'000	All Taxable Benefits Rounded to the nearest £100 £	Pension Related Benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000	Salary (bands of £5,000) £'000	All Taxable Benefits Rounded to the nearest £100 £	Pension Related Benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
PM Davies, Chief Executive (appointed 3 August 2015)	225 - 230	13,400	117.5 - 120	355 - 360	180 - 185	300	40 - 42.5	220 - 225
R Parker, Chief Operating Officer (appointed 1 January 2016)	140 - 145	0	272.5 - 275	415 - 420	45 -50	0	82.5 - 85.0	125 - 130
JN Norman, Chief Finance Officer (appointed 2 January 2017)	40 - 45	0	0	40 - 45				
EJ McKay, Director of Nursing	110 - 115	100	82.5 - 85	190 - 195	105 - 110	100	2.5 - 5.0	110 - 115
JM Over, Director of Workforce	120 - 125	100	45 - 47.5	165 - 170	115 - 120	200	67.5 - 70	185 - 190
PG Chapman, Medical Director (appointed 1 April 2015)	180 - 185	0	180 - 182.5	360 - 365	180-185	0	0	180 - 185
S Budd, Acting Director of Finance (14 September 2015 until 2 January 2017)	90 - 95	100	90 - 92.5	180 - 185	55 - 60	0	22.5 - 25.0	80 - 85

J Fry, Chairman	45 - 50	100	0	45 - 50	45 - 50	100	0	45 - 50
A. Dugdale, Chief Executive (until 14 July 2015)					175 - 180	0	35 - 37.5	210 - 215
J. Cave, Director of Resources (until 13 September 2015)					90 - 95	0	57.5 - 60	150 - 155
GH O'Sullivan, Non-Executive Director (appointed 1 November 2016)	5 - 10	0	0	5 - 10				
T How, Non-Executive Director	10 - 15	0	0	10 - 15	10 – 15	0		10 - 15
RM Jeffries, Non-Executive Director	10 - 15	0	0	10 - 15	10 – 15	0		10 - 15
A Robson, Non-Executive Director	10 - 15	0	0	10 - 15	10 – 15	0		10 - 15
D Richardson, Non-Executive Director	10 - 15	0	0	10 - 15	10 – 15	0		10 - 15
SE Smith, Non-Executive Director (appointed 1 October 2015)	10 - 15	0	0	10 - 15	5 - 10	0		5 - 10
M Fleming, Non-Executive Director (until 31 October 2016)	5 - 10	0	0	5 - 10	10 – 15	0		10 - 15

L. Ollier, Non-Executive Director (until 30 June 2015)					0 - 5	0		0 - 5

Taxable benefits cover the monetary value of benefits in kind, such as car mileage allowances where subject to income tax.

Pension related benefits have been pro-rated / time apportioned for Directors who were appointed or resigned part way through the year.

Fair Pay Multiple

In line with the recommendations of the Hutton Review of Fair Pay, the policy of the Trust is to publish details of the band of the highest paid Director and the relationship between them and the median remuneration of its staff. This comparison involves the people in post at the year end and is based on a full time equivalent basis. The table below discloses this information.

The disclosures in respect of the highest paid director and the information in the following three tables are all subject to audit.

	2016 - 17	2015 – 16
Band of Highest Paid Director's Total Remuneration (£'000)	225 - 230	220-225
Median Total (£)	28,386	27,652
Remuneration Ratio	8.01	8.05

The banded remuneration, of the highest paid director in the Trust in the financial year 2016/17 was £225-230k (2015/16: £220k-£225k). This was 8.01 times (2015/16 – 8.05 times) the median remuneration of the workforce which was £28,386 (2015/16 - £27,652). In 2016/17, 0 (2015/16: 18) employees received remuneration in excess of the highest paid director. Total remuneration includes salary, non-consolidated performance related pay, benefits in kind as well as severance payments. It does not include pension related benefits.

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Total Pension Entitlement

Name and title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2017 (bands of £5,000) £'000	Lump Sum at age 60 related to accrued pensions at 31 March 2017 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2016 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2017 £'000
PM Davies, Chief Executive (appointed 3 August 2015)	5 - 7.5	15 - 17.5	80 - 85	250 - 255	1,695	196	1,891
R Parker, Chief Operating Officer (appointed 1 January 2016)	10 - 12.5	27.5 - 30	45 - 50	125 - 130	550	237	787
EJ McKay, Director of Nursing	2.5 - 5	0 - 2.5	20 - 25	55 - 60	302	64	366
JM Over, Director of Workforce	0 - 2.5	0 - 2.5	20 - 25	55 - 60	259	25	283
PG Chapman, Medical Director (appointed 1 April 2015)	7.5 - 10	22.5 - 25	55 - 60	170 - 175	1,083	207	1,289
S Budd, Acting Director of Finance (14 September 2015 until 2 January 2017)	2.5 - 5	10 - 12.5	15 - 20	55 - 60	331	107	438

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values are recorded at nil, when an individual reaches pension age, or when they start drawing their pension.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme 006Fr arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Revised guidance was issued by HM Treasury on 26 October 2011 regarding the calculation of CETVs in public service pension schemes. Based on this guidance the NHS Pensions Agency, with effect from 8 December 2011, has used revised and updated actuarial factors produced by GAD when calculating CETVs within the NHS Pensions Scheme.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, and uses common market valuation factors for the start and end of the period.

Bonus

The Trust is required by Monitor to disclose any payments that fall with the definition of "Performance Related Bonuses", and it has been determined by the Department of Health that Clinical Excellence Awards (CEA) meet this definition. As such they have been disclosed as a "Bonus". Clinical Excellence awards are given to recognise and reward the exceptional contribution of NHS consultants, over and above that normally expected in a job, to the values and goals of the NHS and to patient care. Clinical Excellence Awards are administered at a national level by the Advisory Committee on Clinical Excellence Awards. These payments were previously classified within Other Remuneration. There have been no new Clinical Excellence Awards payable to the Directors in 2016/17, however the Medical Director is in receipt of clinical excellence awards as part of his remuneration package that were determined in previous years.

Signed on behalf of the Board on 26th May 2017

Chief Executive – Mark Davies

Staff Report

Introduction

Our team is comprised of over 7,500 staff and volunteers who are at the heart of what we do. It is because of each and every member of our team that we are able to turn our vision into reality, seeking every day to "provide every patient with the care we want for those we love the most". Our continual goal is to ensure our staff feel valued and appreciated, such that they feel proud to work here and act as ambassadors for our hospital. This 'Staff Matters' section provides an overview of our workforce strategy.

Recruitment and Retention of Staff

We operate a recruitment process that is fair and open and uses competence and potential as the deciding factors in decision making for all positions. Vacancies are advertised through the NHS Jobs website and on the Trust website.

During 2016/17, we appointed 103 First Post Qualified nurses (91 Adult nursing and 12 Paediatric Branch).

In terms of the medical workforce, we have seen additional recruitment of Consultant and Non-Consultant Career Grade staff, with a small reduction in Junior Doctor numbers primarily due to difficulty recruiting into these posts in certain specialties:

Medical Staff Average FTE	15/16 to 16/17
Consultant level	+13
Non Consultant Career Grade	+13
Junior Doctors	-12

We continue to monitor compliance with EWTD Regulations and New Deal Requirements for its Junior Doctors. The Trust proactively works with departments to ensure working practices are managed to maintain compliance for junior doctors within the changes required to continue to meet patient care and service demands.

The new junior doctors' contract is being implemented which incorporates new working arrangements. On 7 December 2016, 50 doctors transitioned to the new junior doctor's contract. On 1 February 2017, 36 doctors transitioned to the new junior doctor's contract (2016 terms and conditions). On 6 March 2017, 26 doctors transitioned to the new junior doctor's contract and more transitioned are planned during 2017 in accordance with the implementation timeline.

A new reporting module is in place for exception reporting. This exception reporting is applicable to any doctor that has transitioned to the contract (2016 terms and conditions). We have appointed to the Guardian of Safe Working role that is outlined in the contract.

Monitoring exercises will continue to take place for those doctors on the 2002 terms and conditions.

The turnover for all permanent staff for the twelve months to March 2017 was 11.0% which constitutes a small increase from the previous year.

Workforce

The information below shows the average staff numbers within the Trust from April 2016 to March 2017.

Note 4.2 Average number of employees (WTE basis)	**2016/17**	**2016/17**	**2016/17**
	Total	**Permanent**	**Other**
Medical and dental	**913**	417	496
Ambulance staff	**-**	-	-
Administration and estates	**473**	375	98
Healthcare assistants and other support staff	**2,258**	2,188	70
Nursing, midwifery and health visiting staff	**1,886**	1,829	57
Nursing, midwifery and health visiting learners	**11**	4	7
Scientific, therapeutic and technical staff	**452**	415	37
Healthcare science staff	**421**	417	4
Social care staff	**-**	-	-
Agency and contract staff	**249**		249
Bank staff	**305**		305
Other	**-**	-	-
Total average numbers	**6,968**	**5,645**	**1,323**

Note: Staff breakdowns aligned to NHSI reporting requirements

Analysis of Staff costs

The tables below set out the cost and number of staff for the last two years, separately analysed between those staff members with permanent employment contracts with the Trust and those who do not have a permanent employment contract.

This table shows the gross cost of staff, analysed between those who are employed on permanent contracts and others:

	2016/17			2015/16		
	Total	**Permanent Staff**	**Other**	**Total**	**Permanent Staff**	**Other**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Salaries and wages	**241,371**	201,857	39,514	**232,217**	195,089	37,128
Social security costs	**22,708**	18,991	3,717	**17,134**	14,374	2,760
Pension cost - defined contribution plans employer's contributions to NHS pensions	**29,429**	24,611	4,818	**27,842**	23,357	4,485
Termination benefits	**0**	0	0	**26**	0	26
Temporary staff - agency/contract staff	**20,266**	0	20,266	**24,058**	0	24,058
Total gross staff costs	**313,774**	**245,459**	**68,315**	**301,277**	**232,820**	**68,457**

This table shows the number of staff employed in terms of full-time equivalents, analysed between those who are employed on permanent contracts and others:

	2016/17			2015/16		
	Total	Permanent Staff	Other	Total	Permanent Staff	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	**913**	417	496	**867**	370	497
Administration and estates	**473**	375	98	**472**	366	106
Healthcare assistants and other support staff	**2,258**	2,188	70	**2,091**	2,017	74
Nursing, midwifery and health visiting staff	**1,886**	1,829	57	**1,879**	1,830	49
Nursing, midwifery and health visiting learners	**11**	4	7	**9**	1	8
Scientific, therapeutic and technical staff	**452**	415	37	**432**	403	29
Healthcare science staff	**421**	417	4	**403**	397	6
Agency and contract staff	**249**	0	249	**251**	0	251
Bank staff	**305**	0	305	**261**	0	261
Total average staff numbers	**6,968**	**5,645**	**1,323**	**6,665**	**5,384**	**1,281**

Sickness Absence

We continue to monitor the impact of sickness absence and take supportive action to enable staff to return to work at the earliest opportunity.

Sickness Absence % for 2016/17 is as follows:

Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	*2016/17*
4.27 %	3.67 %	4.16 %	4.12 %	3.86 %	3.74 %	4.28 %	4.43 %	4.50 %	4.45 %	4.54 %	4.04 %	*4.17 %*

(*figure subject to change due to subsequent closures of sickness).

Sickness is discussed in detail at various boards and committees including divisional performance committees. The Trust 'Managing Sickness Absence Policy' has been reviewed and re-written as the 'Attendance Policy'. The new policy was introduced in May 2016, supported by briefings leading up to, and following, the launch. More than 30 sessions were conducted, attended by almost 400 managers. The new approach was positively received, particularly in respect of:

- The 'know your staff' principle to people management.
- The empowerment of managers to take decisions
- Phased return – no need to use annual leave/ sickness
- Greater outcome focus.
- Putting the person before the process.
- No expectation that staff must be sanctioned for reaching the 'trigger'.

The feedback from the staff side (representatives of the trade unions) has been very positive. They are reporting a change to the approach that managers are taking in managing attendance and this is having a positive impact on staff. This is further supported by the introduction of a new Special Leave policy – which provides brief, simple guidance underpinned by the principle of 'know your staff'.

As a Trust we monitor the impact of sickness absence on a daily basis and report formally on our sickness levels on a monthly basis through various formal arrangements, including Divisional Boards, Performance Committees, Workforce Sub-board, Hospital Management Board and the Trust Board. We are very conscious that initiatives such as these might not see instant results in absence data. However, early indications are very positive. The actions in our plan were deliberately intended to improve staff physical and mental health as well as encouraging healthier eating by inspiring behaviour changes for the future and as such we should expect to see an influence in our absence rates as initiatives are bedded in.

As at February 2017 (latest data available), for the past seven months (from August 2016), the monthly sickness figure has been either at, or less than, the corresponding month 12 months previously. In fact, for six of the past ten months (from May 2016), the monthly sickness figures have been better than that for the corresponding period 24 months previously. Furthermore, the 12-month seasonally adjusted figure continues to fall.

Going into the future years we anticipate that the impact of policy changes, wellbeing interventions and the prevention work continue to reflect positively on sickness levels.

Local Counter Fraud Service (LCFS)

NNUH works closely with our designated local counter fraud specialist as part of the national scheme led by 'NHS Counter Fraud'. This involves proactive and reactive work to ensure that precious NHS resources are not lost to fraud but rather can be spent on patient care and clinical services – thereby providing a clear route for concerns in relation to fraud to be reported and investigated, and development of an anti-fraud culture.

This process is detailed in the organisation's Anti-Fraud and Bribery Policy.

Staff engagement

One of our top priorities is to encourage the best from our staff, whilst at the same time maintaining their health, safety and wellbeing at work. Our approach to staff engagement is to involve our colleagues in discussions about key issues and this is reflected in the different ways in which we communicate and consult with staff. It is also about listening to staff feedback from the NHS Staff Survey and responding to that feedback accordingly. We offered every member of staff the opportunity to take part in the annual NHS Staff Survey and 3,200 staff completed the survey over October and November 2016.

We have regular meetings with staff side representatives by holding monthly Joint Staff Consultative Committee and Pay and Conditions of Service Committee. We have been shortlisted for the 'Social Partnership Forum award for partnership working between employers and trade unions' category in the 2017 HPMA awards which is recognition of our partnership working approach at the Trust.

During June 2016 we launched our monthly NNUH PRIDE staff awards. These monthly awards aims to recognise and reward both teams and individual staff members who have 'gone the extra mile' for patients, visitors or colleagues. Nominations relate to a specific action or achievement which made a difference to the person nominating. Staff can be nominated by patients, visitors, families and colleagues, with awards for employee of the month and team of the quarter.

Our monthly NNUH Pride Awards recognises the values we hold as an organisation:

People-focused **R**espect **I**ntegrity **D**edication **E**xcellence.

The values are an anchor to remind us what is important and *how* we do what we do is as important as *what* we do. We also hold an annual Staff Awards scheme to recognise the achievements of staff in a number of areas, including leadership, team work and lifetime achievement.

In 2016, there were more than 700 nominations for the Staff Awards and winners are announced at an annual award ceremony held in The Forum in Norwich where the nominated individuals and teams were invited along with staff receiving long service awards.

Communications and consultation

Staff engagement is supported by a comprehensive internal communications programme which includes a weekly e-newsletter, intranet, magazine, monthly team brief, and events such as Nurses Day and Midwives Day. Monthly Viewpoint meeting sessions, which are open to all staff, have been introduced by Chief Executive Mark Davies who leads the sessions with other executive directors talking about specific subjects. Staff are kept up-to-date on a range of performance and finance issues affecting our hospitals through the integrated performance report which is shared with staff at each Viewpoint session.

Where there are issues affecting particular staff groups, including service changes, we hold regular meetings with those staff groups and staff side representatives, as appropriate.

Speak Up and Freedom to Speak Up Guardians

The NNUH Speak Up Policy exists to provide ways for staff to raise any concerns that they may have about things they see or hear in the workplace. Importantly we want staff to feel safe and secure to do so, and feel confident in the process. We are grateful for when staff raise concerns as it ensures an awareness of the issue and enables us, where possible, to remedy the situation.

During 2017 we were pleased to announce that in addition to our existing 'speak up' methods for raising concerns, NNUH have appointed six Freedom to Speak Up (FTSU) Guardians to strengthen our speak up arrangements across NNUH. The six appointed FTSU Guardians are also our NNUH staff governors who cover all staff groups and are accessible and trusted individuals, appointed by staff to represent them at the highest level in the hospital.

Our 'Freedom to Speak Up' Guardians provide an additional point of contact in terms of seeking advice as to how to deal with a concern. One of the responsibilities of the FTSU Guardian role is to ensure that the Board of Directors are aware of concerns, and that they are working to ensure that staff feel supported and encouraged to be open and to speak up. They will help facilitate the raising of staff concerns process by providing advice and support where needed, ensuring organisational policies are followed correctly and that concerns are managed in accordance with our PRIDE values.

Disability Confident

During 2016 the Department of Work and Pensions working closely with disabled people, disability organisations and other key stakeholders, developed a new Disability Confident scheme. This builds on and replaces the best practices of the 'Two Ticks Disability Symbol' model which the Trust previously held.

The Disability Confident scheme will help the Trust to successfully employ and retain disabled people and those with health conditions. Being Disability Confident is a unique opportunity to lead the way in our local community. The scheme has three levels, enabling organisations to attract, recruit and retain disabled people, whilst demonstrating commitment, action and progression, as follows:

Level 1: Disability Confident Committed
Level 2: Disability Confident Employer
Level 3: Disability Confident Leader

As a previous Disability Symbol 'two ticks' employer, during 2016 the Trust migrated to Level 2 - Disability Confident Employer badge holder. During 2017/18 we will apply to retain the Level 2 Disability Confident Employer status and make steps to progress to Level 3.

There are also special schemes for recruiting employees with disabilities, such as Project Search. This is a pioneering intern programme which has led to employment for many young people. It involves NNUH working in partnership with Remploy, Serco and City College Norwich to offer students with learning difficulties and disabilities the chance to learn vital skills and prepare them for paid employment.

The programme started in 2009 and was the first programme of its kind in the UK and it is now being used as an example for other hospitals and organisations to follow.

Employees who develop a disability during the course of their employment receive support from the Workplace Health and Wellbeing Team and the Human Resources Department, as well as their line manager.

- Options are explored for making reasonable adjustments to the person's work activities which might include a change to working hours, duties or use of equipment. The aim is to keep the employee in work and all opportunities are explored, including redeployment.

NNUH Clinical Educator Team

NNUH Scores 'green across the board' for clinical education

The Norfolk and Suffolk Workforce Partnership, part of Health Education England, recently conducted its annual Non-Medical Quality Improvement Performance Framework (QIPF) Review which looks at education provision. at the Trust. The report has shown that NNUH scored 'green' across all eight categories.

NNUH supports the clinical learning of more than 750 individual students from Nursing, Midwifery, Allied Health Professions and Health Care Scientists each year.

The Trust was commended for its work in a number of areas such as Clinical Educator roles, the use of inter-professional learning and the innovative Collaborative Learning in Practice (CLiP) educational approach

Our Attendance Policy which was launched in May 2016 has a toolkit which is dedicated to dealing with staff with disabilities and long term health considerations which encourages managers to:

- consult with individuals
- deal with matters confidentiality and sensitively
- consider everything that is relevant
- consider all possible options and outcomes
- implement the identified and appropriate option where they are considered to be reasonable adjustments.

Equality and diversity

As a major employer and service provider, the Trust seeks to ensure that we deliver on the requirements outlined by the Equality Act 2010 which are to have due regard to the need to:

- Eliminate discrimination, harassment and any other conduct prohibited by or under the Act.
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it.
- Foster good relations between people who share a protected characteristic and people who do not share it, and
- Meet the Public sector equality duty to actively promote equality in policy making, the delivery of service and employment.

There are nine protected characteristics recognised by the Equality Act: Age, Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion and belief, Sex and Sexual orientation.

Breakdown of male and female staff as at 31 March 2017:

	Male	Female
Executive Directors	6	1
Non Executive Director	4	3
Other staff	1,504	5,990

NHS Staff Survey 2016

The annual National NHS Staff Survey has operated since 2003 and allows us to monitor the experiences of our staff and benchmark ourselves against other similar NHS organisations and the NHS as a whole, on a range of measures of staff attitudes and satisfaction. The results are primarily intended for use by NHS organisations to help them review and improve the experience of staff at work, and who in turn are then feel supported to provide high quality care for our patients.

Staff at NNUH have very positive things to say about being a patient at NNUH, with up to 80% recommending it in monthly surveys during 2016. This is absolutely a credit to our staff and to their dedication and commitment. Their views in respect of their experience of NNUH as a place to work is more mixed however, with more recent results showing a gradual improvement but still lower at 56%.

In particular, staff comment on the pressure and challenges they face as a result of the increased demand on the organisation, and the importance of continued investment in staff numbers, skills and space to deal with this – which impacts on their experience at work and the care they are able to provide.

Our overall indicator score of staff engagement from the Staff Survey 2016 demonstrated a small reduction compared to 2015 and was in the lowest (worse) 20% when compared with other acute trusts. Our score was 3.70 out of 5 (the scale being 1 to 5 - 1 being poorly engaged staff and 5 being highly engaged staff). The national 2016 average score was 3.81. Last year (2015) we scored 3.72.

This indicator is calculated by using key findings scores relating to: staff members' perceived ability to contribute to improvements at work; their willingness to recommend the trust as a place to work or receive treatment; and the extent to which they feel motivated and engaged with their work.

Our response rate to the 2016 survey was 46%, with over 3,200 returned questionnaires, which was above the average for acute hospitals in England.

	2016 Survey		**2015 Survey**		**Trust Improvement / Deterioration**
Response Rate	**Trust**	**National Average**	**Trust**	**National Average**	
	46%	43%	49%	41%	Decrease of 3% in response rate

The Trust's top five ranking scores in the 2016 survey for which the Trust compares most favourably with other acute trusts in England are shown below:

	2016 Survey		2015 Survey		Trust improve /Deteriorate
Top five 2016 ranking scores	**Trust**	**National Average**	**Trust**	**National Average**	
Key Finding 15 Percentage of staff satisfied with the opportunities for flexible working patterns (the higher the score the better)	52%	51%	50%	59%	Improvement of 1%
Key Finding 21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (the higher the score the better)	88%	87%	88%	87%	No Change
Key Finding 19 Organisation and management interest in and action on health and wellbeing (the higher the score the better – 1 being low interest in health and 5 being high interest in health)	3.63	3.61	3.58	3.57	Improvement of 0.05
Key Finding 17 Percentage of staff feeling unwell due to work related stress in the last 12 months (the lower the score the better)	35%	35%	37%	36%	Improvement of 2%

Key Finding 16 Percentage of staff working extra hours (the lower the score the better)	72%	72%	72%	72%	No Change

Our bottom five ranking scores from the 2016 survey for which the Trust compares least favourably with other acute Trusts in England were:

	2016 Survey		**2015 Survey**		**Trust Improvement / Deterioration**
Bottom five 2016 ranking scores	**Trust**	**National Average**	**Trust**	**National Average**	
Key Finding 13 Quality of non-mandatory training, learning or development (the higher the score the better– 1 being low-quality training and 5 being high-quality training)	3.94	4.05	3.97	4.03	Decrease of 0.03
Key Finding 4 Staff motivation at work (the higher the score the better - 1 being not enthusiastic/ absorbed and 5 being highly enthusiastic/ absorbed)	3.82	3.94	3.85	3.94	Decrease of 0.03

Key Finding 2 Staff satisfaction with the quality of work and care they are able to deliver (the higher the score the better - 1 being unsatisfactory delivery of work/ care and 5 being highly satisfactory delivery of work/ care)	3.78	3.96	3.76	3.93	Improvement of 0.02
Key Finding 31 Staff confidence and security in reporting unsafe clinical practice (the higher the score the better - 1 being not confident/ secure and 5 being confident/ secure)	3.51	3.65	3.49	3.62	Improvement of 0.02
Key Finding 6 Percentage of staff reporting good communication between senior management and staff (the higher the score the better)	23%	33%	21%	32%	Improvement of 2%

Taking action:
Action is being taken at both divisional and corporate levels, having undertaken consultation with trade union representatives and our governors to understand their perspectives on the feedback reflected in the staff survey. We will build on the staff survey results to identify and bring together an action plan in helping make the hospital the best possible place to work and help achieve our aspirations around the highest level of staff experience and engagement.

Our priorities are to ensure that our staff feel valued and supported, are able to fulfil their potential and give of their best. NNUH has put in place a regular staff survey so that there are more frequent opportunities to gain feedback from colleagues, in addition to the full annual survey. This is monitored and reported at the Board of Directors to support ongoing discussions around staff experience and engagement.

Looking at the NNUH staff survey 2016 findings in comparison to 2015, 22 of the 32 key findings show improvement. In particular, what staff said that was good about working at NNUH, were the percentage of staff appraised, organisational/management interest in staff health and wellbeing, recognition and feeling valued by the organisation and by managers, support from one's immediate line manager; and the last two findings, the percentage of staff who believe that the organisation provides equal opportunities for career progression and the percentage of staff satisfied with the opportunities for flexible working.

We will be looking at the findings that were more challenging by working with Divisional management to tackle these as a priority. We want to both understand the issues in those areas where staff are not so satisfied with working in the Trust and celebrate the areas with the best scores where staff have said this is a fantastic place to work. We want to learn from them and how we can spread any good practice and learning with other areas in the Trust.

The survey results are being shared widely across divisions, departments and wards which will inform the identification and agreement of priorities for the divisions and trust wide in alignment with our PRIDE values. The plans will be reported to and monitored by the Hospital Management Board.

Workplace Health & Wellbeing (Occupational Health)

The service continues to deliver programmes to promote the health and wellbeing of our staff as well as the organisations that contract services from us.

Over the past year, the team have been supporting the Trust in its work towards NHS England's National CQUIN (Commissioning for Quality and Innovation) target relating to Improving Staff Health and Wellbeing. As part of this programme, we developed and submitted to the commissioners a substantial plan of proposed initiatives to encourage and improve staff wellbeing and then implementing the actions throughout the year. The plan consisted of 4 key focus areas – leadership, promoting mental wellbeing, promoting physical wellbeing and enhancing the environment. Thirty five actions were identified to implement in the plan and these consisted of policy review (e.g. attendance policy, retirement policy, roster policy etc), promoting various physical health initiatives (e.g. rubbing club, walking group, introducing the 'midday mile', yoga etc), promoting mental wellbeing initiatives (promoting the NNUH choir, ensuring suitable access to different therapies including mindfulness and resilience training)

The 2016 flu vaccination programme for staff also was part of the National CQUIN and this was the most successful programme to date with 78.8% staff vaccinated at the end of February. Our front line staff vaccination rate was 81.4%, the 6th highest in the country out of 262 Trusts, and one of only 77 Trusts to achieve the challenging 75% compliance rate of the CQUIN.

Our success, was undoubtedly as a result of increased resource to ensure high accessibility of the vaccines was available to all staff alongside a very thorough and prominent communication plan, including our very own in house produced 'Flu song' video which featured our hospital choir as well as other staff members.

The Head of Workplace Health and Wellbeing has continued to work with other regional OH leads on a two year streamlining project which endeavours to allow information to be transferred between NHS organisations on staff members who are moving employment. The aim is to reduce both cost in repeated activities and time of OH services regionally and allow more proactive intervention to take place. 3 of the 4 objectives have now been completed to date and an interim solution is being trailed for the final area whilst awaiting technology solutions for complete resolution.

After a successful year winning new external business last year, the team within WHWB has ensured delivery of all contracts has been maintained in line with agreed timeframes. We are pleased to report that we have also re-secured one of our major contracts in this year for a further contractual period.

As a result of the new business, we have increased our clinical team in the last 12 months and these staff members have been successfully inducted to the team. In addition, we have seen personnel changes in our business team over the last 12 months and have since reviewed our business plan and developed a new marketing strategy.

Our full five year assessment review of the Faculty of Occupational Medicine SEQOHS (Safe, Effective, Quality OH Service) accreditation programme is due in 2017 and as such we have been collating all relevant evidence. We uploaded our final submission in February 2017 and now awaiting our on site assessment which will take place in July 2017.

Health & Wellbeing / Staff Experience Working Group

Our staff experience group has met on a monthly basis and been working on various initiatives. On 1st June 2016, we successfully launched our new monthly staff award was enabling patients and colleagues to nominate staff who have shown great kindness or dedication which goes above and beyond their job role. The new NNUH Pride Award is supplementary to the Trust's annual staff awards scheme, providing a year round opportunity for patients who want to say thank you for their care and staff to say thank you to their colleagues. The Awards are based on the Trust's values: People-focused, Respect, Integrity, Dedication and Excellence (PRIDE). Each month there are up to two members of staff who receive recognition and one team winner every quarter. The NNUH PRIDE awards are being supported by Barnham Broom Hotel which is providing an 'Afternoon Tea for Two' or ' Fitness Voucher' for individual winners with hospital service provider Serco providing the winning teams with cake and fruit to share. This initiative has been really well received.

Our overall Health & Wellbeing Programme has had a 12 month focus on 'Work- Life Balance ' Each month, we have featured topics to assist staff in improving their own personal health and wellbeing and had a newsletter providing key information as well as having some associated events. Examples of the monthly topics were 'Make exercise a must do, not a should do' and 'have that holiday', The WHWB team have delivered wellbeing and resilience workshops to staff members to support this programme.

Our weekly activities continue ie running club, choir, yoga and monthly walking group have seen increased attendance throughout this year. The NNUH Choir has had a busy year supporting local charities. In addition, we were very proud to be invited to participate as the 'entertainment' for the NHS East of England Leadership awards – which took place at Duxford. Singing under the wings of Concorde was a surreal and exciting experience for this group of staff!

Staff Development

Apprenticeships

Our hospitals well established apprenticeship programme continues to go from strength to strength with 98% of our apprentices going onto employment with 92% staying within the Trust. Due to a significant cut in HEE funding our target for 2016/17 was only 64 for staff on programme, we actually achieved 150.

We offer a wide range of apprenticeship frameworks at entry level intermediate Level 2, Advanced Level 3, Higher frameworks at Level 4 and Level 5 and going forward there will be Level 6 (degree) and Level 7 (Masters).

Our Apprenticeships are structured and the apprentices are well supported by their teams, their Mentor, the education provider and the apprenticeship team. We now have clear evidence that apprenticeships offer a pathway through to Higher registered training such as Nursing, Midwifery, ODP, Biomedical Science, Audiology, and Management.

In March 2015 working in partnership with HEE, Norfolk County Council, Norfolk and Suffolk Care Support, and City College Norwich we were the first Trust in the East of England to offer an `***Integrated Health & Social Care'*** pilot.

We recruited 6 Apprentice Health & Social Care Assistants on a 12month fixed term contract to undertake a Level 2 health and social care framework. The aim of the pilot was to give apprentices a broader understanding and experience of how care is delivered in both settings. The programme was a huge success with apprentices going on to posts within the Trust, Norfolk Community Health and Care, and social care sector. In November 2016 we were nominated for the ***Norfolk Care Awards 'Most Supportive Employer' - Student Placement category.*** At the Awards dinner in February we were very happy to receive a 'Highly Commended' status in recognition of the success of the integrated programme.

Hilary Winch, Head of Health and Wellbeing and leader of the flu programme

Best ever flu vaccination performance at NNUH!

More than 70% so far of staff at NNUH have opted in to its “Proud to be an NNUH flu fighter!” campaign and are now vaccinated against flu this year.

It is the Trust’s best ever performance on flu vaccinations as NNUH aims for as many staff as possible to benefit from a flu vaccination before Christmas, providing staff with daily opportunities to have their free flu jab to protect their patients, colleagues and families.

The Governments policy on delivering 3million apprenticeships by 2020 *(English Apprenticeships: Our 2020 vision*) commences on 6th April 2017 when a Levy on all employers with a payroll over £3m will be taxed 0.5% of their payroll. The Government target for all public sector organisations is that 2.3% of their workforce will either be apprentices or existing staff on apprenticeship programmes.

Levy payments will be taken by HMRC monthly through PAYE. **For our hospital the levy equates to approximately 1.56 million per year = £130,000 per month.** The levy can **only** be used to pay for education, and end point assessments. The Government will apply a monthly 10% top-up to our levy pot. That means for every £1 that enters our digital account to spend on apprenticeship training, we get £1.10.

In October 2016 working in partnership with two local Sixth Form colleges we commenced our first '**Internship' programme**.

The aim of the internship is to support students who are potentially going to apply to University, by giving them 1 day per week work experience so that on their university applications they have real and appropriate work experience. Feedback from the Interns and Managers is very positive, with both gaining a lot from the experience and we will look to develop this programme in the future.

School visits / Career information sessions

The Apprenticeship team continue to build strong links with local schools, colleges and sixth forms and over the last year have attended events that have enabled over 3700 students, parents and teachers to gain a better understanding of the Trust, the wider NHS and the varied and differing career opportunities available within it. This is a 17% increase in activity from 2015/16.

'Step Into Health' - Armed Forces Attachment Programme

Following the national roll out of the programme in 2015 interest continues to grow across the UK. In October the programme received a visit from Prince William, Duke of Cambridge. The Duke participated in an information day being held at the Hampshire Hospitals NHS Foundation Trust meeting both service personnel attending and members of the National Team.

A further 21 care organisations are now actively interested in supporting the programme across the UK. Going forward NHS Employers will now be taking the lead on the programme and will utilise the networks and relationships they have with other organisations and national partners to raise the profile and encourage participation. A National Programme Lead is to be employed whose role it will be bring employer representatives together.

Prince's Trust 'Get into Health' Programme

Work continues with the Prince's Trust 'Get into Hospital Services' programme. This programme supports young people aged between 16 and 25 years who have been long term unemployed by facilitating the opportunity to complete a 6 week programme which includes a 4 week work placement within our Hospital.

The placement element of the programme enables candidates to develop their skills, confidence and self esteem in a supportive environment in various departments across the hospital. In Partnership with Serco we have been supporting this programme since 2009 and have seen over 300 young people participating.

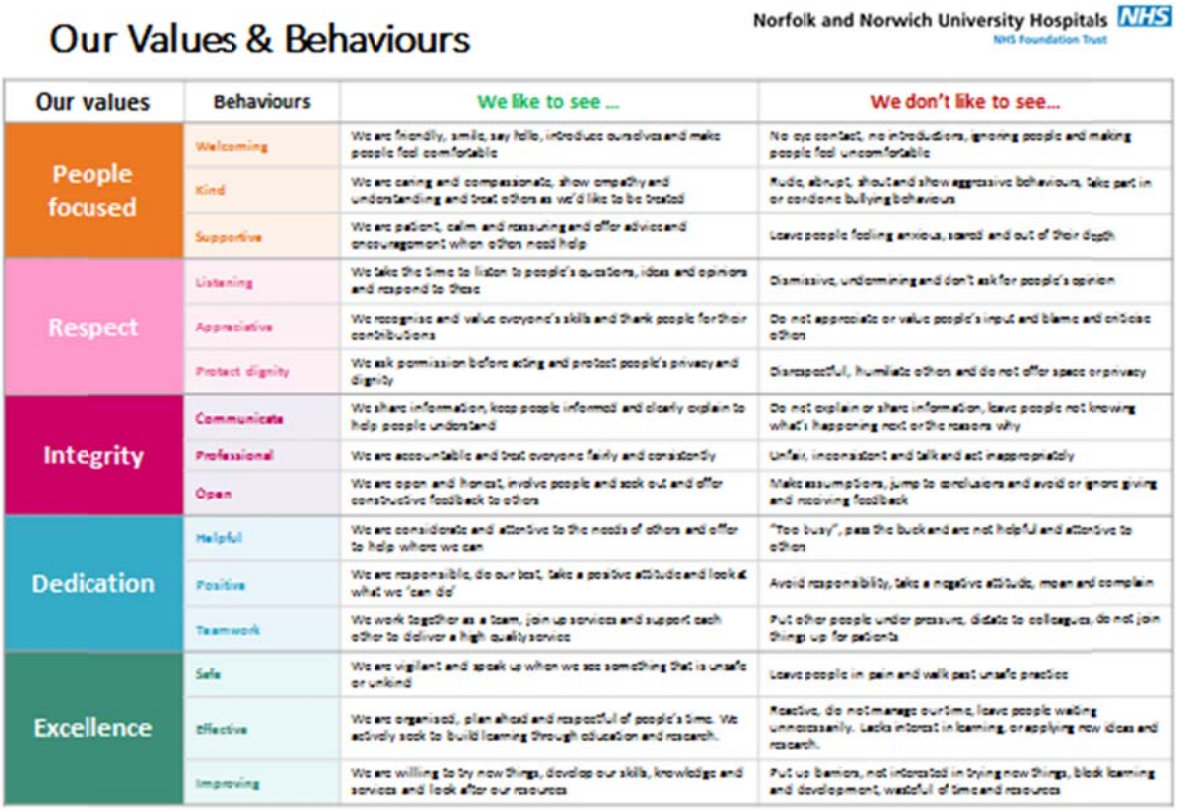
Job Centre Plus

Regular 'taster' days have been held over the year to enable Job Centre Plus customers the opportunity to gain an understanding of the NHS and the work opportunities available to them.

PRIDE Values

The PRIDE Values into Action programme launched in July 2016. Since its launch we have had nearly 2,000 members of staff and patients participate in the PRIDE Values into Action listening events and surveys which contributed to describing the behaviours that will consistently support the best staff and patient experience across our hospitals.

The feedback has helped us to shape a behavioural framework using the words of our staff and patients. The behavioural framework will sit alongside our PRIDE values and will support us in many different ways – for example, recruiting the best people, celebrating achievements, providing standards for how teams work together and for our development.



Our Values & Behaviours

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Our values	Behaviours	We like to see ...	We don't like to see...
People focused	Welcoming	We are friendly, smile, say hello, introduce ourselves and make people feel comfortable	No eye contact, no introductions, ignoring people and making people feel uncomfortable
	Kind	We are caring and compassionate, show empathy and understanding and treat others as we'd like to be treated	Rude, abrupt, shout and show aggressive behaviours, take part in or condone bullying behaviours
	Supportive	We are patient, calm and reassuring and offer advice and encouragement when others need help	Leave people feeling anxious, scared and out of their depth
Respect	Listening	We take the time to listen to people's questions, ideas and opinions and respond to these	Dismissive, undermining and don't ask for people's opinion
	Appreciative	We recognise and value everyone's skills and thank people for their contributions	Do not appreciate or value people's input and blame and criticise others
	Protect dignity	We ask permission before acting and protect people's privacy and dignity	Disrespectful, humiliate others and do not offer space or privacy
Integrity	Communicate	We share information, keep people informed and clearly explain to help people understand	Do not explain or share information, leave people not knowing what's happening next or the reasons why
	Professional	We are accountable and treat everyone fairly and consistently	Unfair, inconsistent and talk and act inappropriately
	Open	We are open and honest, involve people and seek out and offer constructive feedback to others	Make assumptions, jump to conclusions and avoid or ignore giving and receiving feedback
Dedication	Helpful	We are considerate and attentive to the needs of others and offer to help where we can	"Too busy", pass the buck and are not helpful and attentive to others
	Positive	We are responsible, do our best, take a positive attitude and look at what we 'can do'	Avoid responsibility, take a negative attitude, moan and complain
	Teamwork	We work together as a team, join up services and support each other to deliver a high quality service	Put other people under pressure, dictate to colleagues, do not join things up for patients
Excellence	Safe	We are vigilant and speak up when we see something that is unsafe or unkind	Leave people in pain and walk past unsafe practice
	Effective	We are organised, plan ahead and respectful of people's time. We actively seek to build learning through education and research.	Reactive, do not manage our time, leave people waiting unnecessarily. Lacks interest in learning, or applying new ideas and research.
	Improving	We are willing to try new things, develop our skills, knowledge and services and look after our resources	Put up barriers, not interested in trying new things, block learning and development, wasteful of time and resources

Supporting the need to embed our NNUH Values and Behaviours, a detailed action plan has been developed. This identifies the key enablers which Corporate Communications and Workforce will deliver to support Divisions to embed our values and behaviours throughout the organisation.

Health and Safety

The Health and Safety team advises on staff safety in relation to the main risks present in a healthcare environment. The team assists with risk assessment and incident investigation as well as proactively auditing and monitoring standards and compliance across all Trust premises.

The main projects for the year 2016/17 were:

- The introduction of more "sharps" safety devices.
- Emphasis on reviewing fire risk assessments and provision of regular and varied fire safety training sessions
- Establishing a network of link staff to assist areas in their management of safety.
- Reviewing and updating the database used for the management of the Control of Substances Hazardous to Health (COSHH)

Training

The Health and Safety team develops and delivers training packages and ensures that there are competent trainers to cover the mandatory training needs of the organisation related to fire, health and safety, manual handling, risk assessment, prevention and management of aggression, chemicals and waste.

The team also compiles e-learning packages and assessments used for revision training for staff in various health and safety topics. The training process is regularly evaluated and reviewed to ensure it is effective.

Incidents

There are five categories of health and safety related incidents that are reported most frequently for staff. These are slips, trips and falls, needle-stick and sharps injury, patient moving and handling, verbal aggression and physical aggression. There was a 1% decrease in reported staff safety incidents compared with the previous year.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Incidents

During 2016/2017, the Health and Safety Department reported 23 staff injuries to the Health and Safety Executive. These were due to the employee being absent for or requiring a change of duties for more than seven days. This is a decrease in reportable incidents of 23% on the previous year.

The number of RIDDOR incidents is reflected as an incidence rate against the national average. The Trust's overall incidence rate is 328 per 100,000 employees. The national incidence rate for healthcare in 2016 was 388.

More detail on health and safety performance is included within the Health and Safety Annual Report that is presented to the Trust Health and Safety Committee in April 2017.

Kneale Metcalf received Professional Excellence Award

NNUH Stroke Consultant Physician receives regional award

A NNUH Consultant Stroke Physician has received a regional award to highlight his outstanding teaching work to raise awareness of stroke recognition.

Dr Kneale Metcalf, Consultant Stroke Physician, was awarded the Professional Excellence Award at the East of England Stroke Association 'Life After Stroke Awards'.

Nominated by the East of England Stoke Association, Dr Metcalf said: "I feel very honoured to be given this Professional Excellence Award for teaching. As a Consultant Stoke Physician, teaching others is an important part of my work – a duty which I very much enjoy. The East of England Stroke Association carries out amazing work in terms of both research and awareness and I would to thank them for nominating me".

Off payroll engagements

The Trust has a policy that all substantive staff are paid through payroll unless there are exceptional circumstances. No Board members were engaged on an interim and off-payroll basis during the period 1 April 2016 to 31 March 2017.

In addition the Trust does employ contractors from time to time to support projects who may be engaged on an off payroll basis. The table below shows the details:

Off payroll engagements as of 31 March 2017 for more than £220 per day lasting for longer than six months	
No. of existing engagements as of 31 March 2017	3
Of which:	
No. that have existed for less than one year at the time of reporting	3

The existing arrangement outlined above, has been subject to an assessment as to whether assurance needs to be sought 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 1 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months	
No. of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	6
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	6
No. for whom assurance has been requested	6

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure ***must*** include both off-payroll and on-payroll engagements.	7

Staff exit packages

There were no new staff exit packages in the year ended 31 March 2017 (2015/16: Set out in the table below).

Staff exit packages for the year ended 31 March 2016				
	Number of compulsory redundancies	**Number of other departures agreed**		**Total number of exit packages by cost band**
<£10k	-	2		2
£10k - £25k	-	5		5
£25k - £50k	-	2		2
£50k - £100k	-	1		1
£100k - £150k	-	1		1
£150k - £200k	-	1		1
		12		**12**

As part of the National savings and efficiency requirements, the Trust introduced a voluntary severance scheme.

Of the 12 non compulsory departures 3 being mutually agreed resignations (MARS) totalling £397k, and 9 being voluntary redundancies totalling £155k. Total cost of exit packages for all staff including senior executives is £552k (14/15 £542k).

NHS Improvement's Single Oversight Framework

Area	Metric	2016/17 Q3 Score	2016/17 Q4 Score
Financial sustainability	Capital service capacity	4	4
	Liquididity	4	4
Financial efficiency	I&E margin	4	4
Financial controls	Distance from financial plan	2	2
	Agency Spend	2	2
Overall Scoring		4	3

The overall scoring for Q3 would have been a 3, however because we were in Financial Special Measures at that time it defaulted to a 4.

As can be seen in Q4 the overall score is a 3 and remains a 3 as we have exited Financial Special Measures.

NHS Improvement's Single Oversight Framework

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

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

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

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website. As of 31 April 2017, NHSI has identified that NNUH FT is in 'Segment 3' of its SOF. This reflects the Voluntary Licence Undertakings given by the Trust, as detailed in the Annual Governance Statement 2016/17 included in this Annual Report.

On 15 March 2017 the NHSI Executive Director of Regulation confirmed formally that the Trust was being released from Financial Special Measures on the grounds that we have *"demonstrated a robust CIP governance structure; have a cohesive and substantive management team in place; and have demonstrated delivery and remain on track to deliver against [our] recovery plan"*.

The subsequent Certificate of Compliance from NHS Improvement (25 April 2017) confirms that in respect of all undertakings introduced through the September 2016 (Financial Special Measures) variation, *"the Licensee [Trust] has been fully complaint".*

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

Area	**Metric**	**2016/17 Q3 score**	**2016/17 Q4 score**
Financial sustainability	Capital service capacity	4	4
	Liquidity	4	4
Financial efficiency	I&E margin	4	4
Financial controls	Distance from financial plan	2	2
	Agency spend	2	2
Overall scoring		**4**	**3**

Statement of the chief executive's responsibilities as the accounting officer of the Norfolk and Norwich University Hospitals 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.

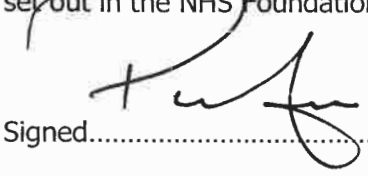
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require the Norfolk and Norwich University Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Norfolk and Norwich University Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

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

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the Norfolk and Norwich University Hospitals NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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



Signed..... Date: 26 May 2017

Mark Davies

Chief Executive

Annual Governance Statement for the year ended 31 March 2017

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.

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 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 Norfolk and Norwich University Hospitals NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has a Risk Management Strategy which sets out the accountability and reporting arrangements to the Board of Directors for risk management within the Trust. Operational responsibility for the implementation of risk management has been delegated to our Director of Nursing and other named staff.

During the course of this year the Board reviewed and approved revisions to our Risk Management Strategy. This has made available to all Trust staff through our intranet documents management system (TrustDocs) and is accompanied by a Risk Management Policy. The focus of our risk management approach is on proactively identifying and avoiding risks rather than reacting to ones which have materialised.

Our increased focus on risk management is evidenced by establishment of a Risk Committee by the Management Board. The Committee is tasked with overseeing the operation of our risk management systems and processes. In its early meetings during 2016/17 the Committee has focussed on enhancing our arrangements for the identification and management of corporate risks and it reports regularly to the Management Board, in accordance with defined Terms of Reference.

During 2016/17 our processes for risk management were subject to Internal Audit review. This resulted in a 'reasonable' assurance rating – providing assurance to the Board that the controls in place in this area are suitably designed and consistently applied, with some recommendations on how we improve further and ensure that the control framework is effective.

The Risk Management Department co-ordinates and supports risk activity across the Trust. The mandatory corporate induction programme covers both clinical and non-clinical risk and the Trust's approach to managing risk and maximising quality in patients' care. In addition a range of risk management training is provided to staff and there are policies in place which describe roles and responsibilities in relation to the identification, management and control of risk. Staff training covers requirements for the safe delivery of services, proper use of equipment and wider aspects of management, health and safety and quality assurance training.

The Trust learns from good practice through a range of mechanisms, including clinical supervision, reflective practice, individual and peer reviews, performance management, continuing professional development, clinical audit and application of evidence-based practice. The implementation of guidance from the National Institute of Clinical Excellence (NICE) is overseen by the Clinical Effectiveness Governance Sub-Board.

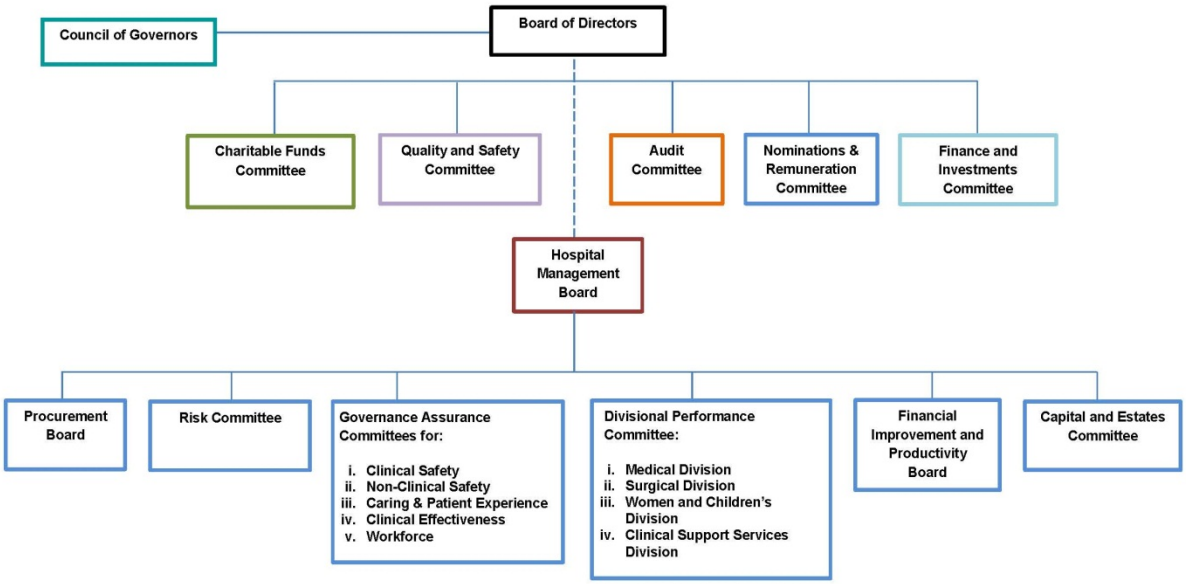
The Risk Management Strategy and supporting procedures set out the key responsibilities for managing risk within the organisation, including ways in which risk is identified, evaluated and controlled. Risk management is embedded throughout the organisation, with a culture focussed on prevention of risks, reporting of incidents and learning. This is detailed in our policies, including our Incident Reporting Policy and procedures and staff training and awareness, both mandatory and general.

Reduction of risk and maintenance of quality are promoted by constantly reinforcing a culture of openness and transparency and encouraging staff to identify opportunities to learn from patient feedback and to improve the care and services we provide.

The risk and control framework

The Board of Directors meets bi-monthly in public and at every meeting it receives reports which detail risk, financial and performance issues and, where required, the action being taken to reduce identified high level risks. This reporting to the Board of Directors is supported through the Trust's governance structure, in particular through the Hospital Management Board with its Committees and Governance Sub – Boards.

2016/17 was the first full year in operation of the two Board Committees established in 2015/16 - the Quality and Safety Committee and the Finance and Investments Committee. In addition during 2016/17 the Trust Board approved the creation of two further Board committees, namely a Charitable Funds Committee and a Nominations and Remuneration Committee. The Board receives regular reports from each of its Committees and the overall governance and assurance structure is as illustrated overleaf:



The Board's Audit Committee has responsibility to oversee the maintenance of an effective system of integrated governance, risk management and internal control, across the Trust's activities. The Terms of Reference for the Trust's Audit Committee are based on the model set out in the NHS Audit Committee Handbook (2014) and the Committee is tasked with reviewing the adequacy of the structures, processes and responsibilities within the Trust for identifying and managing key risks. The Audit Committee's Annual Report sets out the ways in which it has carried out its responsibilities during 2016/17.

Information and assurance is provided to the Board through:

- The monthly Integrated Performance Report – which is made available to the Board, Governors, staff and public (via our website);
- Reports from Committees of the Board, specifically Audit Committee, Quality and Safety Committee and Finance and Investments Committee;
- Work of internal and external audit, external reports, PLACE Inspections and the Quality Assurance Audit programme.

Risk is assessed at all levels in the organisation from the Board of Directors to individual wards and departments. This ensures that both strategic and operational risks are identified and addressed and risk assessment information is held in an organisation-wide Risk Register. A risk scoring matrix is used to ensure that a consistent approach is taken to assessing and responding to clinical and non-clinical risks and incidents. Those risks with a high residual risk rating (following the impact of appropriate mitigating actions) are detailed in a High Risk Tracker – reported to both the Board of Directors and Management Board through the Integrated Performance Report.

The Hospital Management Board is tasked through its Terms of Reference with assisting me in effectively discharging my duties as Accounting Officer and with overseeing the identification and mitigation of key risks arising from or relevant to the operation of the Trust.

It oversees the work of five Governance Sub-Boards, the remits of which are collectively constructed so as to be consistent with the inspection regime of the Care Quality Commission under the following headings:

- Clinical Safety
- Non-Clinical Safety
- Caring & Patient Experience
- Effectiveness
- Workforce

The Management Board has also established a number of other Committees to scrutinise and support areas such as Procurement, Financial Investment and Productivity and Capital Planning. A Divisional Performance Committee also oversees the work of the four clinically-led Divisions, within the structure detailed below.

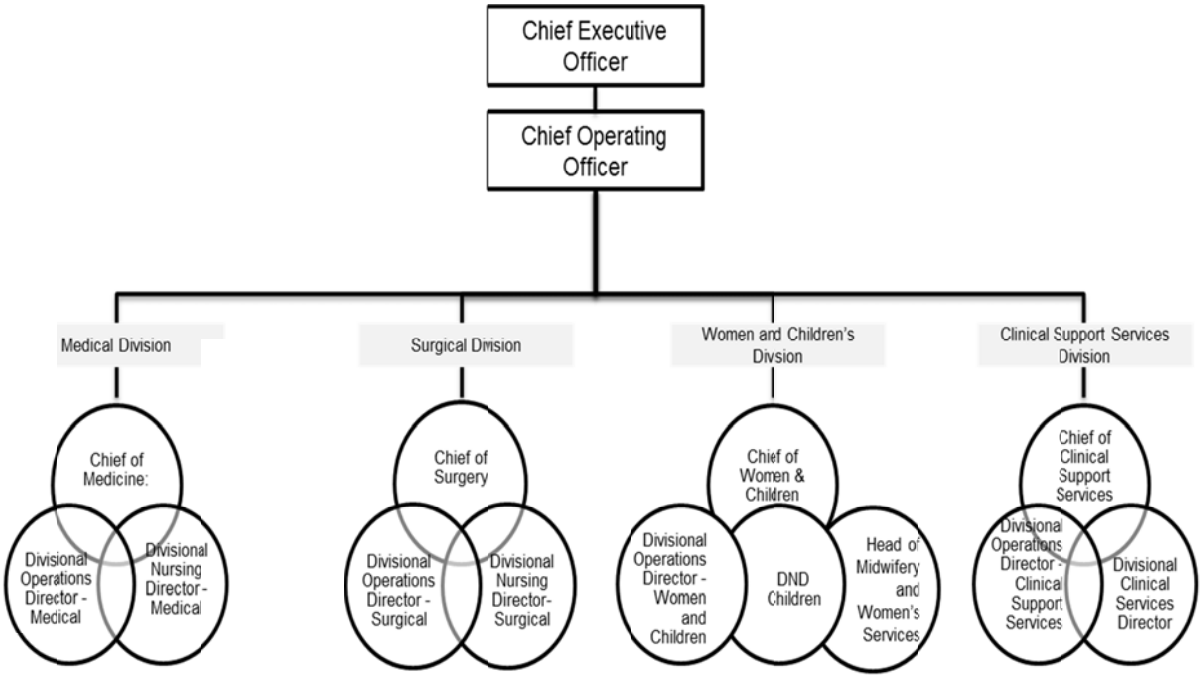
Each of the Management Board committees and governance sub-boards have Terms of Reference and they report regularly to the Management Board on areas of risk or issues that require escalation.

The Trust last underwent a full inspection by the Care Quality Commission (CQC) in November 2015 and the report was issued in March 2016. No areas of the Trust were rated as 'Inadequate'. In its report the CQC judged the Trust to be 'Good' for the domain of Caring, but 'Requires Improvement' in the domains of 'Safety, Effectiveness, Well-led and Responsiveness'. The overall rating for the Trust was therefore that it 'Requires Improvement' to ensure full compliance with the registration requirements of the Care Quality Commission. In this the Trust's rating was in common with 62% of the 162 Trusts inspected by the CQC up to April 2016.

An action plan relating to recommendations made by the CQC was established. This was subject to Internal Audit review, providing *reasonable assurance* that the control framework in place for delivery of the Action Plan was suitably designed and consistently applied. We have subsequently commissioned additional expert input to assist in ensuring that our control framework is effective. Proposed strengthening of our clinical governance structures and processes will be encapsulated in a Quality improvement Plan for approval by the Management Board during 2017/18.

2016/17 has been the first year of our new divisional structures in the Trust. Following a consultation exercise with staff, the Board approved creation of a four division structure, with each division led by a leadership triumvirate of a clinical Chief of Division, a Divisional Nursing Director and a Divisional Operations Director. The revised structure has been in place since 1 April 2016 after several months of 'shadow running'.

This clinically-led divisional structure forms a key part of our management and governance structure and is represented opposite:



The full delegation of authority to the new divisions during 2016/17 was necessarily slowed by the internal controls associated with Financial Special Measures, however this process is now again in development to take effect in 2017/18. In the meantime, in March 2017 our Internal Auditors reviewed our divisional governance arrangements and have confirmed that the Board can take *"substantial assurance"* that the controls in this area are suitably designed, consistently applied and operating effectively.

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 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.

Significant Risks

Major risks facing the Trust, both in-year and in future, are as follows:

- High levels of elective and emergency demand relative to the available operational capacity pose risks for delivery of the Trust's targets for A&E, cancer and 18-weeks;
- The impact of persistent high levels of demand on staff resilience and morale;
- The requirement to make very significant financial savings to return to financial balance;
- Lack of resources available for investment in the Trust and its services for patients;
- The need for sufficient capacity to deliver all the improvements necessary to counter the current and future challenges facing the Trust.

The Trust has mitigating activities in place to minimise the potential impact of these risks so far as possible, with the impact of these assessed through reports to the Board and in particular the metrics set out in the monthly Integrated Performance Report. Very significant challenges remain however with regard to the Trust's operational and financial sustainability in the current organisational configuration and price structure of the health economy.

NHSI (Monitor), the independent regulator of Foundation Trusts, investigated the Trust's non-achievement of the operational performance targets outlined above in 2015/16 and concluded that it has reasonable grounds to suspect that the Trust was in breach of its Provider Licence, which requires achievement of relevant national targets. Monitor has accepted voluntary Undertakings from the Trust with respect to the production and delivery of improvement plans and has concluded that implementation of these Undertakings *"will secure that the breaches in question do not continue or recur".*

Threats to delivery of the Trust's Strategic Objectives are recorded in detail in the Board Assurance Framework which identifies the assurances available to the Board of Directors in relation to the achievement of those Objectives. The Framework document also details the actions to be taken to provide additional assurance and to counter the identified threats. There is a defined process for the Framework to be subject to regular review by the Risk Committee, Management Board and Audit Committee.

A key element of the Undertakings given to NHSI is that the Trust should set out a long-term strategy to address the increasing demand and capacity pressures faced by the Trust. In compliance with the Undertakings the Trust has detailed plans to expand the capacity of the Trust to treat patients through the creation of a new Ambulatory Care and Diagnostics centre. It also proposes expansion of our interventional radiology facilities. Planning of these developments is underway and one of the challenges facing the Trust in 2018/18 will be to secure the necessary capital to fund these schemes.

Incident Reporting

Incident and near-miss reporting is encouraged across all staff groups and specialties across the Trust within an open culture focussed on learning and improvement. The Trust has a single web based incident reporting system which is used by all staff groups to record patient and staff safety incidents, near misses and serious incidents. The number and type of incidents reported and learning from these incidents is disseminated and monitored through the risk and governance structure and a communication route to all staff based on Organisation Wide Learning (OWL) newsletters and updates.

A high comparative rate of incident reporting is viewed as an indicative measure of a healthy safety culture. The Quality and Safety Committee receives regular reports on the rate of incident reporting in the Trust accordingly. Incident reporting for Acute Trusts is measured as a rate per 1000 bed days. National data indicates that the Trust consistently performs above average in its rate of incident reporting relative to other Acute Trusts.

Patient Involvement in Risk

The Trust works closely with the local organisations which are part of the formal structure for NHS patient and public involvement, such as the Health Overview and Scrutiny Committee and Healthwatch.

Our Foundation Trust has a membership with approximately 16,000 public members, many of whom are actively involved with the Trust in a number of ways, not least a regular programme of meetings for members about different aspects of our activities.

The members elect governors who sit on the Trust's Council of Governors and who represent the views of members when contributing to development of the Trust's forward plans and priorities. The Trust's Council of Governors receives regular updates on strategic developments in the Trust and performance against key targets and governance requirements.

The views of patients are sought in a variety of additional ways, including patient electronic surveys, nationally mandated surveys, comment cards and other activities. The Board receives regular reports on feedback from patients through the Caring and Patient Experience Sub-Board.

Patients and external partners provide a further crucial part of our quality assurance and risk control processes, through our programme of Quality Assurance Audits. These consist of small teams making unannounced audit inspections of wards and departments in the Trust, reviewing compliance with a series of pre-determined standards. A number of such teams include an external inspector, providing independent assurance of the rigor and fairness of the QAA process. During 2016/17 we reviewed and revised our QAA process, to strengthen its coverage across inpatient and out-patient areas. The revised scheme was approved by our Quality and Safety Committee and the results from the QAA programme are reported to the Board and are published.

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

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

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

Risks associated with data security are addressed separately in the Information Governance and Cyber Security section of this statement.

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

In 2015/16, Lord Carter of Coles carried out a national review of cost-effectiveness and variation across the NHS. The resulting report revealed that this Trust has an Adjusted Treatment cost (ATC) of 93, representing a 7p saving for every £1.00 spent when compared against national benchmarks.

Based on this national data the Trust is successful in implementing the Board's commitment to optimising the effective and efficient use of the Trust's resource base. In 2015/16 however the Trust reported a significant deficit of £21.9m.

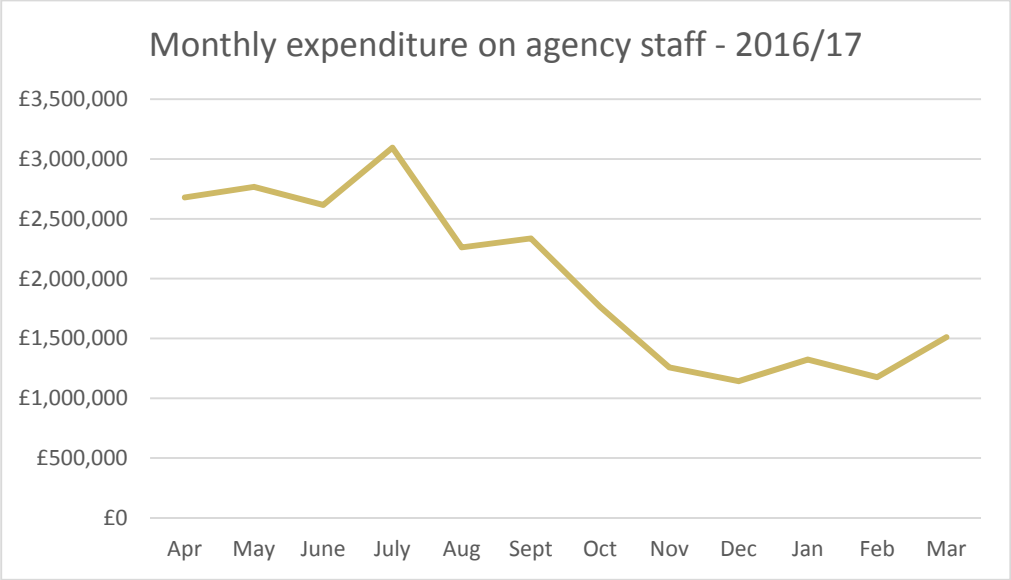
The Trust volunteered to participate in a Financial Improvement Programme commissioned by NHS Improvement which commenced in the early part of 2016/17. As part of this programme the Trust was partnered with an expert team from PWC. We also engaged an experienced Turnaround Director, in accordance with Voluntary Undertakings given to NHSI in April 2016. In addition in September 2016, NHSI varied the April 2016 licence Undertakings and placed the Trust in Financial Special Measures (FSM).

As part of the annual audit, the external auditors are required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They do this through their work on the audit of the Trust's annual report and accounts, by reference to reports from our regulators (including NHS Improvement and the CQC), by examining documentary evidence and through discussions with the Trust. The external auditors have concluded that in light of the regulatory issues highlighted by NHSI, as detailed above, they have not been able to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

During 2016/17 the Trust implemented a wide-ranging efficiency and cost-savings programme. With great commitment from our staff we have been successful in generating savings of c.£25m and have delivered the target of a c.£25m deficit outturn, as agreed with NHSI. Consequently, on 15 March 2017 the NHSI Executive Director of Regulation confirmed formally that the Trust was being released from FSM on the grounds that we have *"demonstrated a robust CIP governance structure; have a cohesive and substantive management team in place; and have demonstrated delivery and remain on track to deliver against [our] recovery plan"*.

The subsequent Certificate of Compliance from NHS Improvement (25 April 2017) confirms that in respect of all undertakings introduced through the September 2016 (FSM) variation, *"the Licensee [Trust] has been fully complaint".*

A key element of that financial improvement concerned the reduction in expenditure on temporary staff. In large part that was achieved through accelerating the recruitment of substantive staff to fill vacancies. By reducing reliance on more expensive temporary staff this was therefore good for the Trust, patients and the staff teams.



A core part of our financial improvement was maintaining a focus on avoiding adverse impact on quality and safety though financial savings. We have established a robust systematic process whereby all financial improvement plans are subject to a Quality Impact Assessment overseen by our most senior nursing and medical leaders. This QIA process ensures that there is appropriate risk assessment of savings plans and that there are defined metrics or processes identified to measure any adverse impact. This process is professionally administered by our Programme Management Office and subject to scrutiny and assurance oversight by the Board's Quality and Safety Committee.

It must be recognised that the Trust faces significant financial challenges in the year ahead, in common with the rest of the NHS. We have however accepted our Financial Control Total and have set about making further substantial financial improvements during 2017/18, with the aim of achieving financial balance by Year End.

Whilst recognising the significant financial challenges ahead, after making enquiries, the directors have a reasonable expectation that the Norfolk and Norwich University Hospitals NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trust continues to adopt the going concern basis in preparing the accounts.

Our expectation is informed by the anticipated continuation of the provision of our services in the future, as evidenced by inclusion of financial provision for those services in Contracts for Service, being the NHS Standard Contract 2017/18 signed with the Trust's main Commissioners.

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 a well-established process for establishing its quality priorities for the forthcoming year, in line with national guidance and led by our Medical Director and Director of Nursing. This guidance is that priorities should not change significantly from one year to the next without good cause. Our priorities were established through consultation with clinical staff and based on emerging themes and areas of priority consistent with national guidance and reports, complaints and compliments, past incidents and feedback gathered from our patients. Draft priorities were discussed with our governors and reviewed by the Quality and Safety Committee before approval by the Board.

Each of the priorities are assigned to one of the three domains of Clinical Safety, Clinical Effectiveness, and Patient Experience with an executive lead for each. Progress in achieving the priorities is reported to staff, Board, Governors and public through the Integrated Performance Report.

For the Annual Quality Report, the Trust employs the same assurance processes as used for other aspects of performance information. The report draws heavily on the monthly Integrated Performance Report, which includes trend data across a wide range of local and national quality indicators, subject to regular review through the governance sub-boards and Management Board.

Information to support the quality metrics used in the Quality Report is held in a number of Trust systems, including Datix (electronic risk management system), PAS (patient administration database) Telepath (electronic pathology system) and ICNet (infection control system). The data is utilised day-to-day in the Trust's operations and, where appropriate, it is submitted to the National Information Centre, which operates national checks to ensure its reliability and accuracy. Further quality data is drawn from the reports that are produced for the Clinical Safety Sub-Board and the Caring and Patient Experience Sub-Board.

The Trust retains the services of specialised and skilled coding and informatics staff to produce and analyse data and to ensure the accuracy of reporting. We also have a Data Quality team who provide training for staff and audit compliance with data collection and reporting requirements.

A draft of the Quality Report is shared with our stakeholders, notably our commissioning CCGs, Norfolk Healthwatch, Suffolk Healthwatch and Trust Governors who are invited to submit comments regarding its content, including on the quality and balance of the of the data and views reported. These are reflected as relevant in the final report.

Information Governance and Cyber Security

The Trust scored 82%, Not-Satisfactory (Level 2 or above not evidenced for all requirements) in the Information Governance Toolkit at the end of March 2017. A work programme has been developed to improve the Trust's Information Governance Toolkit score in 2017-2018.

Information governance (IG) training is mandatory for all staff members and is renewed on an annual basis. The Trust continued to raise awareness of Information Governance and the importance of protecting personal information with its staff members through a comprehensive training programme.

To complement this learning, a wealth of policies, guidance and best practice are made available to staff members via the Trust's intranet. The Trust did not attain Level 2 in Requirement 112 (IG Training) of the IG Toolkit and an action plan is in place to resolve this anomaly.

Personal data related incidents are reported on the Trust incident Reporting Systems that are reviewed at the Caldicott Approval Group and the Information Governance Steering group on a monthly and six weekly basis, respectively. The lessons learnt are shared with staff members and they enabled the Trust to review and continually improve its information Governance processes for the safekeeping of personal information and to ensure compliance with the Data Protection Act 1998 and the Caldicott principles. The personal data related incidents are fed to the board through the Non-Clinical Safety Sub-board.

Data Security and Information Governance risks are managed primarily through incidents and by complying with the IG Toolkit's Information Security Assurance initiative. The identified risk is prioritised, control measures implemented, reviewed on a regular basis and escalated to Trust Risk Register if deems appropriate.

The Trust experienced and reported two level 2 SIRIs to the ICO in the financial year 2016-17. The ICO concluded no further action was required for one incident and the incident closed while the second incident is currently under investigation both locally and by the Information Commissioner's Office.

A summary of Level 1data-related incidents reported during the year is shown below:

Category	**Breach Type**	**Total**
A	Corruption or inability to recover electronic data	0
B	Disclosed in Error	12
C	Lost in Transit	1
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	0
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	1
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	2
K	Other	0

During 2016/17 the Trust's controls in relation to Cyber Security were specifically reviewed by RSM, our Internal Audit providers. This resulted in a conclusion that the Trust could take 'reasonable' assurance that the controls in place are suitably designed and consistently applied. A number of areas for improvements to be made were identified and the associated recommendations are being implemented and progress regularly reported to the Audit Committee.

At the end of March RSM carried out a 'Network Resiliency Audit' and NHS Digital did a 'CareCert' audit to see whether the Trust has sufficient control in place in terms of IT Security. The Trust is currently waiting for the outcome of these two audits.

A rigorous framework of quality governance is in place. This includes a programme of internal and external audit of the quality of performance information under the Trust's Performance Management Framework. The standards for the quality of information are set out in the Trust's Data Quality Strategy and Data Quality Policy.

In March an Internal Audit Review of the process for collecting data concerning the length of time patients waited in A&E indicated that the correct or adequate processes were not being followed and that this required remedy. Immediate action was taken and we asked Internal Audit to carry out a follow-up review in April 2017. The outcome was that the auditors were able to confirm the robustness of data quality during the period of their review. We will ensure that this is subject to periodic ongoing review to ensure that the management actions we have put in place are embedded and are being applied consistently.

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 and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors has met regularly and kept arrangements for internal control under review through discussion and approval of policies and practice and monitoring of outcomes agreed as indicators of effective controls. The Board reviews a monthly Integrated Performance Report covering a wide range of performance metrics – these show the key relevant national priority and regulatory indicators, with additional sections devoted to safety, clinical effectiveness and patient experience. This monthly integrated summary is supplemented by more detailed briefings on any areas of adverse performance. The selection of appropriate metrics is subject to regular review by the Board, with changes in priorities or areas of concern reflected in that selection.

Clinical Audit

The Trust has systems and controls in place to ensure that high quality clinical audits are conducted and their findings acted upon by all directorates and specialties across the Trust. There is a Trust Medical Lead for Clinical Audit and each specialty within a directorate has its own clinical audit lead. The Trust Clinical Audit Lead, the Clinical Effectiveness and Improvement Manager and specialty audit leads are responsible for developing, monitoring and reporting an annual clinical audit programme that reflects local and/or Trust issues around service quality or patient safety. The Clinical Audit Plan is subject to review by the Board's Audit Committee and its Quality and Safety Committee.

All clinical audit projects are registered on an electronic system and monitored to completion and subsequent re-audit. The Medical Audit Lead and the Chair of the Clinical Standards Group both sit on the Trust's Effectiveness Sub-Board which is accountable to, and reports audit activity to, the Management Board. Clinical Audit is therefore a key element of our governance arrangements for ensuring compliance with key standards and best practice.

Internal Audit

In addition to Clinical Audit, the Internal Audit plan is a risk based programme of reviews based on areas of management concern, emerging risks, and national and historical experience. During 2016/17 we have specifically endeavoured to increase the impact and value of our Internal Function, through increasing the involvement of the Management Board and Divisional leaders in identifying priorities and overseeing the implementation of Internal Audit recommendations.

The audit plan is agreed by the Audit Committee, and covers risk management, governance and internal control processes across the Trust – including financial management and control, human resources and operational governance. The work includes identifying and evaluating controls and testing their effectiveness, in accordance with NHS internal audit standards. A report is produced at the conclusion of each audit assignment and, where scope for improvement is found, recommendations are made and appropriate action plans agreed with management. Reports are issued to and followed up with the responsible Executive Directors, and the results of audit work are reported to the Audit Committee.

In addition to the planned programme of work, internal audit provides advice and assistance to senior management on control issues and other matters of concern. The Internal Audit function also provides an anti-fraud service to the Trust and during 2016/17 we have initiated a programme of work to implement new national guidance to ensure the transparent reporting of potential conflicts of interest.

Where scope for improvement is identified during an internal audit review, appropriate recommendations are made and action plans agreed with management for implementation and these are monitored by the Audit Committee. During 2016/17 Internal Audit identified opportunities for particular improvement in a number of areas, notably:

- A&E Data Quality (as detailed above)
- Management of Additional Programmed Activities
- Partnership Working arrangements (Eastern Pathology Alliance)
- IT Network Resilience
- Key Financial Controls (Charitable funds)

We will be implementing recommendations in each of these areas as we continue to strengthen our governance arrangements and will carry-out follow-up reviews to ensure that the all appropriate actions have been taken.

Based on the work undertaken in 2016/17, the Head of Internal Audit has concluded that *"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".*

The early months of 2017/18 have already demonstrated the value of our use of the Internal Audit Process. An internal Audit review in 2015/16 identified a number of issues in relation to Cyber Security. Recommendations were implemented, not least in accelerating the programme to end reliance on devices using Microsoft XP software. These steps, in conjunction with investment in additional security approved by the Management Board, placed the Trust in a good position to withstand the global ransomware attack that affected many organisations across the world in May 2017.

The Board Assurance Framework has been revised during 2016/17 to reflect the risks associated with achievement of the Trust's strategic objectives. This process has involved assessment of our Strategic Threats by the Management Board and Board of Directors. The assurance framework document details the assurance processes and controls put in place by the Board during 2016/17, not least through its additional assurance committees and the enhanced role of the Management Board. Internal Audit review has confirmed that the revised Board Assurance Framework is in line with best practice

Conclusion

My review confirms that Norfolk and Norwich University Hospitals NHS Foundation Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives. Capacity remains a significant risk and control issue for the Trust and its ability to achieve key performance targets. The Board is addressing this in particular through its strategic plans capacity expansion. These are focussed on ensuring that we will have or create adequate capacity to ensure that we can meet the ongoing needs of our patient population on a sustainable basis.

I have taken careful note of the opinion provided by the Head of Internal Audit which is that *"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".* This accords with my own assessment that whilst much has been done, there is still more to do.

Signed:

Mark Davies
Chief Executive **Date: 26 May 2017**

Approval of the Accountability Report

I confirm my approval of the Accountability Report.

Mark Davies
Chief Executive **Date: 26 May 2017**

Quality Report 2016/17

Part 1 - Chief Executive's Statement on Quality

This was my first full year as Chief Executive at the NNUH and we have made good progress. We have a strong track record of delivering good clinical outcomes and a high standard of patient experience in both our hospitals.

It is humbling and gratifying to see the efforts made by staff for our patients. I feel enormously proud to work with such a passionate and committed team who put safety at the heart of everything they do. We are particularly pleased with the consistently high scores given to us by patients in the Friends and Family test.

Our partnership with the University of East Anglia continues to deliver a wide ranging programme of research which is aiming to improve the care we deliver to patients now and in the future. We aim to adopt best practice wherever possible, embracing innovation, and most importantly learning and improving.

Our track record on infection prevention and control has been impressive and we are pleased to say there have been no cases of hospital-attributable Methicillin Resistant Staphylococcus aureus (MRSA) in 2016/17. In fact, in the last five years there has only been one case of hospital acquired MRSA which reflects the tremendous hard work and dedication of our teams.

We are working hard to deliver and sustain rapid performance improvements including the use of temporary facilities and seven day services just to keep pace with demand. In the longer term, we will need permanent solutions to help solve the pressures on our capacity which will, in turn, help us to improve on our access targets. Our plans include building an Ambulatory Care and Diagnostic Centre (ACAD) and developing our services for interventional radiology, cardiac catheter labs and critical care. Building work has already commenced on-site on the Quadram Institute which, when complete, will house the largest endoscopy unit in Europe.

On cancer, we continue to do well on the two week waits and 31 day target despite an increase in referrals of nearly 9% which now number over 2,000 a month. There have been more challenges in delivering the 62 day target for GP referral to treatment because NNUH, like many other Trusts nationally, is continuing to see an increase in the number of referrals and requires more capacity in diagnostics, outpatient services and surgery. Ensuring that our cancer patients are treated quickly continues to be a major

Over the last year we have increased investment in the integrated discharge team to support safe and timely discharges throughout the organisation. One of the areas where extensive work has been completed is with 'stranded patients' - those patients with a hospital stay of more than 14 days – and we have seen real success with this.

Patient safety continues to be our top priority and our aim has been to reduce avoidable harm and when an incident does occur, ensure that we learn and improve. We have achieved important improvements in patient safety with the introduction of several initiatives. We have taken an innovative approach by providing emergency kit bags for wards which contain the key equipment needed to treat Sepsis fast. Suspected cases are reported with the same hospital emergency system as that used for a cardiac arrest.

The SAFER bundle has also been implemented with a significant increase in the percentage of patients that had a documented Senior Review. This early review also forms part of the Red to Green initiative which ensures every patient knows what is happening to them every day to progress their care and avoids unnecessary waiting. A simple daily assessment is carried out to identify whether each patient has a clinical and practical care plan in place which will progress their recovery (Green Day) or whether their care has not progressed or there are problems to resolve (Red Day).

In August 2016, it was announced by NHS Improvement (NHS I), our regulator, that five Trusts including NNUH were being placed in financial special measures. We set up a Programme Management Office to track and monitor financial improvement plans, with oversight from the Financial Improvement Programme Board. This approach has enabled the Trust to demonstrate financial improvement from all the actions taken by the different teams across the Trust. We were brought out of Financial Special Measures in February 2017 after working hard to bring down our deficit from £32m to £25m.

There is no doubt that in 2017/18, the environment in which we work will continue to be challenging, but I am confident that by supporting a culture of learning and improvement we will provide our patients with the safe, high quality care and experience they deserve.

The content of this report has been subject to internal review and, where appropriate, to external verification. I confirm, therefore, that to the best of my knowledge the information contained within this report reflects a true, accurate and balanced picture of our performance.

Mark Davies, Chief Executive

30th April 2017

Information about this Quality Report

We would like to thank everyone who contributed to our Quality Report.

We welcome comments and feedback on the report; these can be emailed to *communications@nnuh.nhs.uk* or sent in writing to the Communications Department, Norfolk and Norwich University Hospitals NHS Foundation Trust, Norfolk and Norwich Hospital, Colney Lane, Norwich NR4 7UY.

Further copies of the report are also available on request from the addresses above.

If the report is required in braille or alternative languages please contact us and we will do our best to help.

Part 2a - Introduction and priorities for improvement

Part Two of our report begins with a review of our performance during the past twelve months compared to the key quality targets that we set for ourselves in last year's quality report. Where possible, we have included comparative performance data from previous reporting periods, to enable readers to assess whether our performance is improving or deteriorating.

The focus then shifts to the forthcoming twelve months, and the report outlines the priorities that we have set for 2017/18, and the process that we went through to select this set of priorities.

This is followed by the mandated section of Part 2, which includes Board assurance statements and supporting information covering areas such as clinical audit, research and development, Commissioning for Quality and Innovation (CQUIN) and data quality.

Part 2 concludes with a review of our performance against a set of nationally mandated quality indicators.

Progress against our 2016/17 priorities

Our Quality priorities for 2016-17 were derived from consultation with staff through our divisions, through consultation with our CCG commissioners through the Clinical Quality Review Group, and through consultation with our public through our Council of Governors. They were ratified by our Management Board and Trust Board and have been reported through our Integrated Performance Report (IPR).

Detailed action plans and measures were developed for each of our quality priorities and, throughout the year, performance has been monitored by the appropriate Executive Sub-Boards and governance committees.

We continued to disseminate learning points for issues such as medication administration, pressure ulcer prevention, and falls avoidance through our innovative Organisation Wide Learning (OWL) bulletins.

In reviewing our progress against our targets, this report will highlight not only those areas where we have done particularly well, but also those areas where further improvement is still required.

Review of our 2016/17 Quality Priorities

	Quality Priority	Quality Aim	Rating
Patient Safety	Reduction in medication errors	Focusing on having zero insulin errors causing *NPSA* category 'moderate harm' or above	Mostly Achieved
	Prompt recognition and treatment of sepsis	Through improved screening and compliance with the Sepsis 6 care bundle	Achieved
	Keeping patients safe from hospital acquired thrombosis	Through achieving 95% compliance with thromboprophylaxis risk assessment (TRA) as evidenced on the Electronic Prescribing and Medicines Administration system (EPMA).	Achieved
	Incident reporting and management	Remain within the top 25% of acute trusts for incident reporting on NRLS, with 100% compliance with Duty of Candour	Progress Achieved
Patient Experience	Treat patients with privacy and dignity	With 100% of patients in all areas reporting through FFT that they are 'satisfied' or 'very satisfied' with the standard of care that they receive	Progress Achieved
	Improved continuity of care and experience	Reduced ward moves and reduced numbers of outliers. No more than 20 patients recorded on WardView as boarders, as measured by a monthly average report	Progress Achieved
	Improved discharge processes	EDL to be completed within 24 hours in 95% of discharges	Progress Achieved
	Dementia screening and assessment	For new admissions over 75 to be appropriately screened and assessed for dementia, in accordance with national reporting requirements	Achieved
Clinical Effectiveness	Acute Kidney Injury	Improve communication with GPs	Achieved
	Keeping patients safe from infection	C. Diff within trajectory target, 0 Hospital Acquired MRSA bacteraemia	Achieved
	Improve quality of care through research	Year on year increase in patients recruited into research studies. Aim to achieve 5000 recruitment into NIHR studies in 2016-17	Achieved
	Timely medical review of all patients	Senior review - every patient should be reviewed by a doctor every day. All new and unstable patients and all patients for potential discharge should be reviewed by an ST3 or above.	Progress Achieved

Red – Quality priority not achieved
Amber – Quality priority partially / mostly achieved or significant improvement achieved
Green – Quality priority achieved

In order to measure ourselves and report properly against our quality priorities we must be able to collect and report meaningful data. This regular measurement has proved to be difficult within a paper based records system for two of our 2016/17 specific quality priorities which we have therefore been removed for 2017/18 ("acute kidney injury" and "dementia screening and assessment").

Patient Safety – Reduction in Medication Errors

What was our aim?

To have zero insulin errors causing NPSA category 'moderate harm' or above

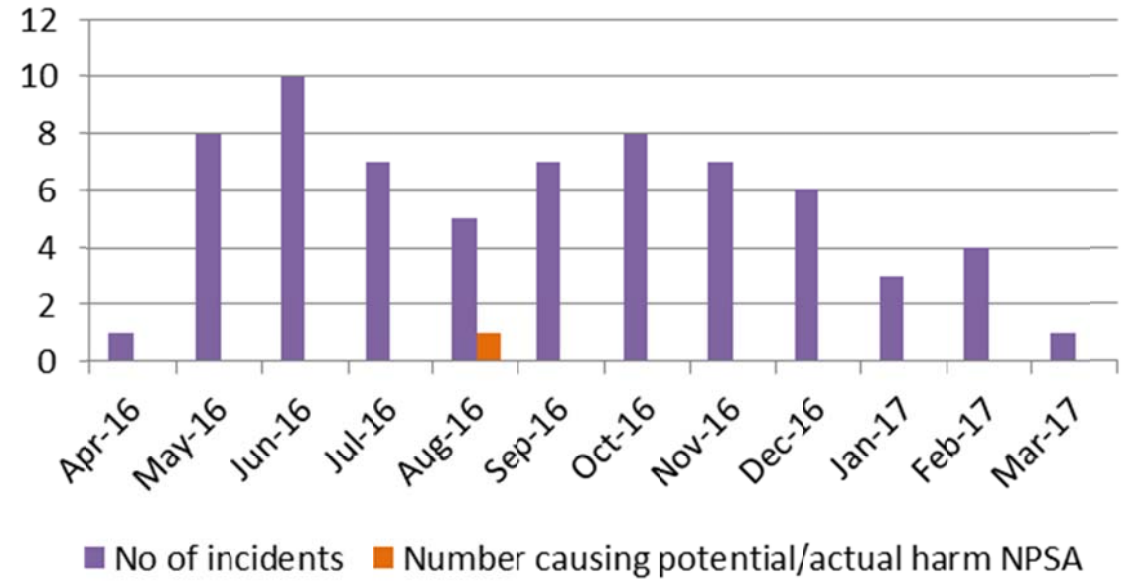
How did we measure our performance?

We monitor all reported incidents involving insulin every month via the medication incident group and send a report to the Clinical Safety Sub Board, governance Leads and Dr Jeremey Turner Service Director for Endocrinology.

How did we do?

At the end of February 2016/17 there had been one insulin error in this NSPA category (3 in 2015/16). The learning from the case review is the need to identify from the EPMA those patients at risk with diabetes and focus the resource of the diabetic team on supporting that group – e.g. patients at risk of diabetic ketoacidosis and those on variable rate insulin infusions.

Figure 1 - Insulin incidents by month



Source: NNUH data, national definition used

Patient Safety - Prompt recognition and treatment of sepsis

What was our aim?
To improve screening and compliance with the 'Sepsis 6' Care bundle, of which the single most important aspect is the administration of antibiotics within an hour of diagnosis.

How did we measure our performance?
Our performance during 2016-17 was measured using national Commissioning for Quality and Innovation (CQUIN) stipulated Key Performance Indicator (KPI) criteria as follows:

- The percentage of patients who meet the criteria for sepsis screening that were screened for sepsis.
- The percentage of patients who present with severe sepsis, red flag sepsis or septic shock that receive intravenous antibiotics (within one hour of arrival to emergency admitting areas for 'admission sepsis' and within 1 hour of diagnosis for 'sepsis developing as an inpatient') and who received an empiric review within three days of the prescribing of antibiotics.

KPIs are measured using strict auditing criteria, set nationally.

How did we do?

Figure 2 – Sepsis screening and antibiotics administration and review

Area of focus	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
ED screening	90%	92%	94%	90%	92%	94%	92%	90%	90%	92%	90%	94%
IP screening	Establishing baseline			90%	92%	90%	90%	92%	90%	90%	90%	90%
ED abx	53%	50%	63%	70%	77%	73%	83%	87%	77%	83%	80%	77%
IP abx	58%	53%	53%	63%	63%	80%	83%	79%	84%	90%	91%	93%

Source: NNUH data, national definition used

During 2015-16, our average performance for screening (adult and paediatric) patients who met the criteria for sepsis in Emergency Departments was 84.19%.

We launched a new and innovative 'Sepsis Screening and Emergency Treatment Pathway' for inpatients. This treats sepsis with the same level of priority as a cardiac arrest. If the doctor caring for the patient raises the sepsis alarm using the 2222 emergency number, a "Sepsis Emergency Treatment Kit" is delivered to the patient by our Portering staff. The kit contains all essential items needed to deliver the 'Sepsis 6' bundle. In addition, a member of the Critical Care Outreach Team or a Site Practitioner receives an emergency call and attends the patient to help the ward staff administer timely care.

This new pathway has enabled us to have a consistent method for the timely recognition and treatment of sepsis across all inpatient areas; a key improvement on previous years. We are now working with our ED and Women's and Children's colleagues to refine their existing processes, with an aim to have paperwork and processes that where possible are as generic and consistent across the organisation as possible

World Sepsis Day sees new patient safety initiative at NNUH

On World Sepsis Day (13th September 2016), new Sepsis Emergency Kit bags for treating in-patients with suspected Sepsis were launched at NNUH as part of a patient safety initiative.

Dr Michael Irvine, Consultant in Intensive Care Medicine at NNUH, said: "Timely treatment is critical when treating patients for Sepsis as survival rates are improved significantly if antibiotics can be administered within 60 minutes of diagnosis. Patients are also less likely to have serious health complications if we provide prompt treatment. However, Sepsis is more difficult to identify than conditions like heart attacks and strokes, as the symptoms are often more generalised and non-specific."

"We are taking an innovative approach and providing emergency kit bags for wards which contain the key equipment needed to treat Sepsis fast. Suspected cases will be reported with the same hospital emergency system as that used for a cardiac arrest.

Patient Safety - Keeping patients safe from hospital acquired thrombosis

What was our aim?
To achieve 95% compliance with thromboprophylaxis risk assessment (TRA), as evidenced on the Electronic Prescribing and Medicines Administration system (EPMA).

How did we measure our performance?
Data on thrombosis risk assessment (TRA) completion rates is generated electronically from the Electronic Prescribing Medicines Administration (EPMA) system. Results help to identify potential problems and inform Trust Guidelines.

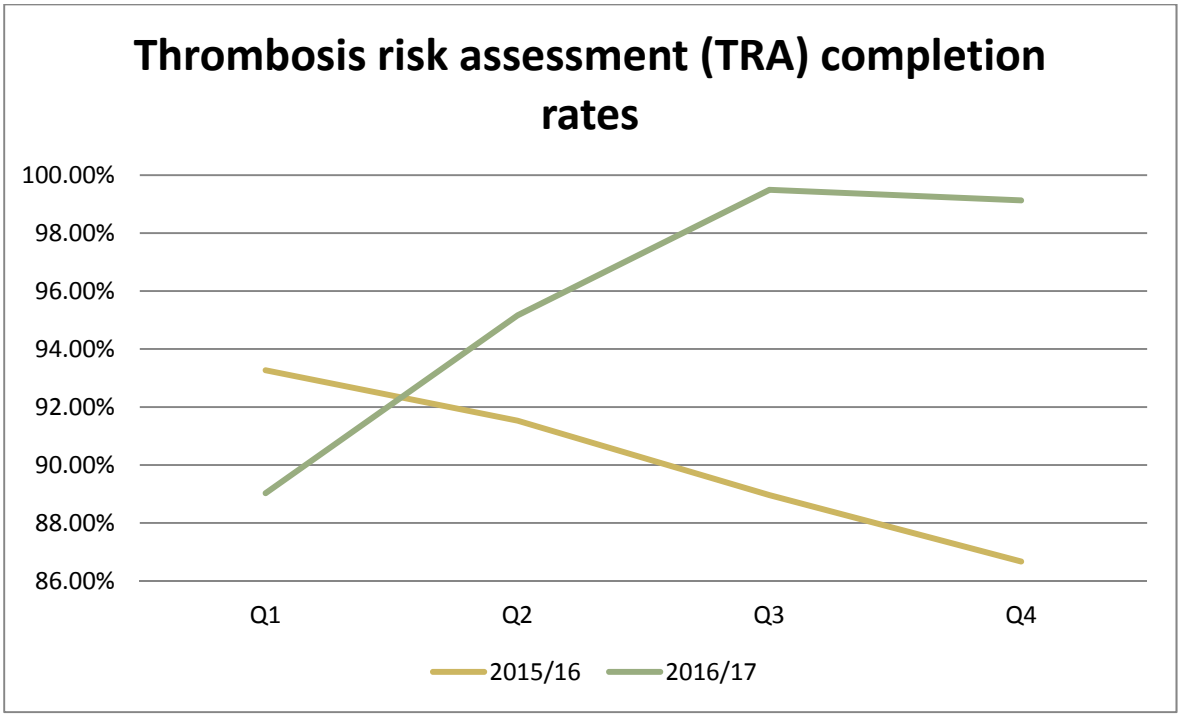
RCAs are carried out by the VTE Team on all Hospital Acquired Thrombosis (HATs) that are reported on Datix. The HATS are all initially classified as 'moderate' on Datix and then downgraded if appropriate following the RCA. The RCA target for HATs is 100%.

Two-monthly reviews of medication incidents involving anticoagulants have been introduced to identify any emerging themes or actions needed to reduce risk of similar incidents occurring in the future.

The Thrombosis and Thromboprophylaxis Committee meets on a two-monthly basis and has an active involvement in raising awareness of thrombosis issues across the Trust and in Education.

How did we do?
Figure 3 shows that 2016/17 compliance is now nearing 100%.

Figure 3 - Thrombosis risk assessment (TRA) completion rates



Source: NNUH data, national definition used

Patient Safety - Incident reporting and management

What was our aim?
To remain within the top 25% of acute trusts for incident reporting on NRLS, with 100% compliance with Duty of Candour.

How did we measure our performance?
All patient incidents, regardless of their severity, are recorded on DATIX and are submitted quarterly to the National Reporting and Learning System (NRLS).

The Risk Management Team currently maintains a Duty of Candour (DoC) Compliance database which tracks compliance regarding DoC across the Trust.

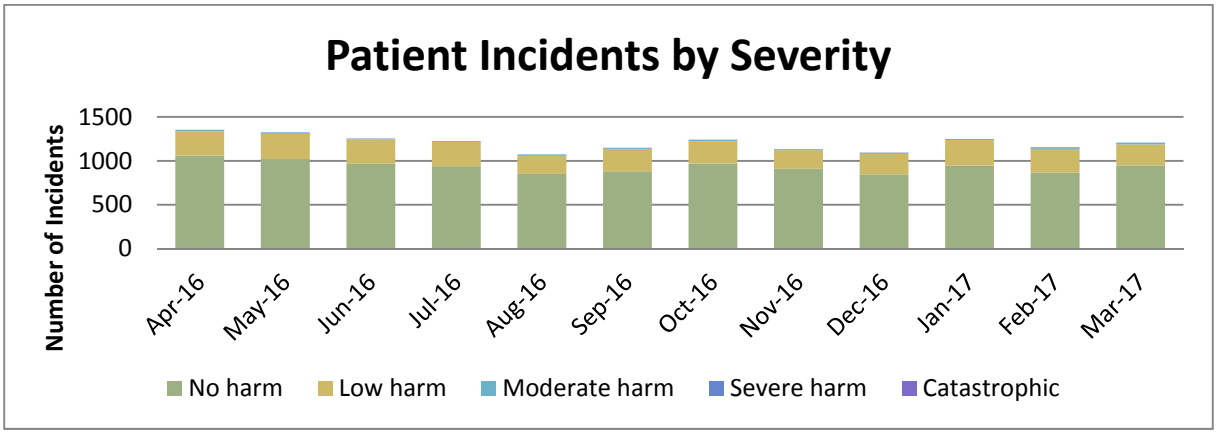
All Moderate Harm or above severity incidents which are reported an Datix are verified with the Consultant / clinical lead and a DoC "Compliance Statement" document is completed to confirm that all actions have been taken and documented.

Entries in the database between January and September 2016 were used to randomly select patient records where DoC actions had been confirmed as been fulfilled by clinical staff. A DoC audit was undertaken in October and November 2016, involving the review of twenty-seven sets of patient case notes. Each case was reviewed to establish whether the completion of all DoC actions had been fully documented in the patient records.

How did we do?
In the twelve months ending 31st March 2017, 14,464 incidents were recorded on DATIX. Of these, 14,282 (98.74%) caused either no harm or low harm to patients. In 2015/16 there were 15,283 reported incidents, of which 15,104 (98.83%) caused no harm or low harm. This indicates that the percentage of no/low harm events is reasonably static, although overall the number of reported incidents has reduced during 2016/17.

Our most recently published incident reporting rate is 41.08 incidents per 1,000 bed days (for incidents reported to NRLS between 1st April 2016 and 30th September 2016. When comparing this figure against 136 other Acute (non- specialist) organisations within our cluster, the median reporting rate for the cluster is 40.03 incidents per 1,000 bed days and the NNUH is ranked at 61st out of 136.

Figure 4 - Patient Incidents by Severity



Source: NNUH data, national definition used

Patient Experience - Treat patients with privacy and dignity

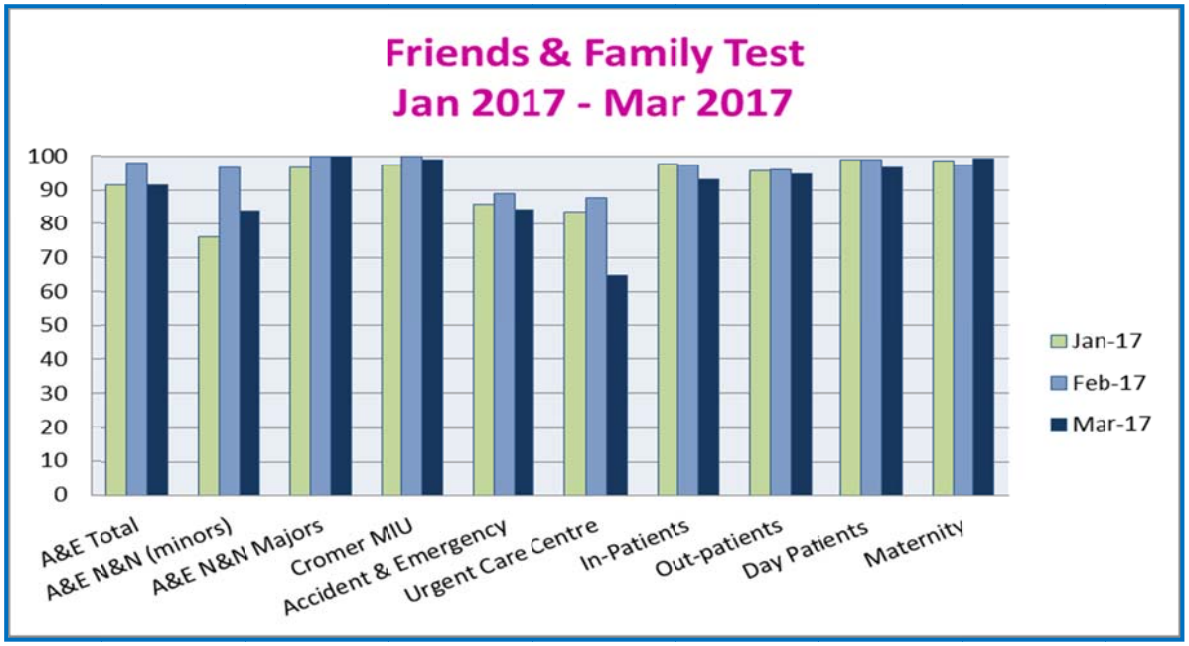
What was our aim?
For 100% of patients in all areas to report through FFT that they are 'satisfied' or 'very satisfied' with the standard of care that they receive

How did we measure our performance?
Performance by ward is monitored through the monthly performance meetings between the Director of Nursing and her senior team.

All negative free-text additional comments made during the collection of Friends and Family feedback is themed, reviewed and actioned at Directorate level and via the Patient and Experience Working Group; a group which includes external public representatives.

How did we do?
Our overall performance in Inpatients, A&E, Day Patients and Out-patients and Maternity are shown in Figure 5.

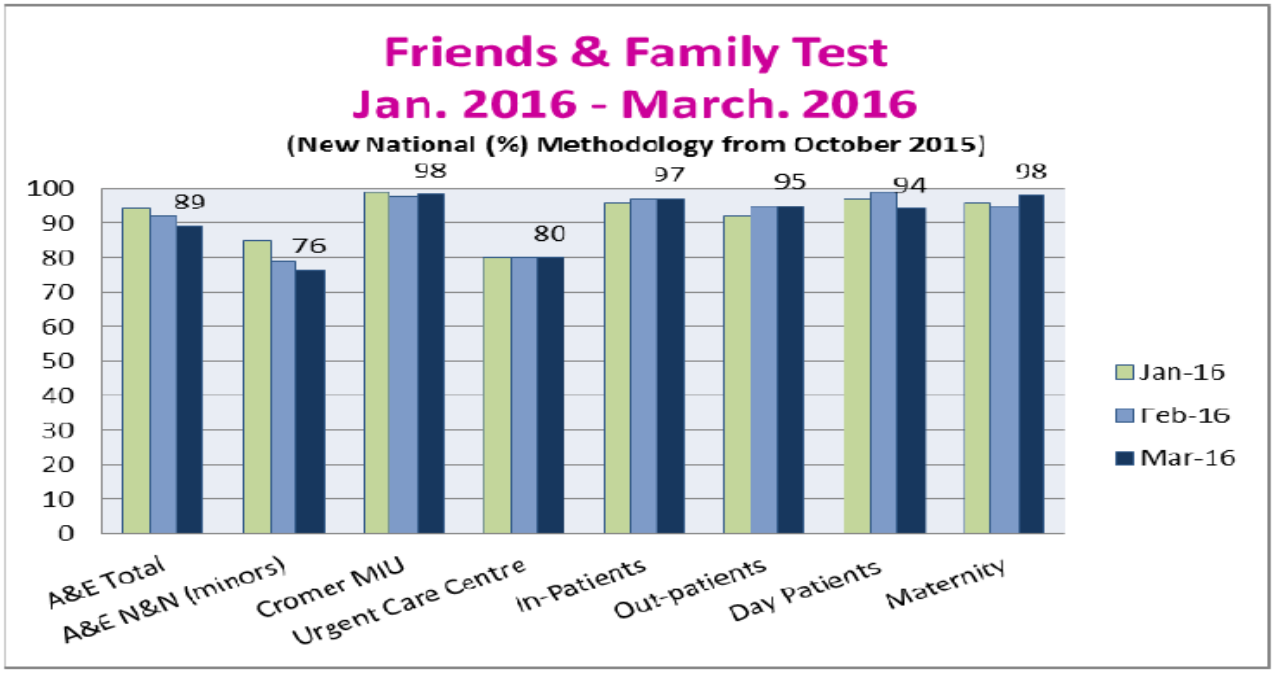
Figure 5 – Friends and Family Test Results, November 2016 – January 2017



Source: NNUH data, national definition used

Figure 5a shows the performance in the same three months of the previous year; most areas have seen a maintenance or modest improvement of their high scores compared to 2015/16.

Figure 5a – Friends and Family Test Results, January 2016 – March 2017



Source: NNUH data, national definition used

Patient Experience - Improved continuity of care and experience

What was our aim?

To reduce ward moves and reduce numbers of outliers, so that no more than 20 patients at any one time are recorded as boarders, as measured by a monthly average report. The term 'boarder' is a patient who is not cared for on the speciality ward which would be most appropriate for their condition.

How did we measure our performance?

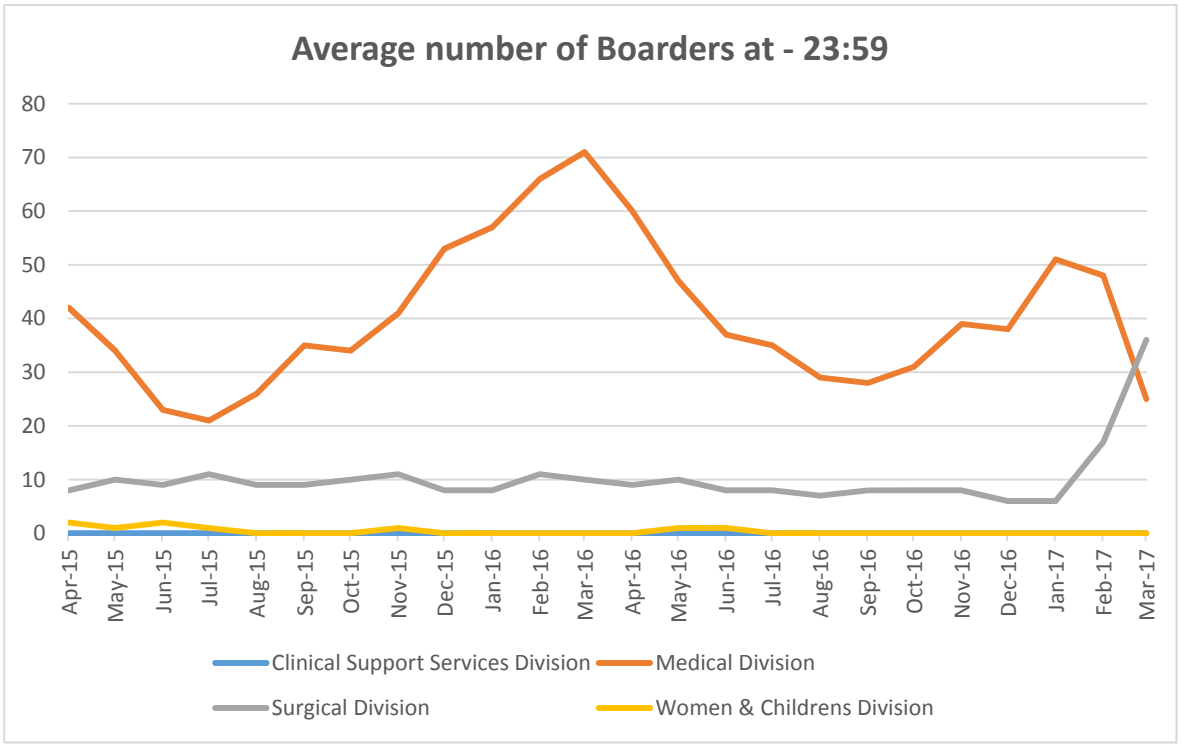
Our Information Services (IS) team produces a monthly automated report which monitors the amount of transfers in each inpatient area (i.e. the number of times that patients have been transferred once, twice etc. during the course of their inpatient stay).

How did we do?

During February 2017 a sample review of notes was carried out of patients who were recorded as having had multiple transfers during their stay. No significant concerns were identified in relation to inappropriate multiple transfers once appropriate exclusions had been applied (i.e. to exclude patients whose nominated consultant had changed or patients who had simply been moved from one bed space to another in the same ward or moved to an out-patient setting for a necessary procedure).

Figure 6 shows that boarders from the Surgical Division and Women and Children Division have remained relatively static, and boarders from the Medical Division have decreased sharply since February 2017. The Medical Division accounts for by far the largest numbers of boarders, and their figure of 25 boarders in March 2017 is a significant improvement on the March 2016 position, when there were 71 medical boarders.

Figure 6 - Average number of boarders at 23:59 hours



Source: NNUH data, national definition used

Patient Experience - Improved discharge processes

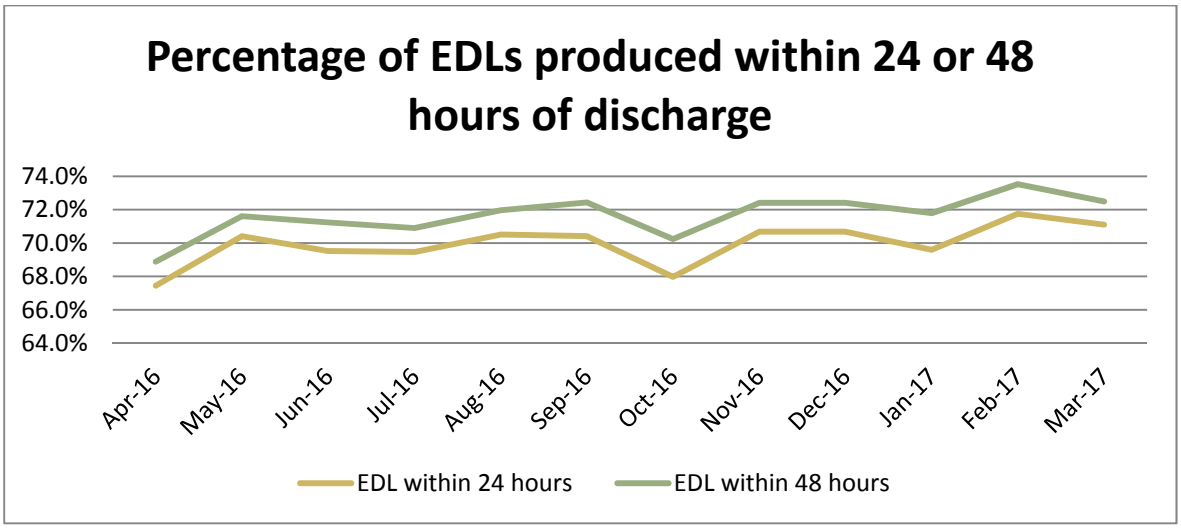
What were our aims?
Electronic discharge letter (eDL) to be completed within 24 hours in 95% of discharges

How did we measure our performance?
Our Information Services department records this data, which is then published in the monthly Integrated Performance Review.

How did we do?

In regard to the production of EDLs within 24 or 48 hours of discharge, Figure 7 shows that our performance has improved marginally over the course of the year, but there is still considerable room for improvement. This issue is being addressed internally, and compliance is monitored closely by our commissioners.

Figure 7 - Percentage of EDLs produced within 24 or 48 hours of discharge



Source: NNUH data, local definition used

Patient Experience - Dementia screening & assessment

What was our aim?
For new admissions over 75 to be appropriately screened and assessed for dementia, in accordance with national reporting requirements

How did we measure our performance?
A daily report identifies the current inpatients that require a memory assessment test and those who, following assessment, require further dementia assessment.

Memory assessment screens are carried out by our fully trained administrative staff and are recorded on our Patient Administration System (PAS). If, as a result of that memory assessment screen, a patient is identified who needs further dementia assessment, this assessment is carried out by our clinical staff and the results are recorded on the Integrated Clinical Environment (ICE) system and shared with the patient's GP and dementia assessors working in Norfolk and Suffolk Foundation Trust. This in turn facilitates tertiary referral to specialist mental health services if required.

How did we do?
Since launching dementia screening and assessment in November 2012, we have achieved compliance of at least 90% for each separate element of the pathway (screening, assessment and referral) in every single month except for February 2017 when – due to a major system change in reporting – our performance in respect of the assessment element only dropped sharply. This was a one-off 'blip' that was corrected the following month and has not reoccurred. We are proud of having maintained throughout 2016/17 the level of compliance that we achieved during the three previous years, when compliance was a requirement of the national dementia screening and assessment CQUIN.

NNUH help shape future new-born care

NNUH has introduced screening for all babies for congenital heart defects upon birth, after the successful completion of a national pilot program.

The East Anglian hospital was one of seven to be invited to join the first phase of the Department of Health national screening pilot to test pulse oximetry screening (POS) on new born babies as part of the newborn discharge process.

The new pilot proposed screening all babies upon birth for congenital heart defects not detected during pregnancy by routine ultrasound scans and newborn examination.

Clinical Effectiveness - Acute Kidney Injury

What was our aim?
To improve communication with GPs for patients who have experienced an episode of acute kidney injury (AKI) during the course of their admission.

How did we measure our performance?
We developed a bespoke report on the Integrated Clinical Environment (ICE) system which enables us to interrogate all electronic discharge letters (eDLs) to identify if appropriate AKI information was included in the discharge reporting to GPs. Appropriate information includes, but is not limited to:

- the stage of AKI alert,
- any medication review that was carried out during the admission, and
- the timing/frequency of follow-on tests that should be carried out in primary care.

How did we do?
In the ten month period 1st April 2016 – 31st January 2017, the inclusion of appropriate AKI information in eDLs improved by 83% when compared against the baseline period (the whole of the twelve months ending 31st March 2016).

This confirms that communication to GPs is improving, although further improvement is still both possible and desirable.

To further improve communication, two information leaflets were produced for GPs by the Eastern Pathology Alliance to help GPs to manage the care of patients who have experienced an episode of AKI.

The first of these leaflets is called 'AKI Information for Primary Care'. It educates GPs on the risk factors for community-acquired AKI and the steps that GPs can take to help reduce the risk of AKI developing or worsening in the primary care setting. The leaflet includes an algorithm that GPs can follow to ensure that they are following best practice guidelines in the care of patients with elevated serum creatinine.

The second information leaflet - called 'Post-AKI care: what to do when a patient has been discharged after an episode of AKI' - includes guidelines for the ongoing care and treatment of patients who have been discharged from secondary care after an episode of AKI. This guidance leaflet supplements the information that is included in the eDL.

Clinical Effectiveness - Keeping patients safe from infection

What was our aim?
C. Diff within trajectory target, 0 cases of Hospital Acquired MRSA bacteraemia

How did we measure our performance?
It has been mandatory for NHS acute Trusts to report all cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia since April 2004. Surveillance of C. difficile infection (CDI) was originally introduced in 2004 for patients aged 65 years and over. This was then extended to include all cases in patients aged 2 years and over in April 2007. Public Health England uses the surveillance data to produce spreadsheets and graphs that we used to measure our performance against other acute Trusts.

Internally the Infection Prevention and Control (IP&C) report continued to be sent out to staff throughout the year, with surveillance and alert organism graphs and tables data updated monthly. Local C. diff and MRSA data by ward is presented monthly to matrons and ward managers as part of on-going surveillance.

The post-infection review process continues following every case of hospital-acquired case of C. diff. This brings together the clinical teams from the hospital and the clinical Commissioning Group (CCG) who jointly review the evidence in order to establish whether there were any lapses in care.

How did we do?
Our 2016-17 Clostridium difficile objective was to stay below 49 hospital acquired cases. The objective was achieved and there was an improvement on the 2015-16 figures with a total of 42 C. diff cases deemed to be hospital acquired. We successfully appealed 22 cases resulting in a final total for the year of 20.

Figure 8: CDiff Performance

Summary Table		Non-Trajectory	Trajectory	Pending	Total
Quarter	4 (to date)	2	0	4	6
	3	3	4	0	7
	2	5	9	0	14
	1	6	4	0	10
April 16 to March 17		16	17	4	37
April 15 to March 16		*24*	*32*	*0*	*56*

Source: NNUH data, national definition used

Our 2016-17 MRSA bacteraemia (blood stream infections) objective was zero hospital acquired cases. The objective was achieved and there was an improvement on 2015-16 with 0 hospital acquired MRSA blood stream infections.

Clinical Effectiveness - Improve quality of care through research

What was our aim?

Year on year increase in patients recruited into research studies. Aim to achieve 5000 recruitment into NIHR studies in 2016-17

How did we measure our performance?

Data on research and development (R&D) is collected by our R&D team and is included in each month's Integrated Performance Report. All studies not achieving 40 day (3/6) and 70 day (0/4) targets are reviewed and the causes of the delay are identified, understood and fed back to research teams.

How did we do?

During 2016/17, our total recruitment was 5,438 for 2016/17, compared against 2015/16 recruitment of 5,008. Fifteen new studies were approved in February, of which fourteen were portfolio studies and six were commercially sponsored.

Figure 9 shows that at the end of February we had exceeded our stated goal of recruiting 5000 participants into NIHR studies in 2016/17. We had also exceeded our CRN portfolio recruitment target (3000).

Figure 9: Recruitment into research studies

Recruitment for 16/17	Number	Percent
Portfolio recruitment target	3000	
Total Recruitment	5438	
NIHR Portfolio	4492	83%
Non Portfolio	946	17%
Commercial Studies	339	6%
Non Commercial Studies	5099	94%

Source: NNUH data, national definition used

Clinical Effectiveness - Timely medical review of all patients

What was our aim?

All new and unstable patients and all patients potentially ready for discharge to be reviewed daily by an ST3 or above.

How did we measure our performance?

The 'S' of SAFER stands for 'Senior Review', which means every patient should be reviewed by a decision maker before 1100hrs each day. A Senior Review is defined as a documented reference in the patient's notes by 1100hrs of one of the following:

- A review by a senior decision maker (ST3 or above)
- An MDT which included a senior decision maker
- A note from a junior doctor that they discussed the patient with a senior decision maker (e.g. plan d/w Dr Bloggs CON)
- A ward round or board round which included a senior decision maker.

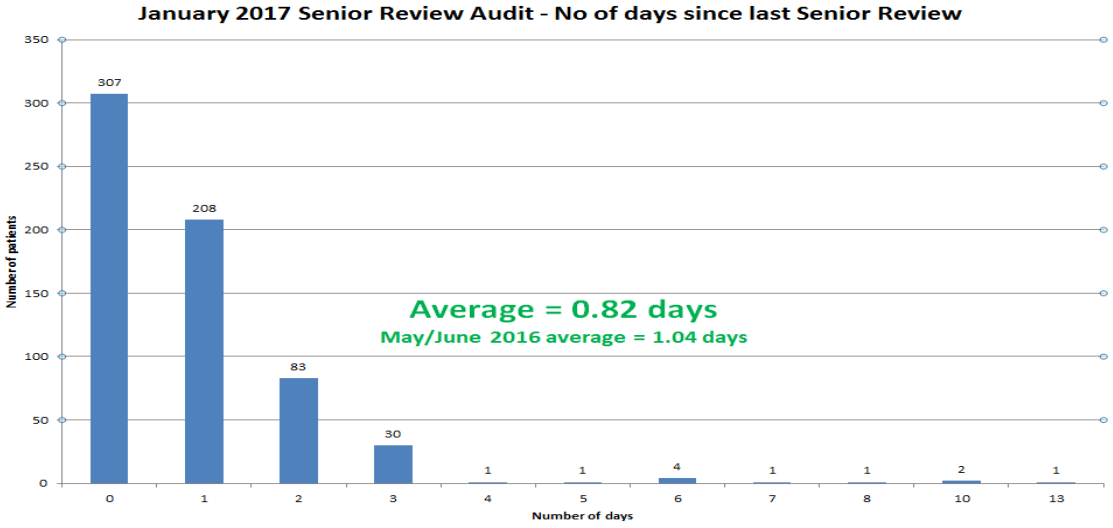
Currently, the only method of measuring whether the above take place is to conduct an audit of patient notes. The baseline audit took place in June 2016 and comprised a comprehensive 7 day audit of over 1000 patient records.

A one day re-audit took place on Thursday 26 January to assess performance against this baseline. A total of 27 wards and 653 patient notes were audited.

How did we do?

The audit evidenced that the percentage of patients that had a documented Senior Review increased from 33% in June 2016 to 53% in January 2017. The average time since the last senior review was 0.82 days, as shown in figure 10.

Figure 10: Number of days since last senior review



Source: NNUH data, local definition used

Monthly audits are planned going forwards to enable continued performance monitoring of this important SAFER element.

NNUH Stroke Patients First in County for Speedy Results

Dr Kneale Metcalf and a patient on the new monitor

Stroke patients in NNUH are the first in the country to benefit from a new monitoring system which will help prevent a second stroke occurring.

With information received from the new system the consultants can prescribe medication within two days, preventing further strokes. Previously this process could take several weeks.

"This is an exciting new use of technology to benefit patient care," said NNUH Stroke Consultant Dr Kneale Metcalf.

Looking Forwards - Our 2017/18 priorities for improvement

To align to our Quality and Safety Improvement Strategy, we have decided to set our quality priorities for the next two years – i.e. for 2017/18 and 2018/19. Each of the priorities sits within one of the three domains of patient safety, clinical effectiveness, and patient experience; assurance in relation to these priorities is provided by the relevant assurance sub-board reporting to the Management Board.

In selecting the priorities, we took into account feedback on the things that are most important to them from many different stakeholder groups, including staff, patients, the public and our commissioners. This feedback was received in many forms, including survey responses, complaints letters, quality monitoring from commissioners, internal reviews of the quality of care provided across our services, and staff suggestions. The shortlist of priorities was then discussed at Management Board, and the final selection agreed and ratified by the Council of Governors.

	Priority	Measure	Goal	Lead
Patient Safety	Reduction in medication errors	Number of insulin errors causing NPSA category moderate harm or above	Zero errors with harm	Medical Director
	Prompt recognition and treatment of sepsis	% of patients screened, and % of patients treated for sepsis	CQUIN criteria	Medical Director
	Keeping patients safe from hospital acquired thrombosis	Percentage compliance with TRA assessment as evidenced on EPMA.	95%	Medical Director
	Incident reporting and management	Position in relation to all acute trusts for incident reporting on NLRS. Percentage compliance with Duty of Candour	Top quartile of all trusts for incident reporting. 100% compliance Duty of Candour.	Director of Nursing
Clinical Effectiveness	Keeping patients safe from infection	Numbers of hospital attributable C Diff cases Number of hospital acquired MRSA bacteraemias	Below trajectory target for C Diff. Zero MRSA bacteraemia	Director of Nursing
	Improve quality of care through research	Numbers of patients recruited into NIHR studies	5000	Medical Director

	Priority	Measure	Goal	Lead
	Timely medical review of all patients	SAFER criteria for patient review: **Senior review** - every patient should be reviewed by a doctor every day. All new and unstable patients and all patients for potential discharge should be reviewed by an ST3 or above. **Review** – there will be a weekly systematic review of patients with extended lengths of stay (>14days) to identify the actions required to facilitate discharge.	100% patients have recorded senior review daily on board round Less than 200 patients with length of stay over 14 days	Chief Operating Officer
Patient Experience	Patients are happy with the experience they receive during their care and treatment	Percentage of patients in all areas report through FFT that they extremely likely or likely to recommend our services to their friends and family	95% or more	Director of Nursing
	Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers	Number of patients recorded on WardView as boarders. Monthly average report	No more than 20	Chief Operating Officer
	Improved discharge processes	Estimated Date of Discharge (EDD) recorded within 24 hours of admission on WardView – SAFER criteria EDL to be completed within 24 hours of discharge	100% compliance 95% compliance	Chief Operating Officer

These priorities have been discussed by and will be agreed through our Council of Governors, Management Board, Quality and Safety Committee, and Trust Board. Each of these quality priorities has an executive lead and a defined measure which we will track and report through the Integrated Performance Report (IPR). The IPR is a public document which is shared with our commissioners.

Designated committees, Boards and Sub-Boards within our corporate and clinical governance reporting structure will have responsibility for the on-going monitoring of the components of our quality and safety improvement strategy, objectives and delivery plans.

Part 2b

Board Assurance Statements

All providers of NHS services are required to produce a Quality Report, and elements within that report are mandatory. This section contains that mandatory information, enabling readers of the report to make comparisons between other Trusts.

Review of services

During 2016/17 the Norfolk and Norwich University Hospitals NHS Foundation Trust provided and/or sub-contracted 43 relevant health services.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 43 of these relevant health services through its performance management framework and its internal assurance processes.

The income generated by the relevant health services reviewed in 2016/17 represents 85.7% of the total income generated from the provision of relevant health services by the Norfolk and Norwich University Hospitals NHS Foundation Trust for 2016/17.

Information on participation in national clinical audits (NCA) and national confidential enquiries (NCE)

The purpose of clinical audits is to assess and continually improve patient care by carrying out review of services and processes and making any necessary changes indicated following the reviews.

National Confidential Enquiries are nationally conducted investigations into a particular area of healthcare, which seek to identify and disseminate best practice.

During 2016/17 39 national clinical audits and 4 national confidential enquires covered relevant health services that Norfolk and Norwich University Hospitals NHS Foundation Trust provides.

During that period Norfolk and Norwich University Hospitals NHS Foundation Trust participated in 100% national clinical audits (38/38) and 100% national confidential enquires (4/4) which it was eligible to participate in. We also participated in other national audits which fall outside of the Quality Account recommended list.

The national clinical audits and national confidential enquiries that Norfolk and Norwich University Hospitals NHS Foundation Trust was eligible to participate in during 2016/17 are as follows (see Figure 11). The national clinical audits and national confidential enquiries that Norfolk and Norwich University Hospitals NHS Foundation Trust participated in during 2016/17 are as follows: (see Figure 11). Norfolk and Norwich University Hospitals NHS Foundation Trust participated in 100% of the NCAs and NCEs in which it was eligible to participate.

The national clinical audits and national confidential enquiries that Norfolk and Norwich University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, are listed below (see Figure 11 – detail on the data collection status of each NCA/NCE is shown in the final column) 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.

Figure 11: National clinical audits and national confidential enquiries

Key		
National Clinical Audit	National Confidential Enquiry	Not applicable to NNUH

National Clinical Audit (alphabetical order)	Eligible	Took part	Participation Rate Cases Submitted	Completed / In-progress/ Ongoing
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	Y	905/1004 (90%)	On-going
Adult Asthma	Y	Y	43/20 (215%)	Completed
Adult Cardiac Surgery	N	N/A	N/A	
Asthma (paediatric and adult) care in emergency departments	Y	Y	42/42 (100%)	Completed
Bowel Cancer (NBOCAP)	Y	Y	435/435 100% (April to Jan 2017)	On-going
Cardiac Rhythm Management (CRM)	Y	Y	Pace 1066/1072 (99%) Electrophysiology 134/134 (100%)	On-going
Case Mix Programme (CMP)	Y	Y	883/883 (100%) (April to September 2016)	On-going
Child Health Clinical Outcome Review Programme	Y	Y	Chronic Neurodisability Study: Clinician 5/10 (50%) Notes 5/10 (50%0 (Data collection still underway) Young People's Mental Health study: Clinician 1/5 (20%) Notes 4/5 (80%) Data collection still underway	In progress In progress
Chronic kidney disease in primary care	N	N/A	N/A	
Congenital Heart Disease (CHD)	N	N/A	N/A	
Coronary angioplasty/National Audit of Percutaneous Coronary Intervention (PCI)	Y	Y	1077/1455 (74.0%)	On-going
Diabetes (Paediatric) (NPDA)	Y	Y	311/311 (100%)	Complete
Elective Surgery (National PROMs Programme)	Y	Y	Hip 746/655 (88%) Knee	On-going On-going

National Clinical Audit (alphabetical order)	Eligible	Took part	Participation Rate Cases Submitted	Completed / In-progress/ Ongoing
			648/580 (90%) Hernia 777/572 (74%) Varicose Veins 228/191 (84%)	 On-going On-going
Endocrine and Thyroid National Audit	Y	Y	21	On-going
Falls and Fragility Fractures Audit Programme (FFFAP)	Y	Y	National Hip Fracture Database – 806/806 (100%) (2016) Fracture Liaison Service – Not required to submit data National Inpatient Falls Audit – Postponed to 2017	On-going Ongoing Planned
Head and Neck Cancer audit	Y	N/A	The organising body did not finalise the dataset and submission method so participation was not possible	On-going
Inflammatory Bowel Disease (IBD) Programme	Y	Y	3/3 (100%) Paediatrics Adults did not participate	On-going
Learning disability Mortality Review Programme (LeDeR Programme)	Y	N/A	Audit still being established – Not yet running in our region	On-going
Major Trauma: The Trauma Audit and Research Network	Y	Y	603/683 (88.2%)	On-going
Maternal, Newborn and Infant Clinical Outcome Review Programme	Y	Y	Maternal deaths: 2/2 (100%) Perinatal deaths: 9/26 (35%)	On-going On-going
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death	Y	Y	Non-invasive Ventilation study: Clinician 1/3 (33%) Notes 3/3 (100%) Cancer in Children, Teens and Young Adults study: Data collection in progress	In progress In progress
Mental Health Clinical Outcome Review	N	N/A	N/A	
National Audit of Dementia	Y	Y	50/50 (100%)	Completed
National Audit of Pulmonary Hypertension	N	N/A	N/A	
National Cardiac Arrest Audit (NCAA)	Y	Y	83/83 (100%) (April to Sept 2016)	On-going
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Y	Y	Pulmonary Rehab Audit in progress data being submitted Continuous Secondary Care Audit opened for data collection 3rd Feb 2017	In progress Ongoing

National Clinical Audit (alphabetical order)	Eligible	Took part	Participation Rate Cases Submitted	Completed / In-progress/ Ongoing
National Comparative Audit of Blood Transfusion	Y	Y	Audit of Patient Blood Management in Scheduled Surgery 22/45 (49%) Management of patients at risk of Transfusion Associated Circulatory Overload (TACO) Audit started March 2017	Completed In-progress
National Diabetes Audit - Adults	Y	Y	National Pregnancy in Diabetes (NPiD) Audit: 47/57 (82%) (April –Dec 2016) National diabetes Adult (NDA) 462/462 (100%)	On-going Completed
National Emergency Laparotomy Audit (NELA)	Y	Y	345/345 (100%) (Year 3 ran from 1st Dec 2015 to 30th Nov 2016)	On-going
National Heart Failure Audit	Y	Y	179/826 (21%)	On-going
National Joint Registry	Y	Y	1116/1116 (100%) (Jan to Dec 2016)	On-going
National Lung Cancer Audit (NLCA)	Y	Y	545/545 (100%)	Ongoing
National Neurosurgery Audit Programme	N	N/A	N/A	
National Ophthalmology Audit	Y	Y	2473/2473 (100%) Data collection still in progress	In progress
National Prostate Cancer Audit	Y	Y	417/417 (100%) (April to Dec 2016)	On-going
National Vascular Registry	Y	Y	Acute Aortic Aneurysms 69/120 (58%) Carotid Endarterectomy 45/100 (45%) Bypasses 17/80 (estimated) (currently 21%) Major Amputations 43/100 (43%)	On-going On-going On-going On-going
Neonatal Intensive & Special Care (NNAP)	Y	Y	1294/1294 (100%)	On-going
Nephrectomy Audit	Y	Y	Figures not yet available anticipated 100%.	On-going
Oesophago-gastric Cancer (NAOGC)	Y	Y	163/163 (100%) (April 2016 to Jan 2017)	On-going
Paediatric Intensive Care (PICANet)	N	N/A	N/A	
Paediatric Pneumonia	Y	Y	In progress data entry period ends April 2017 Anticipated	In-progress

National Clinical Audit (alphabetical order)	Eligible	Took part	Participation Rate Cases Submitted	Completed / In-progress/ Ongoing
			90-100%	
Percutaneous Nephrolithotomy (PCNL)	Y	Y	Figures not yet available anticipated 100%	On-going
Prescribing Observatory for Mental Health (POMH-UK)	N	N/A	N/A	
Radical Prostatectomy Audit	Y	Y	Figures not yet available anticipated 100%	On-going
Renal replacement therapy (Renal Registry)	Y	Y	800/800 (100%)	On-going
Rheumatoid and Early Inflammatory Arthritis	Y	Y	Not able to submit data during 2016-17 audit halted until new provider identified	To be reinitiated
Sentinel Stroke National Audit Programme (SSNAP)	Y	Y	971/1024 (95%)	Ongoing
Severe Sepsis and Septic Shock – care in emergency departments	Y	Y	50/50 (100%)	Completed
Specialist rehabilitation for patients with complex needs	N	N/A	N/A	
Stress Urinary Incontinence Audit	Y	Y	Figures not yet available anticipated 100%	On-going
United Kingdom Cystic Fibrosis Registry	Y	Y	Adult 79/79 (100%) Paediatrics 65/65 (100%)	On-going On-going

The reports of 18 national clinical audits were reviewed by the provider in 2016/17 and Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Appendix A).

The reports of 135 local clinical audits were reviewed by the provider in 2016/17 and Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (See Appendix B).

Participation in research and development

The number of patients receiving relevant health services provided or sub-contracted by Norfolk and Norwich University Hospitals NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 5,438 (5,008 in 2015/16).

Commissioning for Quality and Innovation (CQUIN)

A proportion of Norfolk and Norwich University Hospitals NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between the Norfolk and Norwich University Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at http://www.nnuh.nhs.uk/TrustDoc.asp?ID=605&q=cquins.

The amount of Trust income in 2016/17 that was conditional upon achieving quality improvement and innovation goals was approximately £9.2m, and the Trust is expecting to receive approximately £8.3m. The amount of Trust income in 2015/16 that was conditional upon achieving quality improvement and innovation goals was £9.25m, and the Trust received £8.0m.

We took part in three of the national CQUINs in 2016/17 (Workplace Health and Wellbeing, Sepsis and Antimicrobial Stewardship), and we also agreed eight CQUINs with specialist commissioners and a further six local CQUINs with our CCG commissioners. The local CQUINs focused on strategically important areas including:

- Introducing a pathway for frail patients,
- improving our discharge processes
- improving diabetes care
- increasing the number of people who die in their preferred place of care

Care Quality Commission (CQC) reviews

Norfolk and Norwich University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

Norfolk and Norwich University Hospitals NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against Norfolk and Norwich University Hospitals NHS Foundation Trust during 2016/17.

Norfolk and Norwich University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Data Quality

Norfolk and Norwich University Hospitals NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Figure 12: Data Quality

The % of records in the published data which included:	the patient's valid NHS number was:		the patient's valid General Medical Practice Code was:	
	NNUH	Nat Avg.	NNUH	Nat Avg.
Admitted patient care	99.9%	99.2%	100.0%	99.9%
Outpatient care	99.9%	99.5%	100.0%	99.8%
Accident & emergency care	99.0%	96.6%	100.0%	98.9%

Information Governance Toolkit Attainment Levels

Norfolk and Norwich University Hospitals NHS Foundation Trust's Information Governance Assessment Report overall score for 2016/17 was 82%, and was graded RED (not satisfactory). We did not achieve Level 2 in one of 45 Requirements. Requirement 112 mandates that 95% of staff members should have completed the IG training by end of March; this was not achieved. Thus, we our status/grading dropped from 'Green' to 'Red'. We have an action plan to address this.

Left to right David Willis, Nicola Wilson, Yasmin Tate and Dr Jenny Nobes

New advanced technology at the NNUH to treat skin cancer

Patients with certain skin cancers are being treated with a new piece of specialist radiotherapy equipment with advanced technology for cancers on and close to the surface of the skin.

The Xstrahl radiotherapy unit adds to the comprehensive range of treatment techniques on offer to patients with Cancer in Norfolk. NNUH is at the forefront of treating those with cancer and is the only centre in Norfolk to offer this type of treatment. .

The new specialist equipment offers a dedicated treatment environment for the vast majority of skin cancer patients who require radiotherapy. It has the benefit of being able to treat patients with superficial X-Rays, which only penetrate a few millimetres into the skin, and is very suitable for early skin cancers. It is particularly useful for treating skin tumours around the eyes and nose, because it avoids causing any unnecessary damage to normal tissues by treating a very small area.

Clinical Coding error rate

Norfolk and Norwich University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission. Norfolk and Norwich University Hospitals NHS Foundation Trust will be taking the following actions to improve data quality (DQ):

- We plan to set up a monthly meetings for the new Departmental Validators to enhance communication and share best practice
- We hold quarterly meetings with Ward Clerks to enhance communication and share best practice
- We continue to work collaboratively on PAS Enhancements to support staff in meeting policy, to support 18 weeks and to enhance patient experience
- 18 week training is on-going and monitored on a monthly basis; eLearning compliance performance has improved. 23 out of 26 specialties have enhanced performance for 2016/17
- The 18 Week Audit Programme 2016/17 included:
  - 26 x Audits Completed
  - 18 x Specialties improved performance, 2 specialties achieved the 90% target
  - 7 x Specialties have decreased in performance
  - 1 x Specialties performance remained the same as 2015/16

All information within the Norfolk and Norwich University Hospitals NHS Foundation Trust is derived from individual data items, collected from numerous sources, which must comply with local and national data standards. It is essential to have measures and processes in place to ensure data are accurate, valid, reliable, relevant, timely and complete. We aim to have 100% accurate and timely data, compliant with NHS standards and Trust Policies.

Performance against the national quality indicators

For each of the following mandated indicators, our current performance is reported alongside the national average performance and the performance of the best and worst performing acute foundation trusts. Wherever possible, comparative data are also shown for the previous two reporting periods, to enable readers to assess our performance trends.

No data for 2016/17 (and little data for 2015/16) is yet available on the NHS Digital website (from where Trusts are instructed to obtain the data in the published Quality Report guidance). The absence of this data in the public domain has been escalated to our external auditors for national advice.

Figure 13: Table of mandated national quality indicators

SHMI value and banding						
Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
SHMI value and banding	No data yet published	No data yet published	No data yet published	No data yet published	1.056 Band 2	1.035 Band 2

No data published for 2016/17
Location: https://indicators.hscic.gov.uk/webview/ > SHMI indicator > Download September 2016 publication > SHMI data at trust level, select from value and banding columns
Current version uploaded: Mar-17 (contains only data for Oct16 – Sep16). // Next version due: Jun-17

% of patient deaths with palliative care						
Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
% of patient deaths with palliative care coded at either diagnosis or specialty level for the reporting period	No data yet published	No data yet published	No data yet published	No data yet published	19.5%	17.4%

No data published for 2016/17
Location: https://indicators.hscic.gov.uk/webview/ > SHMI indicator > Download September 2016 publication > SHMI contextual indicators > Palliative care coding > Percentage of deaths with palliative care coding
Current version uploaded: Mar-17 (contains only data for Oct16 – Sep16). // Next version due: Jun-17

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.
The Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services. By increasing the amount of analysis on the factors underpinning SHMI, the Trust is confident that it will be able to improve its performance.

PROMS						
Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
Patient reported outcome scores for groin hernia surgery	No Trust data yet published	No Trust data yet published	No Trust data yet published	No Trust data yet published	0.095 (Apr-Sep)	0.098

Patient reported outcome scores for varicose vein surgery	No Trust data yet published	No Trust data yet published	No Trust data yet published	No Trust data yet published	0.088 (Apr-Sep)	0.142
Patient reported outcome scores for hip replacement surgery	No Trust data yet published	No Trust data yet published	No Trust data yet published	No Trust data yet published	0.421 (Apr-Sep)	0.376
Patient reported outcome scores for knee replacement surgery	No Trust data yet published	No Trust data yet published	No Trust data yet published	No Trust data yet published	0.293 (Apr-Sep)	0.272

Data is only available at CCG level and last reporting period is 2014/15 as of 6/04/2017
Location: 3.3 Patient reported outcome measures (PROMs) for elective procedures
Current version uploaded: Sep-16 // Next version due: Sep-17

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that the outcome scores are as described for the following reasons: The number of patients eligible to participate in PROMs survey is monitored each month. Results are monitored and reviewed within the surgical division.
The Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve these outcome scores, and so the quality of its services: Our primary goal over the forthcoming months is to focus on improving the patient experience for patients that undergo primary knee replacement surgery.

28 day readmission rates

Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
28 day readmission rates for patients aged 0-15	No data yet published	No data yet published	No data yet published	No data yet published	No public data	12.47 %
28 day readmission rates for patients aged 16 or over	No data yet published	No data yet published	No data yet published	No data yet published	No public data	12.6%

There is no data published for 2012/13, 2013/14, 2014/15 and 2015/16 as of 6/04/2017.
Current version uploaded: Dec-13 // Next version due: TBC

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that these percentages are as described for the following reasons: This is based upon clinical coding and we are audited annually.
The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services: We have continued to review readmission data on a monthly basis to identify emergent trends, e.g. the rate rising in a particular specialty or for a particular procedure.

Trust responsiveness

Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
Trust's responsiveness to the personal needs of its patients during the reporting period.	No Trust data yet published	No Trust data yet published	No Trust data yet published	No Trust data yet published	No public data	68.3

Data only available at CCG level, reporting period 2015/16 (provisional) as of 6/04/2017
Location: https://indicators.hscic.gov.uk/webview/ > 4.5 Responsiveness to Inpatients' personal needs > CCG OIS - Indicator 4.5
Current version uploaded: Sep-16 // Next version due: Sep-17
The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The data source is produced by the Care Quality Commission.
The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this data, and so the quality of its services: By increasing the amount of feedback we gather from patients in real time through the Friends and Family test and our inpatient feedback project, we are able to identify emergent issues very quickly and to swiftly take any appropriate corrective action to address the cause of the problem.

% Staff employed who would recommend the trust						
Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
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.	No data yet published	No data yet published	No data yet published	No data yet published	71.5%	68.3%

No data found in the portal

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this score is as described for the following reasons: The data have been sourced from the Health & Social Care Information Centre and compared to published survey results.
The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services: We now send out the survey to 100% of staff, which gives us a broader range of responses and a clearer picture of where we can target our improvement.

% of patients assessed for VTE						
Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
Percentage of patients who were admitted to the hospital and who were risk assessed for VTE during the reporting period	No data yet published	No data yet published	No data yet published	No data yet published	91.2% (Apr-Dec)	97.9%

No data available in NHS indicator portal

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this percentage is as described for the following reason: The data have been sourced from the Health & Social Care Information Centre and compared to internal trust data.
The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services: Reporting is now possible via the Electronic Medicines Administration System. Monthly reports are issued to managers detailing VTE performance by area, to enable prompt corrective measures to be implemented if compliance appears to be deteriorating, and monthly data is also provided to our commissioners. Overall performance is monitored monthly by ward or department.

C difficile						
Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
Rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	No data yet published	No data yet published	No data yet published	No data yet published	54.75	55.43

Rates found for financial years of 2014/15 and 2015/16. No data for 2016/17
Location: https://indicators.hscic.gov.uk/webview/ > NHS Outcomes Framework - Indicator **5.2.ii**
Current version uploaded: Aug-16 / / Next version due: Aug-17
The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons: The data have been sourced from the Health & Social Care Information Centre, compared to internal Trust data and data hosted by the Health Protection Agency

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services: Measures are in place to isolate and cohort-nurse patients with suspected and confirmed C.Diff, in order to contain the spread of infection, and our Infection Control team works in a targeted way to quickly contain any emergent outbreaks. Rapid response deep cleaning processes are in place to contain any suspected infections, and these are complemented by an established and effective programme of preventative deep cleaning, aimed at avoiding an outbreak entirely if at all possible.

Patient Safety Incidents per 100 admissions

Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
Number and rate of patient safety incidents per 100 admissions	No data yet published	No data yet published	No data yet published	No data yet published	21.3 rate No:7,297 (Apr-Sept)	42.8 rate No:14,843
Number and percentage of patient safety incidents per 100 admissions resulting in severe harm or death	No data yet published	No data yet published	No data yet published	No data yet published	0.12% No: 9 (Apr-Sept)	0.09% No: 14

Most recent period available in indicator portal is Oct 2013 – Mar 2014, with 6,630 safety incidents; rate of 8.1. // Notes further down indicate that a more up to date version might be available in S:\Corporate Departments\Trust Management\Quality Report\2015-16 Quality Report\Mandated Indicators\Patient Safety Incidents

Location: 5.6 Patient safety incidents reported (formerly indicators 5a, 5b and 5.4) > NHS Outcomes Framework

Current version uploaded: Nov-16 / / Next version due – May-17

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this number and rate are as described for the following reasons: All internal data were thoroughly re-checked and validated, in collaboration with our external auditors. This review has given us the necessary assurance that the revised data reflect our true position.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this number and rate, and so the quality of its services: Through the improvements we have made to our incident reporting protocols, and as a consequence of having constantly promoted the message that each and every incident must be reported, we are confident that we will continue to improve the quality of our data, and increase our understanding of the factors that lead to incidents occurring.

Part 3

Other Information

Performance of Trust against Selected Metrics

This section of the report sets out our performance against a range of important indicators, covering the three dimensions of quality:

- **Patient safety**
- **Clinical effectiveness**
- **Patient experience**

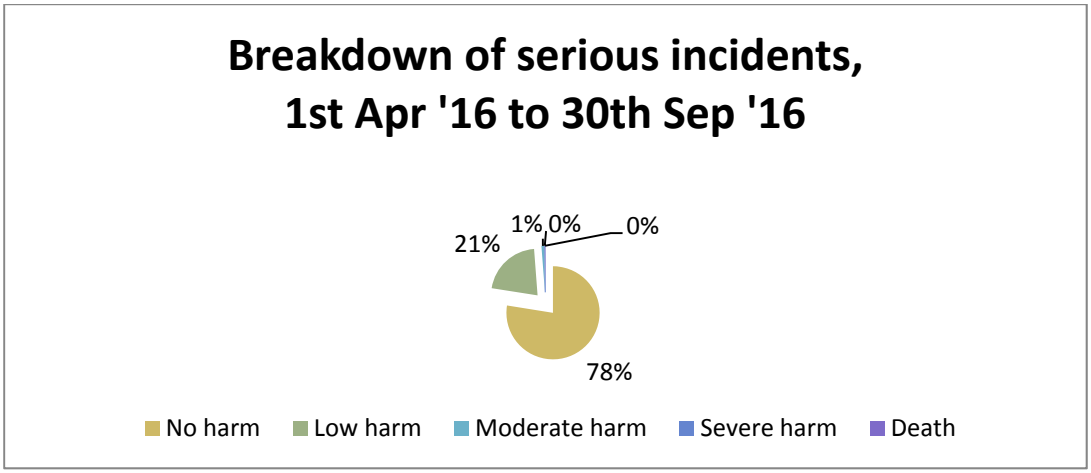
The information is presented wherever possible to allow comparison with previous reporting periods and with the performance of other Foundation Trusts. Many indicators were also included within previous reports, reflecting their continuing importance as determinants and markers of the quality of patient care. Where indicators were included in previous reports but have been excluded from the current report, readers can access the latest performance data by reading the public Trust Board papers, which are accessible at the following web address:

http://www.nnuh.nhs.uk/about-us/the-trust/trust-board-papers/

Patient Safety – Serious Incidents (SIs)

As in previous years, pressure ulcers (PUs) and falls have together accounted for the majority of the recorded SIs during the period covered by this report. In respect of PUs, the figure includes hospital-acquired and community-acquired ulcers. Hospital-acquired PUs are monitored closely to identify trends by ward and department and to highlight opportunities for improvements in clinical care. Full RCA is carried out on all Grade 2 and 3 hospital-acquired PU cases, with the learning outcomes shared with the clinical teams. SI figures are reported monthly to the Trust Board via the Clinical Safety Sub-Board, and learning points are disseminated to all staff groups.

Figure 14: Serious Incidents



(Source: NRLS*:* *https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-22-march-2017/)*

Patient Safety – Duty of Candour

The Duty of Candour (DoC) is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. DoC aims to help patients receive accurate, truthful information from health providers.

Our 'Being Open and The Duty of Candour' policy has been widely publicised internally and cascaded to all teams. As a further means of raising awareness and understanding among staff of the DoC, we held staff briefing sessions and produced a Briefing Note for clinical staff which was emailed to all clinical staff and provided as a handout to staff undergoing mandatory training.

In respect of DoC, the Risk Management Team currently maintains a DoC Compliance database which tracks compliance regarding DoC in respect of patient incidents across the Trust.

All incidents that are categorised as 'Moderate Harm or above' and reported an Datix are verified with the Consultant / clinical lead; a DoC "Compliance Statement" document is completed and returned to confirm that all actions have been taken and documented. A letter template is also provided for clinicians to use to formulate the required letter.

Patient Safety – Never events

'Never Events' are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

In our hospitals there were four never events during the period covered by this Quality Report (five in 2015/16).

- Retained guidewire following femoral central line insertion
- Incorrect localisation and excision of breast cancer
- Incorrect skin biopsy
- Insertion of wrong sided knee replacement
- Removal of incorrect side of Thyroid gland

Thorough RCA was carried out on all events, and the learning points were disseminated to the teams through Organisation Wide Learning (OWL) bulletins and a Surgical Safety Summit that was held in November 2016. These learning points included the following:

- CXRs after central venous access must always be reviewed by the radiographer.
- The induction programme of all junior doctors who undertake Seldinger catheterisation will advise doctors to check that guidewires are outside the patient at the end of any Seldinger technique.
- Staff who perform skin biopsies must ensure the correct site is identified for biopsy with the patient prior to the procedure commencing.
- The pre-op checklist procedure for skin biopsy must be improved to eradicate the risk of wrong site biopsy

- There is a need to standardise the procedure for confirming implant sizes and implant selection for all Orthopaedic joint replacement surgery.
- Operating theatre practitioners must recognise and minimise the risks associated with repeated interruptions to the surgical team during crucial procedural steps.
- Radiological images (where available) must be checked during the consent process and in the operating theatre as part of the WHO checklist at the time of the surgery and the site of surgery verified.
- The consent process should include a clear confirmation that the site of surgery on the consent form is correct by reference to notes and available images

Actions agreed at the November 2016 Surgical Safety Summit included:

- A working group was convened to review the current WHO Safety Checklist in Theatres in order to make recommendations for changes to this.
- A Theatre Charter is being developed to help improve the safety culture within the operating theatres.
- A Human factors training programme will be developed and delivered involving clinical teams in Theatres and Anaesthetics.
- WHO safety checklist audits which are carried out in theatre will be reviewed
- A working group has been set up to coordinate the implementation of LOCsips (Local Safety Standards for Invasive Procedures) to non-theatre areas as well as in the operating theatres where procedures are carried out.

Patient Safety – Sign Up To Safety and patient safety improvement

We signed up to the 'Sign Up To Safety' campaign, and we are progressing well with all of our goals, which included the following:

- Reducing medication prescription errors through a programme of education, audit and feedback
- Developing Organisation Wide Learning (OWL) tools to allow sharing of lessons learned and highlighting needs for change in practices, systems and processes
- Monitoring and reporting compliance with the requirements under the Duty of Candour to the Trust Board.
- Leading on the development of electronic prescribing across the intra-hospital sites involved.
- Providing regular updates to all staff on clinical performance indicators.

In respect of reducing medication prescription errors, our successful implementation of the Electronic Prescribing and Medicines Administration system (EPMA) has been pivotal in identifying and mitigating the risk of prescribing errors.

We have produced OWLs for EPMA, Medication, Falls and Pressure Ulcers, Information Governance, Incident Reporting and Infection Prevention & Control, Never Events and Risk Management.

Our compliance with Duty of Candour is being monitored and reported monthly via our Clinical Safety Executive sub-boards and the Integrated Performance Report (IPR).

We led on the development of electronic prescribing across the relevant intra-hospital sites, and achieved a smooth and successful implementation.

We provide regular updates to all staff on clinical performance indicators via the Clinical Safety Sub Board, the Divisional Performance and Nursing Quality Dashboards and by making the IPR available to all staff each month.

Patient Safety – CQC ratings and action plan

The Care Quality Commission (CQC) last inspected our Trust in November 2015 and published their report in March 2016. The report highlighted the caring nature of the service provided by our staff. No part of our service was judged to be inadequate and the overall rating of 'requires improvement' was in line with our own self-assessment.

We continue to review and evaluate our compliance with all CQC regulations on an on-going basis and maintain an action plan developed to specifically address recommendations within our March 2016 inspection report. See Figure 15.

Figure 15: CQC Action Plan

Actions to address our 'requires improvement' rating include:	
SAFE	• Formalised the documentation of our processes for assessing and actioning patient acuity assessments • Provided enhanced training for those who undertake investigations • Enhanced the processes that support staff in managing cohorting of patients in relation to infection, prevention and control measures • Enhanced access control within some areas of our hospital • Audited our clinical documentation standards to drive improvements • Re-designed our clinical documentation in relation to 'do not attempt cardio-pulmonary resuscitation' and mental capacity assessment • Enhanced our on-going auditing methods in relation to the storage of medicines • Mitigated some of the constraints of our paediatric environment in the Emergency Department • Standardised the processes for checking certain generic types of emergency equipment • Enhanced the paediatric nursing expertise within our Emergency Department • Audited our discharge paperwork in relation to safeguarding elements • Reviewed options to expand our physical capacity
EFFECTIVE	• Enhanced discharge processes and discharge teams, and communication with our patients, so that daily reviews of all patients, and actions to progress their discharge from our hospital, take place in a timely manner • Reviewed our mandatory training components and enhanced the methods of access to such training • Sourced additional funding to enhance our Specialist Palliative Care Team • Worked to enhance access to IT for some of our off-site services
RESPONSIVE	• Reviewed our bed-base to optimise our ability to improve performance against national access targets for elective care • Reviewed and enhanced our bed managing processes • Made mental capacity training a mandatory component of our staff training and re-designed our processes for documenting these assessments • Reviewed our ambulatory care pathways in our Acute Medical Units • Enhanced the processes for regular patient reviews including the assessment of the need for pain relief in the Emergency Department
WELL LED	• Introduced a clinically led Divisional organisational structure • Undertook a Trust-wide organisational values initiative and developed an associated action plan for embedding the learning from this • Enhanced our staff appraisal systems to reflect our values work • Enhanced clinical leadership in key areas within our Trust

Our ratings grid from the formal inspection is shown in Figure 16.

Figure 16 – CQC Ratings grid

	Safe	Effective	Caring	Responsive	Well-led		Service Overall
Urgent and emergency services	Requires Improvement	Outstanding	Outstanding	Good	Good		Good
Medical care (including older people's care)	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement		Requires Improvement
Surgery	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement		Requires Improvement
Critical care	Requires Improvement	Good	Good	Good	Good		Good
Maternity and gynaecology	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement		Requires Improvement
Services for children and young people	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement		Requires Improvement
End of life care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement		Requires Improvement
Outpatients and diagnostic imaging	Requires Improvement	N/A	Good	Requires Improvement	Good		Requires Improvement
	Safe	**Effective**	**Caring**	**Responsive**	**Well-led**		**Overall**
Trust Overall:	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement		Requires Improvement

Clinical Effectiveness – Achieving cancer referral and treatment times

Our performance against the national cancer targets is shown in Figure 17.

Figure 17 – Cancer performance against the national operational standards

	National Standard	Q4 1516	Q1 1617	Q2 1617	Q3 1617	Q4 1617 *
GP 2WW	93%	98.57%	98.91%	98.28%	97.10%	93.54%
Breast Sympt 2WW	93%	97.81%	96.58%	98.91%	98.68%	97.90%
31 Day First Treat	96%	97.47%	97.17%	97.65%	97.04%	96.93%
31 Day Subs ACD	98%	99.27%	99.73%	100.00%	99.74%	99.50%
31 Day Subs RT	94%	97.64%	97.80%	97.09%	98.44%	98.68%
31 Day Subs Surgery	94%	92.54%	91.80%	96.04%	91.30%	93.42%
62 Day GP	85%	78.91%	81.11%	80.49%	78.38%	72.17%
62 Day Upgrade		66.96%	67.02%	61.54%	60.00%	76.32%
62 Day Screening	90%	91.86%	85.99%	92.25%	85.00%	85.71%
62 Day Breast Sympt	85%	100.00%	100.00%	100.00%	66.67%	91.67%

Source: NNUH data, national definitions used

**Quarter 4 2016/17 data is currently provisional*

We have a 'Cancer First' policy, which ensures that cancer is prioritised over and above RTT. Our performance against our recovery trajectory is closely monitored by NHSi and our commissioners, and 62-day GP referral performance remains a priority for recovery.

Work to set a trajectory for cancer recovery has been undertaken with system partners and our cancer remedial action plan (RAP) has been submitted to our commissioners. The trajectory is for recovery in May 2017. This is despite overarching demand side pressures for cancer referrals (circa 10% annual growth), which present a significant challenge to performance.

A robust monitoring process is enforced to trigger escalation if a patient is at risk of breaching the treatment target; this has been successful in improving performance over the course of the year. Progress is monitored by commissioners at a weekly review meeting, and internal governance is also in place, with a fortnightly meeting chaired by the Divisional Director of Surgery. Daily management of the cancer patient target list continues to be led by the cancer manager, with input from operational managers and patient pathway coordinators. Escalation protocols are in place to encourage rapid removal of obstacles if required.

Clinical Effectiveness – 18 week RTT waiting times

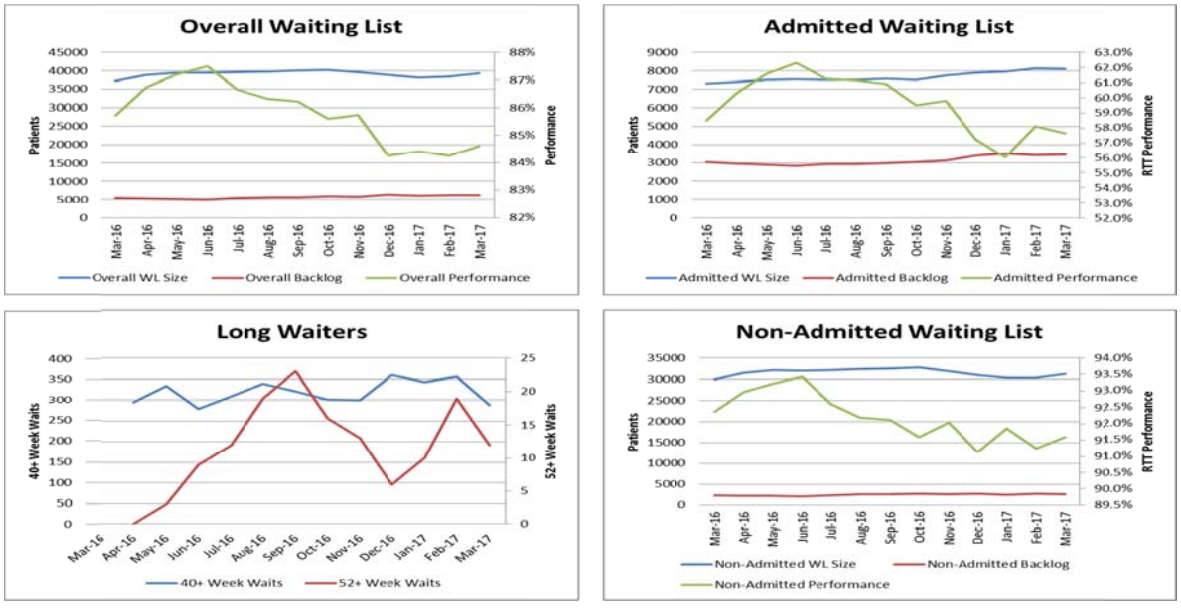
The admitted waiting list has increased from 7,325 patients at the end of March 2016 to 8,143 as at the end of February 2017, as shown in figure 18. Cancer patients continue to be prioritised, followed by the clinically most urgent and longest waiting patients.

Figure 18 – RTT waiting list and backlog

	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Overall WL Size	37275	38886	39583	39587	39621	39858	40071	40320	39632	38934	38248	38514	39384
Overall Backlog	5324	5154	5063	4949	5288	5452	5520	5803	5647	6132	5964	6066	6061
Overall Performance	85.7%	86.7%	87.2%	87.5%	86.7%	86.3%	86.2%	85.6%	85.8%	84.3%	84.4%	84.2%	84.6%
40+ Week Waits		294	333	279	308	338	320	301	299	359	343	356	288
52+ Week Waits		0	3	9	12	19	23	16	13	6	10	19	12
Admitted WL Size	7325	7411	7515	7541	7516	7532	7588	7538	7744	7915	7964	8143	8104
Admitted Backlog	3039	2940	2887	2843	2912	2926	2965	3051	3112	3383	3501	3410	3433
Admitted Performance	58.5%	60.3%	61.6%	62.3%	61.3%	61.2%	60.9%	59.5%	59.8%	57.3%	56.0%	58.1%	57.6%
Non-Admitted WL Size	29950	31475	32068	32046	32105	32326	32483	32782	31888	31019	30284	30371	31280
Non-Admitted Backlog	2285	2214	2176	2106	2376	2526	2555	2752	2535	2749	2463	2656	2628
Non-Admitted Performance	92.4%	93.0%	93.2%	93.4%	92.6%	92.2%	92.1%	91.6%	92.1%	91.1%	91.9%	91.3%	91.6%

Source: NNUH data, national definitions used

Figure 19: RTT Performance



Source: NNUH data, national definitions used

Our recovery trajectory is closely monitored by NHSi and significant partnership work has been completed to establish a recovery action plan with our commissioners. Current recovery trajectories set a return to compliance by October 2018

Detailed system wide recovery planning is being taken forward through system RTT Delivery Board. We are working hard to match capacity with demand, but the NHSi ECIST review has confirmed that our current elective capacity is unable to meet demand to achieve steady state 18 week compliance. To address this issue, we have developed an Outline Business Case for a new Ambulatory Care and Diagnostic Centre, which will provide the much-needed additional capacity. Work has now recommenced on this business case and we are currently examining fast track construction solutions on a site adjacent to the main hospital.

Clinical Effectiveness - NHSi's Compliance Framework (limited to those metrics that were included in both RAF and SOF for 2016/17)

Figure 20 – NHSi compliance framework

Indicator	2016/17		2015/16	
	Goal	Actual	Goal	Actual
C. difficile – meeting the C. difficile objective	49	22	50	32
Max time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway**	92%	84.6% *	92%	81.05%
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	85%	72.12% *		77.24%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	90%	85.71% *		92.86%
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge**	95%	85.9%	95%	85.4%
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	All met	N/A	All met

Source NNUH data, national definitions used.

The standard national definitions for many of these indicators are included within the Technical Guidance for the 2012/13 Operating Framework: http://www.gpcwm.org.uk/wp-content/uploads/file/A-Z%20DOWNLOADS/T%20DOWNLOADS/Technical_guidance_for_the_2012_13_operating_framework_22_dec_11.pdf

**denotes a metric that has been subject to external audit.*

The overall table forms part of the performance dashboard, which is submitted monthly to commissioners and quarterly to Monitor. The green shading indicates that performance was within agreed tolerance levels, whereas the red shading indicates where performance exceeded the agreed tolerance levels. Comparative performance data is available for all

other Foundation Trusts on the Foundation Trust Directory (*https://www.gov.uk/government/publications/nhs-foundation-trust-directory/nhs-foundation-trust-directory*)

Clinical Effectiveness – Clinical research and development

Participation in clinical research demonstrates our commitment to both improving the quality of care we offer to our patients and to contributing to wider health improvement. Involvement in research enables our clinicians to remain in the vanguard of the latest available treatment options, and there is strong evidence that active participation in research leads to improved patient outcomes. We have an active programme to engage health professionals and other staff in research through our research seminars and email updates on relevant research issues.

The Norfolk and Norwich University Hospitals NHS Foundation Trust was involved in conducting 369 clinical research studies (416 in 2015/16) in 37 medical specialities during 2016/17 (38 in 2015/16). 130 new studies were opened in 2016/2017 (111 in 2015/16). There were 150 clinical staff (consultants) (170 in 2015/16) participating in research approved by our research ethics committee during 2016/17; supported by approximately 150 research nurses, research administrators/managers and research specialists in our support departments (e.g. Pharmacy, Radiology, Pathology).

Overview of research activities

2016/17 has been a period of change both locally and nationally. Professor Alastair Forbes was appointed as our Chief of Research and Innovation, a post jointly funded by the University of East Anglia. As part of our continuing relationship with the University of East Anglia as its academic partner and our commitment to developing excellence in research, a further ten jointly funded, Senior Clinical Academic posts will be advertised shortly.

April 2016 saw the implementation of Health Research Authority (HRA) approval, the aim of which is to simplify the approvals process for research in England.

To facilitate consistent local research management, and to greatly improve performance, we participate in the National institute of Health Research (NIHR) Research Support services. We have publicly available Standard Operating Procedures (SOPs) for research.

We are also assessed by NIHR on our ability to deliver the first patient with 70 days from registration of a new study and have reached 86.4% compliance (national average 76.8%) with a steady improvement since 2014; this ranks us 21/170 Trusts providing this information to NIHR. We are also 58.8% compliant in the national research metric for enrolment "to time and target" for commercially supported clinical trials compared to the national average of 52.9%.

Readers wishing to learn more about the participation of acute Trusts in clinical research and development can access the library of reports on the website of the National Institute for Health Research, at the following address: http://www.nihr.ac.uk/Pages/default.aspx and the Trust website http://www.nnuh.nhs.uk/research-and-innovation/research-outcomes-patient-benefits/

The 100,000 Genomes Project

In 2015 Norfolk and Norwich University Hospitals NHS Foundation Trust was successful in a joint bid with NHS Trusts in Cambridge, Nottingham and Leicester to participate in the 100,000 Genomes Project.

The aim of the project is to create a new genomic medicine service for the NHS – transforming the way people are cared for. Patients may be offered a diagnosis where there wasn't one before. In time, there is the potential of new and more effective treatments.

The project will sequence 100,000 genomes from around 70,000 people. Recruitment at the Trust commenced in July 2016 and 37 patients have been recruited. The project will continue until the end of 2018. To date over 20,000 whole genomes have been sequenced nationally.

National research study to revolutionise cancer treatments gets underway in Norfolk

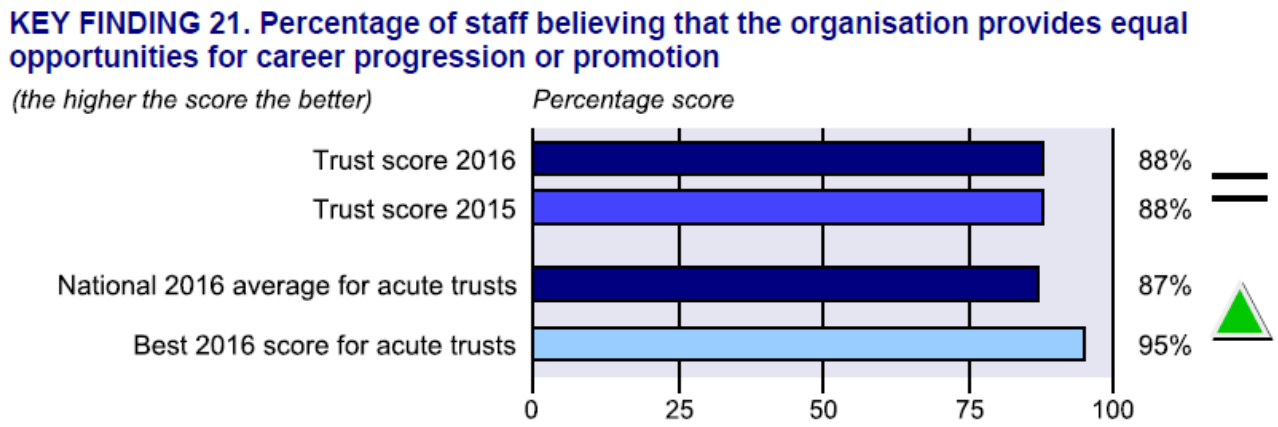
Patient Catherine Harris who was the first patient to take part in the 100,000 genomes research programme

The Norfolk and Norwich University Hospital (NNUH) is one of the hospitals in the UK which is taking part in the 100,000 Genomes Project, a world-leading DNA project which aims to sequence 100,000 complete sets of DNA from around 70,000 NHS patients.

Staff Experience – NHS Staff Survey

Figures 21 and 22 below show the outcomes in respect of Key Findings 21 and 26 in the 2016 Staff Survey. Positive findings are indicated with a green arrow (i.e. where the score has significantly improved since 2015 or compares favourably with other acute hospital trusts in England). Negative findings are highlighted with a red arrow (i.e. where the score has significantly deteriorated since 2015 or does not compare favourably with other acute hospital trusts in England). An 'equals' sign indicates that there has been no change.

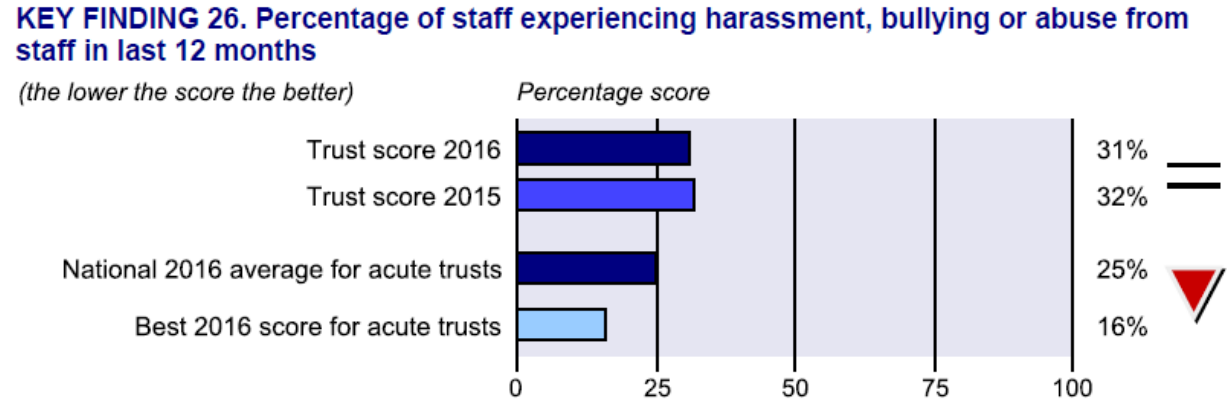
Figure 21 – Performance against KF21



Source: National data, national definition applied

Key Finding 21 shows that 88% of staff believe NNUH provides equal opportunities for career progression or promotion, which is 1 percentage better than the national average for acute hospital trusts in England. This falls in the 'above average' categorisation as stated in the published national staff survey report for 2016.

Figure 22 – Performance against KF26



Source: National data, national definition applied

In respect of key finding KF26, which measures the percentage of staff reporting that they have experienced harassment, bullying or abuse from colleagues in the last 12 month, the score has improved by one percentage point compared to 2015. This however is still six percentage points worse than the average for acute hospital trusts in England, and places us in the highest (worst) 20% of comparator hospitals.

Our PRIDE Values in Action programme, launched in the autumn of 2016, will improve the experience of staff by identifying and addressing the issues at work that can cause dissatisfaction and disengagement, most notably setting standards of behaviour that are congruent with our values, based on the feedback of 2,000 staff and patients that took part in an organisation-wide listening exercise.

NNUH first NHS hospital to introduce revolutionary treatment for Prostate problems

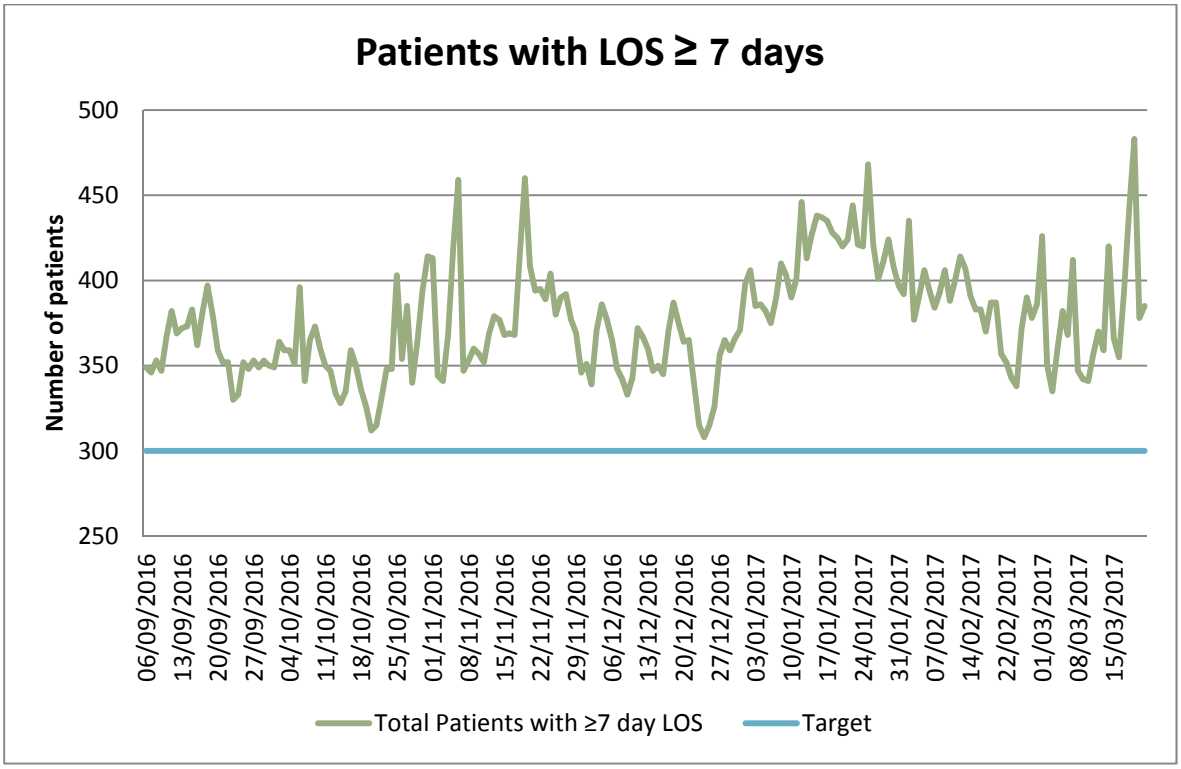
NNUH is the first NHS hospital in the Eastern region to carry out newly approved NICE procedure, UroLift, a permanent implant that has been shown to relieve symptoms of an enlarged prostate in men.

The new medical device is a minimally invasive alternative to operations where the prostate is cut away, such as Transurethral resection of the prostate (TURP) or Holmium Laser Enucleation of the prostate (HoLEP) to treat symptoms caused by an enlarged prostate.

Mark Rochester NNUH Consultant Urological Surgeon explained: “Urolift implants hold back obstructing prostate tissue to open up the urethra and reduce obstruction. I travelled to Copenhagen last year to learn this procedure and to get this started at NNUH. The benefit to patients is huge from being able to get home quicker and reduced side effects and we’re able to carry out more procedures in a day.”

Patient Experience – Encouraging Patient Flow

Figure 23 – Stranded patients



We have expanded our definition of 'stranded patients' to include all patients with a length of stay over 7 days. This will ensure that we maintain an optimal focus on this challenging cohort of patients.

Overall acute Trust DTOCs have reduced from 4.5% to 2.8% (27 patients). DTOCs related to external agencies have remained static at 15 per day against a target of 24 a day to provide backlog reduction.

During 2016, our visibility of the issues impacting flow was improved by the introduction of two complementary initiatives.

The first initiative was the purchase and implementation of a clinical decision support system called 'Clinical Utilisation Review' (CUR). The CUR system is designed to identify the best care setting for patients. Used correctly in admission areas, it identify those patients who would benefit from being signposted to a more appropriate care setting even before they have been inappropriately admitted to the acute care setting. Used correctly in inpatient settings, it identifies those patients who are now fit for discharge to a less acute setting.

To complement CUR, we also launched the Red To Green (R2G) initiative at the end of January 2017 on 5 exemplar wards in the acute Trust and 3 wards in the Community Trust

R2G is a visual way of identifying wasted time in a patient's journey. It focuses on care for patients, and encourages a shift in mind-set, where care is only delivered in an acute hospital bed if that is the *only way* the care can be delivered.

R2G encourages supportive peer challenge of the causes of delay in the patient's care pathway.

A RED day is a day of no value for a patient. Nothing happens to progress the patient's pathway of care through to discharge. Planned treatments, diagnostics or therapies are not undertaken and, if seen in outpatients, the patient's status would not warrant emergency admission.

A GREEN day is a day of value for a patient. Something happens to support the patient's pathway of care through to discharge. All that is planned or requested happens on the day it is requested, diagnostics tests are undertaken and/or reviewed and a clear plan is formulated. If seen in outpatients, the patient's status would warrant acute hospital admission.

R2G is currently being piloted on 6 wards in the hospital, and solutions to mitigate the top causes of delay are currently being explored. The R2G data is collected on the CUR system, enabling the benefits of both systems to be linked.

We are planning to measure median LOS and median time of day of discharge as part of our System ECIP Concordat. Expert advice is being provided from the Emergency Care Intensive Support Team (ECIST) and Dr Ian Sturgess.

Patient Experience – Frailty Strategy

Why focus on frailty?

The British Geriatrics Society describes frailty as a distinctive health state related to the aging process that causes patients to lose their in-built reserves. For many patients living with frailty a seemingly minor episode such as an infection or a new medication can result in significant deterioration in their health.

During 2016/17 we have delivered a range of service developments and system work to support our commitment to deliver excellent care to patients identified as living with frailty. This local focus on frailty is viewed as an essential part of the system response to the challenge of caring for an increasing population of older people with complex health needs over the next 10 years.

The motivation for this work was driven by a range of factors including:

- A national focus on shaping the Urgent Care response to managing frail patients
- Local challenges facing the Acute Trust resulting in complicated pathways and increased length of stay for frail patients
- Mandated Commissioning for Quality and Innovation (CQUIN) requirements
- A focus on patient and carer experience to ensure the best outcomes for patients by only admitting frail patients if absolutely necessary.

At the core of all the initiatives is the mission statement developed by the Acute Frailty team. This supports the aim to move from a small number of geriatricians identifying and managing frailty at the front end of the hospital to an integrated Trust-wide pathway approach, with all departments and teams taking responsibility for delivering care to frail patients.

Frailty Mission Statement

Patients with frailty should be 'known' to all and safety nets should be in place to prevent crisis. If an acute admission is unavoidable, it should be as short as possible and the patient should be discharged safely to their usual place of residence.

Where did we start?

We joined the Acute Frailty Network in September 2015. We have benefited from a 'collaborative improvement' model that encouraged both Acute and Community teams to improve services locally, supported by clinical and improvement experts sharing their experiences through national networking events and site visits.

The Acute Frailty team was able to build on the existing model of service delivery in Older Person's Medicine (OPM). They introduced a screening tool and a highly visible Trust-wide frailty icon (a yellow flower). This icon alerts ward teams to the presence of a frail patient and reminds them of the need to deliver the appropriate elements of a Comprehensive Geriatric Assessment, to initiate appropriate discharge planning and to communicate comprehensive information to community teams.

Next steps included the implementation of an easy to use frailty screening tool and the delivery of Trust wide training and updates to a wide range of staff groups.

Who did we talk to?

The Acute Frailty team initiated collaborative work with a wide range of staff and teams. This partnership work resulted in a wide range of frailty initiatives, examples of which are listed below.

- Multiple ward-based and department-based multidisciplinary teams received frailty training; MDT input ensures that the Acute Frailty pathway is based on a truly holistic approach. Ward-based medical and nursing leads champion the priorities of care for frail patients at daily board rounds and support the delivery of the Comprehensive Geriatric Assessment.

- Increased liaison with clinical teams in the Emergency Department resulted in the earlier identification of frail patients. There is a proactive approach to referring frail patients who are discharged home from the department to the OPM team for follow up appointments or telephone consultation.

- Engagement with Pharmacy teams has ensured that robust medication reviews now commence in ED; we have also introduced a Medication Review tool based on the nationally recognised STOPP/START tool. This screening tool is designed to alert clinicians and pharmacists to potentially inappropriate prescriptions that may lead to medication-related hospital admissions in patients with frailty.

- Increased engagement and collaboration with Community teams resulted in a joint understanding of priorities for frail patients and identified opportunities to develop better system working and improved discharge information through the use of a revised Electronic Discharge Letter.

- Discussions with the East of England Ambulance Service (EEAST) led to a greater understanding of pre-hospital screening for frailty and led to the introduction of a Consultant advice line which is accessible to paramedic crews attending calls in Care Home settings. We hope that this will enable paramedic crews to identify patients who are able to remain in their Care Home setting following specialist OPM advice and potential signposting to other services. In addition to other work with Care Home teams, this should contribute to a reduction in the number of frail patients admitted unnecessarily to hospital from a Care Home.

- Ward based Discharge Coordinators work closely with clinical teams to identify frail patients who are ready for discharge; they provide additional support to patients and carers during the discharge process.

Focus on Patient Experience

Various Trust-wide initiatives helped to raise awareness of frailty. The Acute Frailty team are encouraged by the number of different work areas that now promote an understanding of the care priorities for patients living with frailty. The well-known 'Mrs Andrews' video on YouTube has been used to highlight the patient experience element of the patient journey from admission to discharge. The video describes the factors that may occur during the clinical pathway for frail patients and has been used to ensure that staff working in all settings understand how to manage frail patients.

The focus on the early identification of frailty has resulted in an increase in the number of patients being discharged directly from the Emergency Department; this potentially reduces unnecessary admissions and avoids the complications associated with an acute inpatient stay. We have also seen a steady improvement in the number of frail patients who are discharged back to their usual place of residence; this promotes independence and supports patient choice.

Joint work with the Care Homes Network

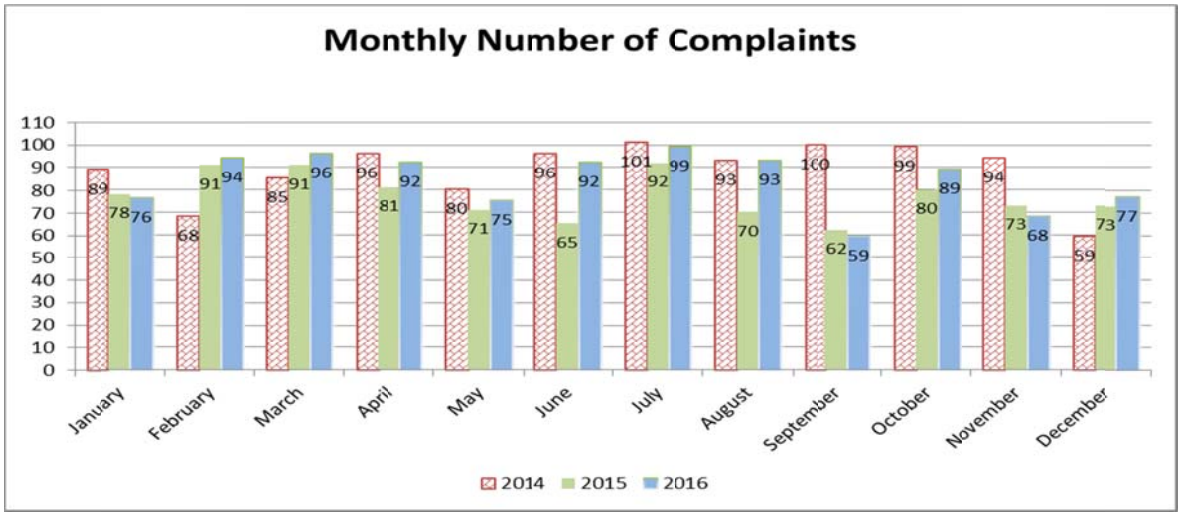
The Acute Frailty team continues to meet with Care Home leads to explore mechanisms that could be developed to increase trust and promote collaborative working; this should allow patients to be discharged back to their usual Care Home without the need for further review.

Patient Experience – Complaints

We have a long-established process for investigating, managing and learning from formal complaints about our services.

In order to ensure that complaints are used to learn lessons and to prompt service improvements for patients, every complaint is reported to the relevant divisional/departmental manager and clinical director so that any necessary actions can be taken. Monthly reports are then reviewed by our Caring and Patient Experience Governance Sub-Board, with summaries provided to the Management Board and Board of Directors.

Figure 24 - Complaints

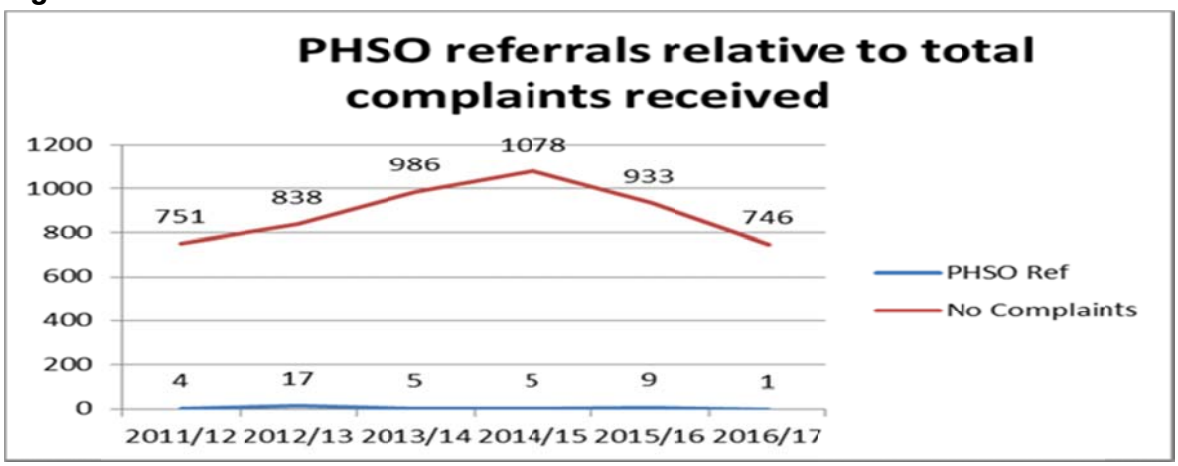


Source: NNUH data, local definition

To ensure that our complaints processes are 'fit for purpose' and are being followed, they are regularly reviewed by our Internal Audit service. They were last reviewed in 2015 and no recommendations for change were made.

During the period covered by this report, an analysis of complaints 'appealed' to the Parliamentary and Health Service Ombudsman (PHSO) was carried out (Figure 25)

Figure 25 – PHSO referrals



Source: NNUH data, local definition

The PHSO has the power to investigate a complaint once local resolution has been completed. A few years ago the PHSO announced that it intended to increase ten-fold the number of complaints it investigates. Figure 25 shows the number of complaints referred to the PHSO from this Trust over the last 5 years. These are single figures each year, except for a spike in 2012/13; this appears to be associated with a change in PHSO threshold relative to the total number of complaints. The number of appeals represents 0.5-2%. The number of referrals from this Trust is low relative to other Trusts, indicating relative success in resolving matters at the first stage.

This conclusion is supported by the periodic review of complaints files conducted by the Healthwatch Norfolk Team which has been consistently complimentary of our approach to managing complaints.

The outcome of PHSO investigations is not always straightforward. For example, sometimes complainants raise new matters with the PHSO which had not been previously notified to us. Nevertheless, all recommendations made by the PHSO are referred to specialties in the usual way to process through the established clinical governance processes.

The annual Clinical Audit Plan now includes reference to those areas that are being audited in response to changes resulting from complaints. This ensures that there is clear follow-up of the implementation of actions agreed.

NNUH recruits first patient to global research study

The Cardiology research team at the NNUH has enrolled the first ever patient to a global cardiology study to look at potentially life-saving treatment.

This new study is a recent addition to the National Institute of Health Research's (NIHR) Portfolio of studies and investigates the impact of a treatment in heart failure patients who experience a sudden worsening of their symptoms. The treatment is called LCZ696 (Sacubitril/Valsartan).

The treatment was previously examined in an international study and was indicated by some to be the future cornerstone of chronic-heart failure therapy. It is now licensed in the UK for adult patients displaying symptoms of a type of chronic heart failure.

Appendix A - Local Clinical Audit – Actions to improve quality

Audit and Survey Title	Results/Actions Taken / Planned
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attack. It supplies participating hospitals and ambulance services in England, Wales and Northern Ireland with a record of their management and compares this with nationally and internationally agreed standards. MINAP published their 2014/15 data on January 30th 2017. The audit demonstrates continuous improvement in a number of aspects of the quality of care for patients following heart attack. Immediate (primary) percutaneous coronary intervention (PCI) is now established as the preferred way to reopen a blocked artery (reperfusion) in ST-elevation myocardial infarction (STEMI). Clinicians have not identified any changes required to local practice.
Cardiac Rhythm Management (CRM)	The aim of the Cardiac Rhythm Management (CRM) audit is to examine the implant rates and outcomes of all patients who undergo pacemaker, implantable cardioverter defibrillators (ICD) and cardiac resynchronization therapy (CRT) implantation procedures in the United Kingdom. The latest report from the CRM audit was published in January 2017. It covered the period from April 2015 to March 2016. Nationally the report found the UK use of ICDs and pacemakers falls short of its use elsewhere in Europe. However the use of CRT implants continues to rise in the UK and is now above the European average. Clinicians have not identified any changes required to local practice.
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	The aim of this national audit is to monitor the clinical care and outcomes of patients receiving percutaneous coronary interventions. Data is collected at each participating hospital continuously. The data covering the period of January to December 2014 was published in April 2017. The PCI procedure, which involves inserting a tube or catheter into the patient's arterial system to reach the locked artery in order to improve blood flow, is associated with fewer complications if carried out through the radial artery rather than the femoral artery. The latest report demonstrates an increase from 26.9% to 75.3% in the use of a safer method of PCI (angioplasty) between 2007 and 2014. Clinicians have not identified any changes required to local practice.
National Heart Failure Audit (HF)	The aim of the Heart Failure national audit is to capture data on clinical indicators which have a proven link to improved outcomes, and to encourage the increased use of clinically recommended diagnostic tools, disease modifying treatments and referral pathways. The latest report on the Heart Failure audit was published in July 2016 and covered the year from April 2014 to March 2015. Nationally the report found that just fewer than 50% of patients with heart failure were managed on specialist cardiac wards. Those that were managed on specialist cardiac wards were more likely to survive to discharge, more likely to receive key disease modifying drugs, more likely to have timely specialist follow up and likely to be alive at follow up.
Audit of Intraoperative Neuromonitoring of Spinal Cord During Corrective Spinal Deformity Surgery.	Neurophysiological monitoring of spinal cord function is an increasingly commonly performed procedure to improve surgical outcomes from corrective spinal deformity surgery. To determine quality, national standards were produced in 2013. This audit was designed to assess how strictly departments around the UK adhere to these Standards. The findings for this Trust demonstrated 100% compliance in all areas. Results have been shared with the clinical team.
Smoking Cessation Audit	This national audit was undertaken to examine whether a properly led and staffed smoking cessation service existed within the Trust and create an environment more supportive of smoking cessation efforts. The results of the audit found that less than half of patients had a formal smoking status recorded, and that of those who were found to be smokers, none had evidence of being offered any smoking cessation advice or service. As a result, a hospital wide education program will be conducted, beginning with foundation trainees as these are the most common front line doctor responsible for the initial clerking.

National Audit for Rheumatoid and Early Inflammatory Arthritis	The aim of this audit was to compare the early management of patients with suspected early rheumatoid or inflammatory arthritis against NICE standards. Data collection for the National Audit did not take place in 2016-17 while a new provider is sought. However the second annual report was published in July 2016 reporting on data collected from February 2015 to January 2016. This report demonstrated that locally GPs refer 14% of patients to the rheumatology unit within 3 days of presentation (nationally 20%); 14% are seen in the rheumatology unit within 3 weeks (nationally 37%); 72% of patients are commenced on appropriate treatment within 6 weeks of referral (nationally 72%); 95% of the patients had an agreed target set at the outset (nationally 92%); 97% of patients had the means to contact the rheumatology unit for advice within 1 working day (nationally 92%. We were 2 of 16 units in East of England which did not have an annual review clinic; our patients felt a greater disease impact on their life compared to the rest of the country however they reported a greater improvement than the rest of the country with treatment.
Sentinal Stroke National Audit Programme (SSNAP)	The audit was undertaken to look at all aspects of the stroke care pathway from admission to recovery against national benchmarks to help identify problem areas. Up until November last year (the most recent report) it has shown a steady improvement in stroke care within the Trust. As a result of the audit, thrombolysis delays and admission delays have all been assessed so further improvements can continue to be made.
Case Mix Programme (CMP) Audit	The aim of this on-going audit was to collect data on all patients admitted to the Critical Care Unit. The annual quality report for 2015/6 was reviewed and data completeness was close to 100% in all fields. All quality indices were comparable with similar units and within the normal range. Unit acquired infection was above the mean but not statistically. This figure relies heavily on reporting and is thus subjective. As a result of the report, no actions were necessary.
National Cardiac Arrest Audit (NCAA)	This audit was undertaken to identify patients who had a cardiac arrest at the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH); to see if the arrest could have been prevented or if a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order should have been made; and to disseminate these findings to improve care. The audit found an initial survival rate of 40% with 20% of patients surviving to discharge. The report was reviewed at the Recognise and Respond Committee meeting in January 2017. It was recommended that monitoring of outcome following cardiac arrest and participation in the National Cardiac Arrest Audit (NCAA) data collection is continued to enable review and improve practice where required.
Audit of Potential Organ Donation	This audit was undertaken to establish the number of patients meeting organ donation referral criteria. The report NHS Blood and Transplant Executive Summary: Actual and Potential Organ Donors for 1 April 2016 - 30 September 2016 was published in November 2016. The audit found that 94% of potential organ donors were identified and referred. 100% of appropriate patients were referred to the organ donation team. Following the audit no changes in practice were required, however regular teaching sessions continue in order to keep all staff up to date with notification criteria for potential organ donors.
National Emergency Laparotomy Audit (NELA)	The National Emergency Laparotomy Audit (NELA) aims to audit the key processes of care for patients undergoing emergency laparotomy and report processes and outcomes for these patients at hospital level. The Second Patient Report of the National Emergency Laparotomy Audit was published in July 2016. This report covered patients submitted to the audit from December 2014 to November 2015. Nationally this report demonstrated that a lack of consistent care for patients undergoing high-risk emergency bowel surgery may be negatively affecting patient outcomes and placing a major strain on NHS resources. During the second year of the audit the cases submitted by the Norfolk and Norwich University Hospital was below 50%. During 2016 processes have been improved and the submission rate to year three of the audit is close to 100%.
National Vascular Registry (NVR) Audit	The National Vascular Registry (NVR) reports on the quality and outcomes for all patients who undergo major vascular surgery in NHS hospitals in England and Wales. The latest annual report was published in November 2016. The Vascular Surgery department at the Norfolk and Norwich is the 5th busiest vascular unit in the UK and has treated more ruptured acute aortic aneurysms than any other hospital. This report demonstrates that this unit compares very favourably with national figures. Mortality rates are lower than average. The unit is in the top third in the UK for symptom to speed of operation for carotid endarterectomy.

National Joint Registry (NJR) Audit	The National Joint Registry collects data on all hip, knee, ankle, elbow and shoulder replacement operations and monitors performance of joint replacement implants. The NJR published their 13th Annual Report in September 2016. This report outlines activity and outcomes up to December 2015. The orthopaedic department at the Norfolk and Norwich Hospital continues to be one of the busiest centres for joint replacements in the country, performing the most primary and revision hip replacements in the Eastern Region. Nationally the outcomes in hip and knee replacement surgery continue to be positive with revision rates at twelve years remaining low at 5% for the majority of procedures and extremely low at 2% for some. After a review of the data it was concluded that there is no compelling evidence to switch the type of implants that we use at NNUH. The outcomes are as good as the best on the NJR database.
National Hip Fracture Database (NHFD) Audit	The aim of the National Hip Fracture Database (NHFD) is to improve the care and secondary prevention of hip fracture – the most common serious injury of older people. The National Hip Fracture Database published their annual report in September 2016. This report covered patients presenting with a hip fracture during 2015.The Orthopaedic Department at the Norfolk and Norwich University Hospital is the third largest hip fracture unit in the country. We have a 30 day mortality of 8.2% adjusted, which is within national limits and is an improvement from the previous year's data where we were identified as an outlier. Two thirds of patients achieve 'Best Practice Tariff' care and efforts are being made to introduce additional operating capacity and also to provide a more consistent holistic approach to care.
Patient Reported Outcome Measures (PROMS) on going National Audit	This audit was undertaken to gain information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. The results are made available via NHS Digital and are disseminated via our Effectiveness Sub-Board monthly. The results are discussed and any actions required are undertaken. PROMS scores are used to improve care for our patients.
Trauma Audit Research Network (TARN) Audit on Trauma Care	The Trauma Audit and Research Network (TARN) is a national database of trauma care. The audit benchmarks national survival figures and trauma care against nationally accepted standards. Submissions to the audit are continuous. As of January 2017 submission numbers for 2016 were 603/683 (88.2%), which exceeded the minimum requirement of 80%. Findings are discussed at the Trauma Committee and actions to improve practice are actively discussed and implemented.
Medical and Surgical Clinical Outcome Review Programme: National Confidential Enquiry into Patient Outcomes and Death (NCEPOD)	The National Confidential Enquiry of Patient Outcomes and Death (NCEPOD) aims to improve standards of clinical and medical practice by reviewing the management of patients, by undertaking confidential surveys and research, and by maintaining and improving the quality of patient care by publishing and generally making available the results of these activities. During this year NCEPOD has published two reports; Acute Pancreatitis Study in July 2016 and Mental Health Care in Acute Hospitals in January 2017. Both of these reports have been reviewed by an identified Trust lead and a gap analysis undertaken to identify required actions for improvement.

Appendix B - Local Clinical Audit – Actions to improve quality

Audit and Survey Title	Results/Actions Taken / Planned
Audit of the Use of Second Troponins after an Initial Negative Troponin in Accident & Emergency (A&E) and Acute Medical Unit (AMU)	This audit was undertaken to assess practice around the trust policy for troponins. The results demonstrated that samples were not always repeated at the appropriate time interval and that in certain cases, a troponin was unnecessarily requested. As a result of this audit, crib sheets to guide blood test requesting and senior-led triaging were instigated by A&E with further education for junior medical staff being undertaken.
Prescribing Audit	This audit was undertaken to assess the practice of antibiotic prescription on the Acute Medical Unit against Trust Policy and Guidelines. Results were positive with 100% being scored for prescriptions having review dates or durations recorded. The lowest compliance score (94% compliance) related to the indication for prescription being recorded on EPMA (Electronic Prescribing and Medicines Administration) interface. As a result of the audit the EPMA interface was recommended to include both the indication and duration together in the same link which will be reviewed.
East of England (EoE) Audit of Primary Percutaneous Coronary (PPCI) Intervention	The aim of this audit was to evaluate treatment times and outcomes of Primary Percutaneous Coronary Intervention (PPCI) in the East of England. The details of every PPCI activation and all PPCI cases carried out at the Norfolk and Norwich University Hospital (NNUH) in 2015 was downloaded from the Cardiology database and collated. This audit found that the level of activity, treatment times and outcomes at the NNUH were comparable with other centres in the region.
Audit of Phototherapy Local PUVA (Psoralen combined with ultraviolet A) Burns	The audit was undertaken to determine the success rate of treatment and to identify episodes of burning and patients having local Psoralen combined with ultraviolet (PUVA). The results demonstrated a good response rate, 62% of patients improved with local PUVA with psoriasis treatment and although burns occur they do not appear above expected. As a result of this audit no actions were required.
Audit of Psoriasis Area and Severity Index (PASI)	This audit was undertaken to determine that phototherapy treatment is improving patients' skin conditions, and to determine that the Psoriasis Area and Severity Index (PASI) scores are being performed. The results of the audit found that PASI scores were not being completed regularly before or after treatment. 6/6 PASI scores were performed pre-treatment but none afterwards. As a result nurses are now being taught how to do perform PASI scores and a re-audit will be undertaken.
Audit of Dermatology Life Quality Index (DLQI)	The audit was undertaken to determine that phototherapy treatment is improving patients' skin conditions, and to determine that the Dermatology of Life Quality Index (DLQI) scores were being performed. The results of the audit found that 10/13 had pre DLQIs performed and no post treatment DLQI scores had been undertaken. The findings have been presented at the phototherapy meeting with minutes distributed to all staff doing the post assessments and a re-audit will be undertaken.
Audit of Documentation of Key Diagnostic Details From Patients With Alopecia Areata Against British Association of Dermatologists (BAD) guidelines.	The aim of this audit was to determine compliance with the British Association of Dermatologists (BAD) guidelines. The results found that although there was good compliance with some of the documentation, some areas were lower and as a result a proforma will be created to aid documentation and a re-audit will be undertaken.
Audit of Glucagon Like Peptide 1 (GLP1)	This audit was undertaken to determine whether the use of Glucagon-like peptide-1 (GLP-1) was in accordance with national and local guidelines. The results demonstrated a compliance of 95.3% and 90.5% in keeping with The National Institute for Health and Care Excellence (NICE) guidelines. As a result of the audit the department are continuing to use GLP-1 in line with NICE guidance and will re-audit in a years' time.

Re-Audit of Parathyroidism	This audit was to determine the management of primary hyperparathyroidism at the Norfolk and Norwich University Hospital (NNUH). The results of the audit found that referral rates from endocrine clinic to surgeons had dropped from 49% to 43% and time to surgery had increased despite reduced referrals. As a result the department will aim to reduce time between endocrine clinic and referral to surgeons. Clinicians are being encouraged to refer to surgeons as the same time as requested imaging rather than waiting for results.
Audit of Insulin Omission and Insulin Errors	The audit was undertaken to determine the number of insulin omissions across the trust inpatient areas and where possible to identify the cause. The results of the audit found more insulin omission errors at the Norfolk and Norwich University Hospital (NNUH) than expected, and these were Trust wide rather than in specific ward area. It was identified that some reported omissions were not real but a facet of the Electronic Prescribing and Medicines Administration (EPMA) reporting system. As a result of the audit further insulin education is required across the Trust and the Diabetes team will work with the EPMA team to determine robust, accurate reporting.
Audit of Hypoglycaemic Episodes from existing data	This audit was undertaken to determine compliance with the documentation of episodes of hypoglycaemia. The audit results found poor adherence to the Trust guidelines for the management of hypoglycaemia both in terms of documenting the treatment that was given and ensuring that the treatment is appropriate. As a result of the audit a sticker is has been developed to determine documentation is correctly completed and to give treatment guidance and a re-audit will be undertaken.
Senior Review Prior to Discharge	The audit was undertaken to determine a senior review has been undertaken prior to discharge or admitted for any child presenting to the Emergency Department (ED). The results found that 91% of children audited had a senior review as per guidance in the Emergency Department. As a result the department will continue to audit and feedback to clinicians who are not maintaining the standard.
Audit of The Use of Non Invasive Positive Pressure Ventilation in Type 2 Respiratory Patients	This aim of this audit was to assess the speed of referral to the respiratory team and the provision of Non Invasive Positive Pressure Ventilation (NIPPV) for patients in type 2 respiratory failure. The results found that 62% of patients were referred to the respiratory team. As a result the respiratory department are hiring a Bilevel positive airway pressure (BiPAP) machine which is likely to improve initiation of treatment.
Audit of Accuracy of Data Input to Symphony	The audit was undertaken to determine whether Integrated Clinical Environment (ICE) requests are correctly made within Symphony and if diagnostic tests are correctly input in correspondence with Central Alerting System (CAS) cards. The audit identified that Symphony does not accurately reflect information on the CAS card in all instances. As a result the department are hoping to disable the two way button for ICE within Symphony which should resolve the issue and will conduct regular monthly audits for discrepancies between CAS cards and Symphony. Training will be provided to all staff on checking all information has been entered correctly.
Audit to Endoscopy Start and Finish Times	This audit was undertaken to evaluate avoidable delays in the start of clinic lists. The results demonstrated that 83% of lists commenced on time or were early and 17% had avoidable delays. Reasons for the delays included the overrun of previous lists and endoscopists undertaking other clinical priorities. Staff have been requested not to overbook lists.
Audit of Lumber Puncture Documentation	This audit was undertaken to evaluate the documentation of elective lumbar punctures and the use of a lumbar puncture checklist. The results highlighted a number of documentation issues such as infrequent recording of the indication, documentation of requested investigations and presence/absence of complications. Infrequent use of the lumbar puncture safety checklist was noted. As a consequence the lumbar puncture checklist pro-forma will be amended to include sections covering the areas or poor documentation and the use of the form will be encouraged via the doctor's induction handbook.
Re-Audit on Secondary Prevention in Osteoporotic Fragility Fracture	The audit was undertaken to see if improvements had been made in bone health assessments of patients with non-hip fragility fractures. The results found that although this remains poor, there had been progress. The NNUH now assesses at a rate higher than the national average. To improve further, informal teaching sessions have been put in place for Orthopaedic Specialist Nurses and a section on Bone Health Assessments has been added to the Older People's Medicine Induction Handbook for junior doctors.

Audit of Anticholinergic Cognitive Burden (ACB) Scoring	The audit was undertaken to determine whether patient's ACB scores are recorded and to determine action is taken for any drugs currently prescribed that have been shown to be associated with falls (and dementia). The audit found of the 10 patients identified with high ACB score a decision was made to omit a drug for one patient, and it was suggested the GP/specialist to do so in 40%. As a result of the audit a modified ACB score has been included in the STOP/START frailty advice for pharmacists/clinicians. Further education will also be continued.
Audit of Medicine Administration Record (MAR) Charts on Henderson Unit	The re-audit was undertaken to identify how effective the coloured stickers on the front of MAR charts are at aiding the recording of allergies. The audit found that the introduction of stickers resulted in an increase from 10% to 92% of patients with allergies recorded on the chart. No further actions could take place following this audit as the unit has now been permanently closed.
Dementia Person Centred Care Audit	This audit was undertaken to establish the use of dementia approved identifications and the 'This is Me' tool for patients across the Trust with dementia. After the summer the results improved significantly after ensuring that blue wristbands were available, addressing issues around wristbands breaking, ensuring all wards have stock of the' This is Me' tool and involving Dementia Link staff in these processes.
Dementia Carer's Audit	This audit was undertaken to determine a good level of clinical care and support is received by carers of patients with dementia. The audit found an overall satisfaction with clinical care and the support received as carers. As a result of the audit there is now a recliner chair available to enable relatives to stay with patients overnight. The audit has seen individual issues raised and addressed by reporting directly to ward managers and the Patient Advice and Liaison Service. These issues may not otherwise have been reported.
Re-audit of Ipsilateral Radiotherapy in Tonsillar Cancers	This re-audit was undertaken to evaluate the contralateral neck recurrence (CNR) rate in patients with tonsillar squamous cell carcinoma after changing from ipsilateral to bilateral neck Intensity Modulated Radiotherapy (IMRT). In total 23 patients with N2b disease were treated with bilateral neck IMRT of which 20 patients had p16 positive carcinomas. The median follow-up was 21 months and the CNR rate was 0% (compared to 7.4% in the first audit) and the 5-year contralateral neck recurrence-free survival (CNRFS) was 100% (compared to 82.9% in the first audit). The results have shown that by changing our practice to bilateral neck radiotherapy we have managed to improve our patient outcomes.
Audit of Vismodegib Use Against Cancer Drug Fund (CDF) Criteria	This audit was undertaken to evaluate the use of Vismodegib against the Cancer Drug Fund criteria. The results demonstrated that Vismodegib was prescribed in accordance with recommendations, although approval by relevant specialist skin cancer multidisciplinary team was not always evident. This was discussed at the Specialist Skin Multidisciplinary meeting educational session as a route to improve compliance.
Vascular Access Audit	This audit was undertaken to determine that new end-stage kidney disease patients planning to start haemodialysis and patients on long-term dialysis are given the type of vascular access as recommended by the United Kingdom Renal Association. The audit also counted the number of 'line infection days'. Data was collected on all suitable patients and reported at quarterly Vascular Access meetings. Over the year the Trust has been very close to the national targets for vascular access of 60% for new patients and reached the national target of 80% for long-term patients. There was one line infection day this year. The renal team are looking at capturing all potential line infections with more 'real time' data.
Acute Kidney Injury (AKI) E-alert Audit	This audit examined the management of patients with Acute Kidney Injury, ensuring that they follow local guidelines and CQUIN goals. A sample was selected from the AKI database stratified by stage of AKI. It was found that there was good compliance with early AKI assessment and management, but improvement was required with discharge summaries and instructions for primary care, although follow-up bloods in primary care is good.
Oxygen Prescribing Audit	The audit was undertaken to determine the Trust emergency oxygen policy is implemented correctly and support safe practice around oxygen management. The Electronic Prescribing and Medicines Administration System (EPMA) has complicated the audit process. Results appear to be worse due to the disconnect that exists between the electronic prescription and the administration/adjustment part of the process. Without more reliable data it is difficult to report a definite change in performance. The audit is to be redesigned to determine it captures the data required. Auditing will recommence on Hethel and Mattishall wards before once again looking at the Trust performance as a whole.

Audit of Outcome Monitoring of Patients on Biologic Therapy	This audit was undertaken to monitor the outcomes of patients currently treated with biologics medicines. Patients on these medicines run an increased risk of infection. Every quarter a report is generated of all mortality and all hospital emergency admissions of patients being treated with biologics. This report is analysed for trends, then presented and discussed at the Rheumatology Governance meeting. Actions included rewriting the Trust's guideline on interruptions in biologic treatments.
Re-audit of Epidural Observations Compliance	This audit was undertaken to measure compliance with epidural analgesia observations required in Trust guidance. The results have improved from last year and a re-audit has been planned for 2017/18.
Re-audit of Removal of Epidural Catheter Risk Assessment Tool (RAT) – compliance with use	This audit was undertaken to measure compliance with completion of the risk assessment tool for epidural catheter removal in areas that support epidural analgesia. The results have improved from last year but the use of risk assessments required improvement. A re-audit has been planned for 2017/18.
Audit of Paediatric Anaesthetic Pre-assessment – a review of quality and effectiveness	This audit was undertaken to clarify that parents and children/young people found the paediatric pre-assessment clinic beneficial; and to identify areas for improvement in the service. The results found that 100% of respondents either strongly agreed or agreed that seeing the Anaesthetist was useful. As a result of the audit the Pre-Operative Assessment (POA) letter will be amended to advise all parents in advance that they will have the opportunity to see an anaesthetist when they come in for surgical/nurse POA.
Handover of Care Audit	This audit was undertaken to determine the safe handover of patients. The results demonstrated 100% of patients had an appropriate member of staff available for the handover and 80% of patients were documented on the handover sheet. As a result junior doctors are being educated about the importance of documentation during their induction and a re-audit will be undertaken.
Audit of Polydioxanone Foil (PDS foil) and Microporous High-Density Polyethylene Implant (MEDPOR)	The audit was undertaken to determine the use of Medpor nasal implants in augmentation septorhinoplasty. The results of the audit found that 17 patients had Medpor implants inserted from 2008-2015. The majority (14) had dorsal nasal implants which were stable. When Medpor was used as a columellar strut (8 cases) it was less stable with one being extruded. As a result of this audit, dorsal Medpor implants will continue to be used in appropriate patients. However, caution is advised when inserting a Medpor columellar grafts and an autologous "shield" graft will always be used in these instances.
Audit on the Surgical Management of Patients Presenting with Unresolved Pneumothorax	The aim of this audit was to determine whether patients with persistent air leak or failed lung re-expansion are referred to thoracic surgery within 5 days of admission. The audit found 11 out of 21 (52%) patients were referred within 5 days. The referral pattern does not comply with the British Thoracic Society guidelines. The plan following this audit is to inform respiratory medicine about the outcome and implement strategies to speed up referrals, within 24 hours of admission, to Thoracic Surgery.
Orthognathic Consent Audit	This audit was undertaken to assess the current consent process and to improve the thoroughness of consent within the department. The results of the audit were generally good. However, the audit demonstrated a lack of documentation in key areas – most notably alternative treatments and frequent risks. As a result of the audit, a proforma was introduced to assist with the consent process. In addition to the above, training for taking consent is now included as part of the formal induction period for senior staff.
Audit of Endometriosis Centre Rolling Patient Outcomes - British Society for Gynaecological Endoscopy (BSGE)	This audit was undertaken to fulfil the Trust's responsibilities as a British Society for Gynaecological Endoscopy (BSGE) Endometriosis Centre and contribute to the national database for the purposes of endometriosis research. The audit found that the Trust completed 30 cases that involved surgery in the pararectal space. Following the audit no changes were required as the Trust has fulfilled the appropriate criteria to maintain their status as a BSGE Endometriosis Centre.
Audit of Staff Knowledge of Diabetes and Pregnancy	This audit was undertaken to determine staff knowledge of current issues and care management for pregnant women with diabetes. The audit results found that knowledge regarding insulin could be improved. Midwives must continue to access electronic training in the safe use of insulin annually.
Audit of Infant Feeding	This audit was undertaken to determine minimum standards in infant feeding were being achieved. The audit results indicated that staff competence level was of the correct standard. A re-audit has been planned for 2017/18.

Audit on Donor Breast Milk (DBM) in the Neonatal Intensive Care Unit (NICU)	The aim of this audit was to evaluate compliance with the Trust guideline on the use of donor breast milk (DBM) on the neonatal unit. The findings demonstrated that all babies receiving DBM met the eligibility criteria; however written consent was not always evident in the notes. In addition Consultant decision to continue DBM once full enteral feeds was established was not always documented clearly. Consent forms have been made more readily available in the Neonatal Unit. A checklist for introduction of DBM has been introduced.
Audit to Recommendations of the Bliss Family Friendly Accreditation Scheme	This audit was undertaken to compare local delivery of neonatal care against the Bliss baby charter standards 2011. The neonatal unit's compliance to the 7 principles. Assessment to the standards was assessed through a range of methods including patient feedback and observational audit. The findings highlighted 16 standards where the unit was unable to fully comply and therefore rated "amber". An action plan has been developed, which includes updating the unit's protocol around lighting and sound.
Audit of Children's Early Warning Scores	This audit was undertaken to evaluate compliance to recording and acting on children's early warning scores (CEWS). The results demonstrated a drop in compliance compared to the previous audit percentages in all three standards. As the audit methodology had changed slightly from previously it was recommended the methodology reverts back and data collection continues. If the same trend continues frequent weekly audits and nurse training will be undertaken. The need to document clinician reviews will also be discussed in the junior doctor training sessions. This will be an on-going audit
Paediatric Oncology Audit	This audit was undertaken to determine if all children with life limiting conditions (LLC) have assessment of palliative care needs and planning of the delivery of care as per national standards, and to establish local guidelines and a management framework. The results demonstrated that standards were not fully achieved and that documentation and advance planning were sub-optimal. This was particularly the case for children with non-cancer LLC. Actions taken and planned include raising awareness of palliative care needs of children with non-cancer LLC through study days and communication skills workshops, the development of a Trust guideline and contribution to a gap-analysis report to commissioners, urging them to commission a dedicated palliative-care service for children. A care pathway has been written and disseminated and will be incorporated into routine care.
Fine Needle Aspiration (FNA) Thyroid Audit	This audit was undertaken to measure the measure the Thy1 rate at the NNUH for Ultrasound-Fine Needle Aspiration. The standard was a diagnostic yield of above 80% and the results demonstrated that we had marginally failed to meet this standard for the past 2 years. As a result of the audit, discussions regarding the technique were held with the operators to determine that improvements can be made by learning from those with lower rates.
Audit of General Practitioner (GP) Minor Injury Assessment (MIA) Pathway	This audit was undertaken to assess the practice around report times for General Practitioners (GP) Direct Access Patients and the appropriateness of GP requests. The audit highlighted that 68% were requesting in accordance with the protocol which was less than previous audits had demonstrated. The report turnaround had greatly improved. As a result of the audit, a link to the protocol was introduced and a patient information leaflet placed on the knowledge Norfolk website; which allows both patients and G.P.'s direct access to the policy.
Handover of Care Audit (Radiology)	This audit was undertaken to determine that patients were being transferred to Radiology appropriately, e.g. having been risk assessed, escorted where appropriate and appropriate documentation available. The results demonstrated that improvements were required and as a result of the audit, a training and education programme for all registered nurses was implemented across the Trust in order to increase awareness of the Risk Assessment Tool documentation and the Trust Policy for Intra Hospital transfers. In addition, plans to raise awareness of the Trust policy in the weekly Team Brief Communications circular were put in place. Where unsafe transfers to radiology occur, Datix forms will now be completed to highlight issues and a re-audit is planned with information to be shared with the Critical Outreach team.
Dietetic Department Documentation Audit	This audit was undertaken to determine that dietetic documentation in patient notes was compliant with standard record keeping protocol. The audit demonstrated high compliance but demonstrated a need to improve documentation of the timing of entries in dietetic notes. As a result of the audit, a more in depth audit will take place in 2017/18 to also encompass the content of dietetic assessments.

Audit of Ophthalmology Photography - Quality of photography	This was a re-audit undertaken to measure patient satisfaction with the current service and to compare this with previous cycles. The results were very positive showing that practice and compliance had stayed at a high level and had even improved since the last project. As a result, no immediate actions were necessary.
Audit of Medical Illustration - Patient Experience	This audit was undertaken to measure patient satisfaction with the current service to compare this with previous cycles. The results were very positive showing that practice and compliance had stayed at a high level. As a result, no immediate actions were necessary.
Audit of the Quality of Life Outcomes for Pregnant Women	This audit was undertaken to assess the effectiveness of physiotherapy in treating antenatal / postnatal low back pain and/or pelvic girdle pain. The results demonstrated that physiotherapy during pregnancy had a positive impact on a patient's condition and should be considered to be an effective and positive treatment for women with pregnancy related pelvic girdle pain and/or lower back pain. Due to positive feedback, it was felt that no immediate actions were required. Further refinement of the audit process for this group of women may yield a higher response rate in future. This may include use of online questionnaires if appropriate. A re-audit is planned in two years' time.
Speech and Language Therapy Bedside Chart / Catering Audit	This audit was undertaken to assess the practice around patient meal times to determine patients were given choice, appropriate support and that they received the appropriate meals. The results of the demonstrated that; patients were not always given the full choices for meals; compliance with speech and language therapy recommendations had improved since the previous audit (with nearly 100% compliance rate); patients requiring red tray support at meal time were not always receiving this promptly; policy on placing thickener behind beds was not always adhered to. As a result of the audit, training of the meal time ordering system was introduced for catering staff, general staff training was introduced on the risks of placement of thickener on the wards and healthcare assistant training was amended to include info around meal time support via red tray system.
Implementation of National Institute of Health Excellence Policy Monitoring of Compliance Audit	This re-audit of compliance to the Trust Implementation of National Institute of Health and Care Excellence Policy reviewed a random selection of the central evidence folders and the central NICE Spread sheet. The audit found that limited evidence was available from Divisional Boards when formal risk assessments relating to NICE were presented. The implementation of the new clinically led divisional structure is anticipated to improve compliance. A re-audit will be undertaken in 17/18.
Implementation of Best Practice National Confidential Enquiries Policy compliance audit	This was a re-audit of compliance to the National Confidential Enquiries Policy. The audit found that compliance to the Policy was good. A re-audit will be undertaken in 17/18.
Audit of Compliance to Policy on Procedural documents	This re-audit of compliance to the Trust Policy on Procedural documents reviewed 30 procedural documents on Trustdocs. The audit demonstrated satisfactory compliance to the policy in regards to Standard Operating Procedures and Non Clinical Policies, however although compliance was higher in relation to last year's audit compliance was poor overall in regard to documents labelled as Procedure. Gate keepers will continue to monitor compliance and a re-audit will be undertaken in 2017/18.
Pressure Ulcers Audit	This on-going surveillance audit reviews all pressure ulcers in the Trust. Various methods are utilised for the audit including: review of Datix Incident Reports, review of ward documentation during Quality Assurance Audits and ward staff reviews of their documentation during matron's rounds. A weekly pressure ulcer report which includes all community acquired pressure ulcers and hospital acquired grade 2 and above is circulated to Senior Staff. A Route Cause Analysis (RCA) is undertaken by ward staff and the Divisional Matron for any reported Grade 2 or above pressure ulcer. An action plan is formulated following each RCA and learning is disseminated within the Divisions to determine learning is shared across the organisation.

Audit of Transfer Guidelines and Clinical Handover of Care	This audit was undertaken to determine that there was documented evidence of patients having been risk assessed prior to intra hospital transfer from ward areas and that the appropriate actions had been taken as per policy. A new Risk Assessment Booklet had been introduced and this audit was to assess compliance with this new method of documentation. This large Trust wide audit was undertaken for several different locations of transfers; ward transfers, theatre transfers and transfers to radiology. The overall compliance with the documentation of the risk assessment process over all these areas was poor. An action plan has been put into place with the support of the Divisional Nurse Directors and Clinical Governance Leads Group. This is to embed the correct practice, make improvements to the transfer process and generally raise the awareness of patient safety on intra hospital transfer.
Audit of Reasonable Adjustments	This audit was undertaken to determine the use of Learning Disabilities resources throughout the Trust. The audit highlighted a range of areas of strength within the Trust, as well as some areas in which improvement is required. As a result of the audit, the following actions were implemented: on-going plan of monitoring of areas to determine good/improved results; amendments to Learning Disabilities referral process to determine on-going appropriate referrals and a focus on the use of care bundles in learning disabilities liaison work with clinical areas. The communication library - 'Everybody Communicates' programme was developed further to determine higher use of Adapted Augmented Communication by staff.
Audit of the Use of Learning Disability Resources	This audit was undertaken to determine the use of Learning Disabilities resources throughout the Trust. The audit highlighted areas of strength within the Trust, as well as some areas in which improvement is required. As a result of the audit, the following actions were implemented: on-going plan of monitoring of areas to determine good/improved results; amendments to Learning Disabilities referral process to determine on-going appropriate referrals and a focus on the use of care bundles in learning disabilities liaison work with clinical areas.
Audit of the Adherence to the Mental Capacity Act 2005 when working with People with Learning Disabilities	This audit was undertaken to assess practice to enable more focused action planning, tailored support and strategic management where necessary. The audit demonstrated good identification by clinical teams of potential needs relating to mental capacity and the need for further mental capacity assessment. There was also evidence of multidisciplinary-working in best interest decision-making. The results demonstrated that implementation of the Mental Capacity Act (MCA)recommendations to meet those identified needs required improvement; including maximisation of capacity, use of supportive resources, documentation of rationale and assessment. The following actions were implemented to determine improvement in practice; comprehensive review of Mental Capacity Act documentation to determine supportive measures more prominently considered; Consideration of more formal reporting and investigation of instances in which Mental Capacity Act not adhered to and review of consent aspects of Quality Assurance Audits documentation and the implementation of a standardised Best Interest template. MCA training is now mandatory.
Tracheostomy Box & Label audit	This audit was undertaken to determine correct equipment availability and accurate label completion with regards to the Tracheostomy Box and bedside labels. The audit results demonstrated that compliance was generally good with only minimal areas requiring improvements.
Audit of Manual handling	A total of 446 Nursing and Patient Care Records were audited in September 2016. The audit demonstrated 90% of manual handling risk assessments were documented on admission. The results were disseminated to all relevant leads and clinical staff for review and action in their areas if required. A re-audit will be undertaken in 2017/18 to continue to assess compliance.
Audit of compliance to Clinical Audit Policy	This re-audit of compliance to the Trust Clinical Audit Policy reviewed a random selection of 24 audit evidence folders from the 15/16 Trust Audit Plan. The audit demonstrated a high level of compliance and no changes to the current policy were recommended. A re-audit will be undertaken in 17/18.

Audit of Critical Care Outreach Team Observation Tool	Quarterly audits looked at the standard of observation recording, documentation in all adult ward areas and of patient's observation charts, when moved from Critical Care Complex (CCC) and Accident and Emergency (A&E) Department to ward areas. Key targets were set for 'Observation Completeness' and 'EWS Allocation Accuracy'. CCC and A&E Dept. had specific targets related to their areas. The results maintained high standards for ward areas achieving 95-97% compliance with 'Observation Completeness' and 98-99% for Early Warning Score (EWS) Allocation Accuracy. Both Critical Care Complex and A&E Department implemented action plans to drive improvement from within their department with key EWS champions leading. Improvement work was assisted and maintained by the EWS Links (health care assistants and registered nurses) and Critical Care Outreach Team (CCOT) nurses. These results were reported to the Clinical Safety Sub Board and appeared on the Matrons dashboard.
Audit of Trust Quality Priorities 2016/17	Our Quality Priorities and the work streams underpinning them have been monitored via our governance committees and reported monthly via the Integrated Performance Reports to the Trust Board. Sepsis screening is among our safety priorities where improvement is demonstrated, whilst some patient experience elements have proved challenging due to a combination of the on-going operational pressures and some extremely aspirational targets. Collection of required reporting information has sometimes been challenging and in some areas not possible. Quality Priorities for 2017-18 will be modified in the light of this experience through consultation with Governors and the Trust Board.
Audit of Transfers of Care	This audit was undertaken to help identify the reasons behind delays in discharge with a view to preventing delays in discharges during peak times. However, the audit highlighted limitations with the information available and the need to have an alternative reporting system to allow better access to the Delayed Transfer of Care (DTOC) information. As a result, the Medworxx CUR system is being introduced to help with patient flow as well as the availability of discharge information.
Audit of Section 5 notices	This audit was carried out to determine the practice associated with discharge notices was effective to help reduce delays, support local authority referrals, improve/expedite discharges and improve patient experience. The audit did however highlight inconsistencies with the information recorded on the discharge notices. As a result, the discharge notice was redesigned to improve the quality and consistency of Discharge Notice completion. In addition to this, Discharge notices will be made available electronically on ICE, ensuring that the progress of discharge notices can be tracked through this system allowing for easier access to information and an improved management process.
Electrophysiology and Ablation Satisfaction Audit	This audit examined whether the electrophysiology service is meeting patients expectations. Questionnaires were sent out to attenders from November 2015 to May 2016. There was a response rate of 79%. Patients were extremely positive about the service. All patients felt it had met their expectations and would recommend it. Comments made by patients also praised the aftercare service. In response to the audit the written material is to be reviewed and reinstating the arrhythmia nurse in the catheter laboratory on procedure days is being considered.
Audit of Nurse-led Patch Test Clinic Patient Satisfaction	The audit was undertaken to assess the patient satisfaction of the Nurse Led Patch Test Clinic. The results found that the majority of patients felt the clinic from referral, consultation and overall dealing with the department was very good. One issued raised was that we could improve on the information supplied about the appointment. The information leaflet has now been updated and a re-audit will take place in 2017/18.
Audit of Gastroenterology Unit Patient Experience 2016	This audit was undertaken as part of the requirements of the Global Rating Scale for endoscopy (GRS) to demonstrate compliance to a range of service measures. The findings demonstrated the service was in accordance with all recommendations and that patient's views on the service remained positive. No actions were considered necessary.
Audit of Satisfaction With the Big C Centre Information Day	This audit was undertaken to evaluate patient and relative/carer satisfaction with the May Big C Centre information day. The day was well attended and the results demonstrate attendees viewed the day very positively and thought it of value. Results have been shared with the Big C who have recommended an additional route for promotion to raise its profile.

End of Life Care Audit (Including Preferred Place of Dying CQUIN)	The audit was undertaken to determine the use of the palliative care rounding tool to optimise nursing care and prescribe appropriate and accurate anticipatory medication for palliative patients. The audit demonstrated around half of appropriate patients anticipated to die were commenced on the palliative care rounding tool. Anticipatory prescribing for Buscopan had improved from 67% to 75%. Documentation of patients' preferred place of death increased from 48% to 80%, and action taken to achieve the preferred place had increased from 38 to 45%. As a result of the audit more education has been arranged for staff all around the Trust. The audit will continue to be undertaken on a quarterly basis.
Syringe Driver Audit 2016/17	The audit was undertaken to monitor the standard of clinical care regarding the care and use of syringe drivers in the Trust. The results indicated that clinical practice appears to be safe and effective. However, the pressure on doctors and nurses may be leading to a delay in re-prescribing and changing syringe drivers. As a result all wards are to undertaken competency completion in use of syringe drivers. Awareness of the syringe driver tracking system will continue and disposable devices have been introduced for patients that are discharged with a syringe driver.
Diabetes Eye Screening - Patient Satisfaction Audit	This was a re-audit to assess patient satisfaction with the service and compare with previous results to determine patient satisfaction was maintained. The results demonstrated that patient satisfaction continued at a high level. As a result, no changes to practice were required.
Patient Satisfaction Survey - Grove Road Clinic	This audit was undertaken to assess the level of patient satisfaction with the new Central Norwich Eye Clinic. Two rounds of data collection have taken place and both sets of results demonstrated a high level of satisfaction with the new service. The feedback did highlight that patients felt that there was a lack of dedicated parking. As a result, Norwich City Council have agreed to provide 3 on road car parking permits which allow parking for 2 hours. A re-audit is planned for 2017/18.
Re-audit of Patient Satisfaction with the One Stop Clinic	The aim of this audit was to obtain feedback from patients attending the Urology One Stop Clinic. The audit results found that there had been no change to the service from the patient's perspective but patient satisfaction had improved since the 2015 audit. As a result of the audit no actions were necessary but the Trust will continue to monitor the time that patients stay in clinic.
Audit of Induction of Labour after Fetal Death	This audit was carried out to review departmental compliance with the Trust Guideline for The Management of Late Intrauterine Fetal Death and Stillbirth. The audit results found that improvements were required. In other areas good compliance was demonstrated. As a result of the audit, families offered SANDS information will be documented in the bereavement documentation destination checklist and clinic follow-up letters. Discussions about fertility and contraception, and the offer of lactation suppression will be included in "Midwives checklist for miscarriage over 12 weeks, Medical terminations, neonatal deaths and stillbirths".
Audit of Information Received Prior to Interventional Procedure - Patient Feedback	This audit was undertaken to determine patients received the appropriate information. The results were positive demonstrating that practice was compliant for the vast majority of standards. Information in patient letters is being reviewed to aid communication.
Audit of Patient Feedback to the General Radiology Department	This audit was undertaken to determine patient satisfaction with the various modalities within the Radiology Department. Results demonstrated that patient satisfaction was high with most patients rating their experience as good or very good. However, some areas for improvement were highlighted. A training resource was emailed to staff to determine improvement in staff communication in areas such as confidentiality and education in radiation protection. Staff were also reminded to offer 2 gowns to all patients to maintain patient dignity.
Audit of Patient Satisfaction of Service Provided on Henderson Ward	This audit was undertaken to assess patient satisfaction from patients seeing a chaplain on Henderson Ward. Henderson Ward was permanently closed during the data collection period so this audit was not able to run as planned. However, the feedback which was received was positive. As this audit focused on practice around the Henderson Unit, no actions can be put in place as a result.
Audit of Paediatric Clinical Psychology - Patient Experience	This audit was undertaken to assess patient satisfaction with the Paediatric Clinical Psychology Service. The results demonstrated that the service was highly valued by families but that the service needed to expand to offer more timely appointments and to cover other specialist areas. As a result of the audit, therapy will be offered in other modalities, i.e. starting with trialling a therapy group for parents as well as running a parents group for newly diagnosed families with Type 1 Diabetes. Plans were also put in place to recruit to the vacant Paediatric Rheumatology post to determine continuity of service.

Audit of Patient Satisfaction Survey of the Dietetic Paediatric Obesity Service	This audit was undertaken to determine service user satisfaction in terms of time spent, quality of the information given and effective communication. As a result of the audit, a review of timescales of follow up and duration of appointments was undertaken to allow for improved practice. Dietary written information was also reviewed with liaison with regional dietetic/weight management teams to combine/agree information. A re-audit was planned once changes have been fully implemented.
Henderson Unit - Patient Satisfaction Audit	This audit was undertaken to identify the level of patient satisfaction on the Henderson Unit. The results demonstrated that there was a high level of patient satisfaction with the Unit as all patients audited stated that they were overall either Very satisfied or satisfied with their stay on the unit. Results were analysed and shared but no action plans could be implemented due to the permanent closure of the Henderson Unit as part of the Trust re-structuring undertaken in 2016
Audit of Patient Experience in Outpatient Rheumatology	This audit was undertaken to identify if patient needs are met and to ascertain any areas for improvement. The results were limited due to a small sample size. The results did show positive patient feedback with regards to satisfaction, but did highlight the potential need for a review of patient information. As a result of the audit, a review of patient information took place to enable the generation of Occupational Therapy Service Information Leaflets for patients to be provided at the point of referral.
Audit of Patient Experience in Hand Therapy Outpatient Clinic	This audit was undertaken to determine patient satisfaction in the Hand Therapy Outpatient Clinic. The results were very positive and demonstrated that patient satisfaction remains at a high standard. Therefore, no immediate actions were required to the service.
Physiotherapy Musculoskeletal Outpatients - Patient Satisfaction Survey	This audit was undertaken to assess patient satisfaction with the Physiotherapy Musculoskeletal Outpatients Service. The results were in keeping with previous cycles of the audit, demonstrating that the confidence patients have with their physiotherapists remaining high with there being many positive comments to support this. Various points of consideration were raised around making the appointment, the reception / waiting room, physiotherapy treatment and overall privacy of the appointment. Following the audit a review the booking of appointments for an agreement of priorities was undertaken.
Voice - Patient Satisfaction Audit	This audit was undertaken to determine patient satisfaction across the nine different clinics provided within the Specialist Voice Service. The results demonstrated high levels of patient satisfaction with the only significant concern being the Outpatient parking facilities. The results were disseminated accordingly with no immediate actions required to practice.
Audit of Patient Experience with the Volunteer Settle in Service	This audit was being undertaken to determine that patients being discharged under the volunteer settle in service, are satisfied and supported appropriately. Initial results demonstrated high levels of satisfaction with the service. However, the settle in service is no longer in place - therefore no actions could be implemented.
Audit of Patient Advice and Liaison Service Activities and Trends	This audit is undertaken to determine activity and trends of patient requests to the Patient Advice and Liaison Service. The audit reviews all requests received by the Patient Advice and Liaison Service. The results are reported monthly to the Caring and Patient Experience Sub-Board for discussion and any actions recommended implemented.
Audit of Patient Advice and Liaison Service - Patient Feedback	This audit was undertaken to monitor whether PALS was providing a good service to its clients and is meeting clients' needs. This audit relates to Key Lines of Enquiry relating to Caring and Patient Experiences and Responsiveness. The audit demonstrated that patients were very positive about the service received. The results were reported to the Caring and Patient Experience Sub-Board for discussion and any actions recommended implemented.
Quality Assurance Audit of Care Quality Commission Fundamental Standards Audit	These audits are based on enhanced Care Quality Commission Outcome standards. Each area now receives two visits annually led by the Clinical Matrons and supported by sisters, charge nurses and allied professional colleagues, alongside our team of external auditor volunteer patient representatives. The annual programme also involves self-assessment, Quality Rounds, Quality Safety Visits and a formal structure for review should any standard be deemed non-compliant. Results are shared with all relevant clinical and managerial teams and are reported monthly to the Trust Board. Feedback from patients is actively sought, especially by our external audit team members and is used to help inform on-going improvements in the services we provide.

Audit of Wandsworth Call Bell	This audit was undertaken to demonstrate compliance with agreed response times for patient and bathroom Calls. Any wards whose call bell audits fall outside of the accepted range of answering Patient and Bathroom calls are discussed at the Matrons Monthly Performance Meetings with the Director of Nursing and appropriate actions are implemented.
Audit of the Management of Diabetes Ketoacidosis (DKA)	This audit was undertaken to assess the management of patients being referred to Acute Medicine with DKA (Diabetic Ketoacidosis). The audit demonstrated that compliance in terms of documenting information is generally good. The audit did identify the need for a better format to document and monitor parameters. Therefore an amended document was produced which will be discussed with the Diabetes team.
Case Notes Audit (Dermatology)	This is was undertaken to determine whether patient's notes are complete for appointments in the outpatient clinics as very often the notes are partial or not available at all. The results found that 92% of patient's notes were complete; however on 2 occasions case notes were unable to be located. As a result of the audit interventions will be designed to improve record-keeping in Dermatology clinics and a re-audit will be undertaken in 2017/18.
Re-Audit: Use of Ciclosporin in Dermatological Patients – Are We Meeting The Standards?	This audit was undertaken to determine the health and safety of the patients commenced on ciclosporin and to determine compliance with the British Association of Dermatologists (BAD) guidance. The results found improved outcomes at re-audit: 100% of patients had their blood pressure checked at baseline and 86.7% at further follow-ups. Improvement is still required with documentation and as s a result a checklist is being designed and a re-audit will be undertaken in a years' time.
Re-Audit of the Documentation of Medication Reviews by Older Peoples Medicine Doctors	This audit was undertaken to monitor the documentation of medication reviews on three OPM wards to determine levels were satisfactory. The re-audit demonstrated there had been improvement, but compliance was still low. 28% of medication reviews were correctly documented. As a result the NO TEARS medication review tool will be taught and a routine weekly medical review will be introduced to help minimise errors.
Audit of Venous Thromboembolism (VTE)	This audit was undertaken to evaluate Trust-wide compliance to completion of thromboprophylaxis risk assessments (TRA). Screening figures for adult inpatients (excluding maternity, surgical day case admissions and other agreed reporting exclusions) were obtained from the hospital patient administration system, main theatre system and the electronic prescribing and medicine administration system. The findings demonstrated that Trust-wide a thrombosis risk assessment was completed for 99.5% of patients during July to December 2016; this is an increase from the 92% for April to January 2015. Monitoring of TRAs will continue for 2017.
World Health Organisation (WHO) Checklist Re-audit	This audit was undertaken to determine compliance with practice surrounding the WHO checklist for both the preparation of the patient as well as documentation in ophthalmology. The results demonstrated that practice is of a high standard with the observational elements providing evidence. However, the documentation did not always reflect this. Therefore, the results were disseminated and discussed as necessary with the department to highlight the importance of ensuring that all aspects of the WHO checklist are followed and documented accordingly.
Audit of Termination of Pregnancies (TOP)	The aim of this audit was to measure compliance with Trust protocols for the medical termination of pregnancies. The results found the audited areas of the service have proven to be excellent in the majority of cases. Documentation of sensitive disposal of pregnancy tissue, supply of antibiotics post procedure and the checking of Anti-D requirements prior to discharge required improvement. As a result of the audit discussions have taken place with ward staff regarding Anti-D requirements and the supply of antibiotics. Discussions were also held with the mortuary and theatre staff about documenting sensitive disposal.
Audit of Hand Held Ultrasound Scanning to Prevent Undiagnosed Breech (Sign Up to Safety Campaign)	This audit was undertaken to determine if all women who attended in labour had a portable ultrasound scan of fetal presentation. The audit demonstrated that documentation could be improved. There is a proposal to amend the documentation in the antenatal record. It has also been recommended that the hand-held ultrasound (HHUS) equipment is relocated to community so that community midwives can undertake the scans prior to induction or labour.
Re-audit of Child Safeguarding Training	This audit was undertaken to evaluate the effectiveness of safeguarding training. All course participants between April 2015 and March 2016 rated their knowledge on specific criteria pre and post workshop. The results clearly demonstrated an increase in knowledge and understanding post workshop with between 61-69% of participants scoring 8-10 for most categories. The mean score for usefulness was 9.1 out of 10. Knowledge on which to contact in the wider National Health Service and Norfolk County Council Children's Services if concerns exist did not score as well and therefore the training module will be reviewed to identify potential improvements in delivery of key points.

Serial Monthly Audits in Blood Transfusion	A number of audits were undertaken to determine compliance with the Blood Safety and Quality Regulations 2005 (as amended) as monitored by the Medical and Healthcare Products Regulatory Agency (MHRA), compliance with ISO 15189:2012 as assessed by the United Kingdom Accreditation Service (UKAS), and compliance with Trust procedure. Improvements identified/implemented were in the areas of reporting of external blood product recalls, documentation of Quality Control procedures, instituting regular IT Quality Control checks, supplier records, maintenance of external blood banks, assessment of Information Technology server room and revising Information Technology permissions.
Serial Monthly Audits in Clinical Biochemistry and Immunology	A number of audits were undertaken to determine compliance with ISO 15189:2012 as assessed by the United Kingdom Accreditation Service (UKAS), and compliance with Trust procedure. Improvements implemented related to pre-examination, examination and post-examination processes.
Serial Monthly Audits in Cytogenetics	A number of audits were undertaken to determine compliance with ISO 15189:2012 as assessed by the United Kingdom Accreditation Service (UKAS), and compliance with Trust procedure. Improvements implemented were in the area of documentation, records, equipment and health and safety.
Serial Monthly Audits in Haematology (including Andrology and Phlebotomy)	A number of audits were undertaken to determine compliance with ISO 15189:2012 as assessed by the United Kingdom Accreditation Service (UKAS), and compliance with Trust procedure. Improvements implemented related to pre-examination, examination and post-examination processes.
Serial Monthly Audits in Microbiology	A number of audits were undertaken to determine compliance with ISO 15189:2012 as assessed by the United Kingdom Accreditation Service (UKAS), and compliance with Trust procedure. Improvements implemented related to pre-examination, examination and post-examination processes.
Programme of Horizontal Quality Management System Audits across Eastern Pathology Alliance	A number of audits were undertaken to determine compliance with ISO 15189:2012 as assessed by the United Kingdom Accreditation Service (UKAS), and compliance with Trust procedure. Improvements implemented related to aspects of the Quality Management System.
Missed Doses Audit	With the advent of EPMA, missed doses are now being regularly "audited" in terms of a report is run regularly. The EPMA team are extracting this data and are working on a method of reporting this on a regular basis which will go to the Medicines Management subgroup of the DTMM.
World Health Organisation (WHO) Checklist Audit	This audit was undertaken to assess compliance with the World Health Organisation (WHO) checklist for interventional procedures undertaken under Computed Tomography (CT) and Ultrasound (US) guidance. The results were positive but the audit did highlight a lack of information being documented with regards to allergies for the CT cases. As a result of the audit, emails were distributed to all staff to highlight importance of the checklist and to remind staff around practice with regards to Soliton. In addition to this, posters are now displayed in the CT control room and ultrasound room respectively to raise awareness.
Audit of Malnutrition Universal Screening Tool (MUST)/Trust Nutritional Standards (Using the British Association For Parenteral And Enteral Nutrition (BAPEN) Nutritional Care Tool)	This audit was undertaken to determine that Malnutrition Universal Screening Tool (MUST) was appropriately completed in a timely and accurate manner. The results demonstrated that further MUST Training is required for the nursing staff. As a result of the audit, ward-based MUST training and focussed MUST training sessions on implementation of MUST Care Plan Actions was introduced. MUST training with Healthcare Assistants Clinical Induction Programme was re-instigated.
Audit of Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) on the Paediatric ward	This audit was undertaken to determine appropriate and accurate completion of STAMP assessment on the Paediatric ward. The results demonstrated that STAMP was not completed on admission for 18 of the 21 patients audited and that it was not always repeated as advised by care plan. Therefore a training programme was devised for ward Nursing Staff regarding STAMP completion on admission, which will be conducted over the next year. Plans for re-audit were also put in place.
Falls Management within Occupational Therapy - Re-Audit	This audit was a re-audit to measure practice in relation to patients at risk of falls (in relation to NICE and College of Occupational Therapists Guidance). This audit demonstrated that overall compliance had improved following implementation of previous recommended actions. However, there was room for further improvement and as a result of the audit, a review of the OT Falls Risk Assessment was undertaken and OT paperwork amended. Tutorials on the preceptorship programme and laminated cue cards were introduced.

Health Records Management Audit	This audit was undertaken to demonstrate users' compliance with tracking plus timely and appropriate handling of case notes. The audit found a significant high proportion of users not complying with this standard, particularly when receipting case notes on PAS. Health Records are investigating the possibility for all newly trained PAS users to visit the Health Records Library and thereby understand the issues arising from poorly tracked case notes.
Audit of Hand Hygiene	This audit was undertaken to demonstrate compliance with parts of the hand hygiene policy. The audit found an average of 97% compliance. The nurse average was 97%, HCA 96%, doctors 98% and others 98%. Results are fed back monthly and the importance of good hand hygiene was emphasised throughout all training. If results are below 95% a follow up is sent to the sister/charge nurse to action learning outcomes, requesting return of the completed plan to Infection Prevention and Control (IP&C). Results are also available on the Nursing Dashboard.
Audit of High Impact Intervention Care Bundles	This audit was undertaken to demonstrate compliance with the High Impact Intervention care bundles for Peripheral Cannulas, Urinary Catheters, Central Venous Catheters, prevention of Ventilator Associated Pneumonia, Renal Dialysis catheters and prevention of Surgical Site Infection using the electronic audit system. Average results for this period for Peripheral Cannulas 82%, Urinary Catheters 90%, Central Venous Catheters 88%, prevention of Ventilator Associated Pneumonia 91%, Renal Dialysis catheters 100% and prevention of Surgical Site Infection 72%. Audit results were fed back monthly. Action plans were sent to sisters/ charge nurses in areas with scores below 80%, to action learning outcomes and return the completed plan to IP&C. Work is on-going to encourage ownership and make changes in practice particularly in relation to consistent documentation.
Audit of Electronic Discharge Letters of Patients who had C-Diff	This audit was undertaken to demonstrate whether a patient with confirmed C. difficile infection has this on their Electronic Discharge Letter (EDL) / death notification. The audit found that 2.6% did not have an EDL and 7.9% of EDLs did not mention C. difficile of these 6.9% were death notifications. A letter is sent to the consultant in charge of the patient asking for the EDL to be updated where required following the audit checks.
Infection Prevention and Control: Surveillance Audit of Central Venous Catheter Infection rates in adults outside Critical Care Complex	This surveillance was undertaken to determine the blood stream and exit site infection rates for adults with central lines in place for 48 hours or more (excluding the Critical Care Complex). In quarter 1 there were no infections and in quarter 2 the rate was 0.55 per 1000 line days, well below the Matching Michigan bench mark of 1.4 per 1000 line days. Results are fed back quarterly on the IP&C monthly report and at training sessions as part of a session for trained nurses that aims to prevent complications with central venous catheters.
Infection Prevention and Control: Surgical Site Infection Surveillance Audit (Vascular and Caesarean Section)	This surveillance was undertaken utilising Public Health England (PHE) protocol for Surveillance of Surgical Site Infection (SSI) 2013 to provide a surveillance programme designed for the NNUH. These surveillance programmes provide quarterly reports of infection rates to the departments involved. This programme aims to promote good practice and reduce SSI rates. Vascular SSI rates to date have reduced from 7.3% at the beginning of 2016/17 to 2.9%. SSI rates following C section have remained between 3.4% and 4.8% over this period.
Audit of methicillin-resistant staphylococcus aureus (MRSA) (hospital acquired) infections and screening for MRSA	This audit was undertaken to demonstrate the timely identification of patients found to be MRSA positive. It also aims to determine the number of hospital acquired cases of MRSA and the number of patients screened correctly. It is in line with the Trust guideline for MRSA screening. The audit demonstrates that the elective screening average is 98% and the emergency screening average is 95% for the Trust.
Audit of Compliance to Trust Isolation Policy	This annual audit was undertaken to determine whether patients are isolated in accordance with the isolation policy. It also provides information on the reasons for side room use. It demonstrated that 33.3% of the side rooms were used for IP&C reasons. There were 6 patients requiring isolation that were placed in a bay. A priority table for isolation is available in the Isolation Policy.

Infection Prevention and Control: Audit of Trust Commodes	This audit was undertaken to demonstrate that all surfaces of the commode are visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages. It also monitors evidence of cleaning with time, date & signature in line with the Trust Guideline for Cleaning and Disinfection in the hospital. The audit found an average of 93% compliance. AMUM and JPU results have been 100% for over 3 years. Following the audit, results are fed back and ward sisters/charge nurses are asked to action learning outcomes. Training is provided if required. Results are also available on the Nursing Dashboard.
Audit of Compliance to Consent Policy	This audit was undertaken to establish the level of compliance with the completion of the consent forms and to ascertain the types of information being recorded. The results demonstrated that there has been an overall improvement in the completion of the Consent forms. There is some additional work on-going to determine that all consent forms are in the new approved template. As a result of the audit, support is offered to transcribe procedure specific consent forms onto the new template as identified. Further review of the new consent template and compliance with completion will be monitored during on-going annual audits.
Audit of Health Record-Keeping Standards	This was a detailed re-audit of compliance with the Nursing and Patient Care Record (PCR) documentation undertaken in September 2016. During this audit 446 PCRs, Discharge Checklists and Nursing Assessments and Plans of Care were reviewed and a very 'literal' assessment made of compliance with documentation was undertaken by the Clinical Audit & Improvement Department team. Overall compliance remains within a 5% variance from 2015 on each of the standards. The results of the audit were disseminated to senior clinical staff within the Trust and the Clinical Safety Sub-Board. Each clinical area is expected to undertake an audit in relation to their documentation in the 17/18 audit cycle.
Audit of Compliance to Discharge Policy	An audit of compliance with the completion of the Home Circumstances and Discharge documentation demonstrated little improvement from that undertaken the previous year. The results have been collated and presented by individual ward area as a means of effecting improved performance. The results have been disseminated to all clinical leads. Next year each area will undertake their specific audit of documentation.
Audit of Slips, Trips and Falls (Patients)	A total of 446 Nursing and Patient Care Records were audited in September 2015. The audit demonstrated that overall performance has improved from 74% to 91% in relation to documentation of falls risk assessments in nursing documentation. The results were disseminated to all relevant leads and clinical staff for review and action in their areas if required. A re-audit will be undertaken in 2017/18 to continue to assess compliance.
Clinical Incidents, Complaints and Claims	Clinical incidents, complaints and claims have been regularly reported via our established governance assurance committees and reviewed in order to identify themes. Lessons learned have been disseminated to staff as per our relevant policies. An opportunity to improve communication with our patients has been a predominant theme and has helped inform a number of improvement projects.
Re-Audit of Inoculation Incidents	An audit was carried out during February 2016 to establish compliance with two elements of an action plan arising from a Health and Safety Executive visit in September 2015. At this time the Trust was issued with a Notice of Contravention of Health and Safety (Sharps Instruments in Healthcare) Regulations 2013. The audit found that compliance with the investigation process was good. There was only one anomaly which had occurred when an incident was reclassified. Compliance with the insulin safety devices was poor. The audit was repeated in May 2016 and this demonstrated greater availability of devices (compliance increased from 52% to 69%) and more awareness of their usage. As some wards still did not have the safety syringe this was followed up and rechecked in June when 100% compliance was achieved. There continue to be injuries whilst using insulin pen devices and these are monitored by H&S Lead Advisor and the Incident inoculation group and investigated accordingly.
Audit of Duty of Candour	This audit was undertaken to assess compliance with Duty of Candour (DoC) statutory obligations. The audit found that Duty of Candour actions were reported by clinicians and nursing staff to be fulfilled; however copies of letters to patients/ relatives were not placed in patient notes in all cases. Following the audit the process for tracking and escalating Duty of Candour has been reviewed and enhanced. A re-audit of compliance is planned for 17/18.
Qualitative Audit of Patient Transfers	The aim of this audit was to establish reasons for multiple patient moves as indicated from our Patient Administration System. Ward to ward transfers were deemed to be for clinical reasons (to appropriate specialty), with step-downs prior to discharges and transfers for dialysis a theme within those with multiple transfers.

Audit of Resus Equipment	The audit was undertaken to determine the process for checking emergency resuscitation equipment and to review the compliance of checks. The results found that there was no standard checklist and that bespoke checklists had been developed without formal ratification. As a result of this audit, a standard equipment checklist template has been developed along with a Standard Operating Procedure for the checking of emergency equipment, these were approved by the Recognise and Respond Committee and are now being used.
Audit of Oxygen and Suction	The audit was undertaken to determine the process for checking oxygen and suction equipment and to review the compliance of checks. The results found that there was no standard checklist and that bespoke checklists had been developed without formal ratification. As a result of this audit, a standard equipment checklist template has been developed along with a Standard Operating Procedure for the checking of emergency equipment, these were approved by the Recognise and Respond Committee and are now being used.
Audit of Glucose Monitoring	The audit was undertaken to determine the process for checking hypoglycaemia boxes and to review the compliance of checks. The results found that there was no standard checklist and that bespoke checklists had been developed without formal ratification. As a result of this audit, a standard equipment checklist template has been developed along with a Standard Operating Procedure for the checking of emergency equipment, these were approved by the Recognise and Respond Committee and are now being used.
Early Warning Score Observation Documentation, and Early Warning Score Response Audit	Quarterly audits of a small sample triggering episodes continue to be undertaken by the Critical Care Outreach Team (CCOT), to look at the response to Early Warning Score triggers ≥4, by adult wards. Real time feedback was given to ward staff by the CCOT when undertaking audits to determine omissions were dealt with by senior nursing staff. Results reported to the Clinical Safety Sub Board and appeared on the Matrons dashboard. Main area requiring improvement was the initial repeating of observations within 60 minutes timeframe. Improvements implemented, assisted and maintained by the EWS Links (health care assistants and registered nurses) and CCOT nurses.
Do Not Attempt Cardio Pulmonary Resuscitation Documentation Audit	This audit was undertaken to monitor compliance with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) processes at the NNUH. The results demonstrated that there was an overall improvement in compliance with respect to – consultant countersignature within 24 hours (51%), non-cognitive patients with documented discussion with relatives (83%), decision discussed with cognitive patients (94%). As a result of the audit it was decided to separate the DNACPR Policy from the overall resuscitation policy and to revise our Patient Care record (PCR) to specifically record whether the patient had capacity to be involved in making the DNACPR decision. This aspect of our PCR had been criticised in the CQC report. The revised policy and PCR were implemented in January 2017.
Audit of Local Induction of Temporary Staff	This audit is an on-going audit and is undertaken to determine that induction of all temporary staff is completed and recorded. The results are reported to the Workforce Sub-Board monthly. The results are discussed and any actions required to improve compliance are undertaken. A new Workplace Induction checklist has now been developed to help improve the experience for new starters and to increase completion rates.
Audit of Mental Capacity Act - Staff Feedback	This audit was undertaken to collect staff feedback in relation to their views of the treatment provided to patients with Learning Disabilities in the Trust. The small number of results received was insufficient to be considered representative of the Trust. Therefore, alternative methods to increase the response rate and to increase the profile and awareness of the subject matter were explored with further data collection planned for 2017/18.
Audit of Local Induction of Permanent Staff	This audit is an on-going audit and is undertaken to determine all new permanent staff complete local induction within 8 weeks of starting and that this is recorded. The results are reported to the Workforce Sub-Board monthly. The results are discussed and any actions required to improve compliance are undertaken. A new Workplace Induction checklist has now been developed to help improve the experience for new starters and to increase completion rates.

Audit of Stress	This audit was undertaken to demonstrate how workplace stressors are identified within the organisation. The audit found that these are being identified in line with the stress at work policy. Trends are reported monthly to workforce sub board and quarterly to Health and Safety committee – it has been noted that the reasons for work related stress have altered in this last year. Predominantly relationship issues in the workplace and change have been cited. Change is a new area of concern for our organisation and reflects the impact of ward changes that occurred in the autumn months. The relationship issues are often linked to the relationship with managers. Line manager training is being introduced. The previous audit identified that Workplace Health and Well Being do not always receive copies of the individual stress risk assessment when requested following a referral. A system to chase these from managers has been instigated – this has improved over the last year. To date we are 75% compliant.

Annex 1 - Statements from Clinical Commissioning Boards, Local Healthwatch organisations and Overview and Scrutinty

Statement from NHS North Norfolk CCG

Commissioner response to: The Norfolk and Norwich University Hospital Trust Quality report 2016/17

North Norfolk Clinical Commissioning Group (The CCG) as the coordinating commissioning organisation for The Norfolk and Norwich University Trust (The Trust) on behalf of Norfolk CCG's confirm that the NNUHFT have consulted and invited comment on their Quality Report for 2016/17.

The CCG have reviewed the report and agree that it meets the required mandated elements and to the best of our knowledge confirm that this provides an accurate representation of the data, information, challenges and achievements experienced by the Trust within the past year.

Performance

As for most acute Hospital around the country 2016/17 has proved a challenging year for The Trust. Capacity and activity has continued to impact upon a number of constitutional performance targets. Focus upon recovery importantly remains upon achieving a minimum 4 hour wait within the Accident and Emergency department for 95% of patients, the delivery of 18 week referral to treatment time pathway and Cancer 62 day GP referral to treatment time targets.

In order to assure the safety of patients who are experiencing delays for treatment The Trust team alongside Norfolk CCG's have developed processes that support robust clinical review in order to monitor these areas of performance and safeguard patients who are or might become vulnerable while they wait for their treatment.

It is disappointing that breaches to these important targets continue. However it is recognised that The Trust undertakes to maintain clear clinical priority wherever necessary to ensure that patients with the greatest need, such as those with Cancer diagnosis, are prioritised for admission and treatment. However while clinical prioritisation is essential this does have further impact upon delays within the 18 week pathway and so throughout this coming year The CCG will increase their focus and support of The Trust in its work to meet and sustain these targets.

Quality of Care

The Trust has undertaken a range of quality initiatives throughout the year. Staff have shown great motivation to innovate and improve the services they offer to patients and receive a high-level of satisfaction from patients experience. Where this is not the case The Trust takes every opportunity to learn from complaints and patient feedback, striving to ensure that patient experience is a fundamental priority to care delivery.

Workforce
Recruitment remains an area of challenge for the Trust, this problem is reflected across other healthcare providers within Norfolk and indeed the country, however The Trust have looked at innovative ways to consider skill-mix of vacancies and improve and speed up recruitment processes.

The annual staff survey identified some areas of staff experience which still requires improvement. The Trust have developed an excellent programme of Wellbeing initiatives for staff in the coming year which will aim to recognise the hard work and commitment of the team while improving work/life balance opportunities for individuals. It is hoped that these improvements will be well reflected within the Staff Survey for 17/18.

The CCG will continue to work with clinicians and managers within The Trust and alongside patients who use the service in order to improve the quality, safety and effectiveness of care wherever possible. This quality report demonstrates the commitment of The Trust to ensure that quality and patient safety remains its key priority over the coming year.

Mark Burgis
Chief Operating Officer
NHS North Norfolk CCG
5th May 2017

Statement from Norfolk Health Overview and Scrutiny Committee

None received.

Statement from Healthwatch Suffolk

None received.

Statement from Healthwatch Norfolk

None received.

Statements from Governors

Hi Mark

I am responding to your request for comments re. the 2016/2017 Quality report, and have a few observations to make as follows:-

Your introductory statement is dated 31 April, and there is a mistake in the third paragraph which I think should read .....now (the) and in the future.

On page 10 the heading for the next section is included at the bottom of the page.

No doubt these small errors would have been picked up in final checks, but wanted to mention as proof that I've had a "good read".

Grateful for the opportunity to read and comment, and commend those contributing to such a comprehensive document for their hard work and diligence.

Kind Regards

Brian Cushion, 08 April 2017

This report has been read by Nina Duddleston and apart from a typing error in the introduction from Mark Davies (on the start of the third line under the photograph of Mark) a few other spelling mistakes already underlined in red in the main report and the need to enter figures in graphs I have no further comment to make on this excellent detailed report.

Nina Duddleston, 11 April 2017

Dear Mark,

Apologies for my tardiness. I have read the report which is a huge piece of work for you all but essential in order to monitor the work of the NNUH going forward.

These are my comments:

There are several figures/diagrams missing from the document and certain sums of money appear as XXs in the version we have which I assume are being sorted out.

In the section, page 16, on Dementia Screening - how did we do - there is a sentence which reads "we have been achieved 90%" which needs changing. In the section on dementia it mentions Admin Staff doing the initial Dementia screen. Are these staff fully trained to do this? As only as a result of the initial screening will a full assessment be offered. To miss someone in the early stages of dementia who could be helped would be very disappointing.

EDLs - we are told the level of letters sent out is disappointing.

Then page 17, under AKIs we are told that there will be leaflets included with the EDLs for GPs. As not enough EDLs are being sent out is this the best way to get information to the GPs?

Page 18 Paragraph before fig 8 lots of ??s.

Page 25, Figure 11. There is the number 21 printed in red against Endocrine & Thyroid. Not sure if it should be in red? Is correct?

Page 34, Patient Safety - Duty of Candour. 3rd paragraph, 1st sentence does not make sense " All moderate harm or above severity incidents which are reported an Datix are"

Page 34, Never Events. These are obviously scary but human error is so hard to control. Silly comment possibly but are not all sites for surgery marked with a pen on the patient?

Page 34, Figure 18 Elective Capacity - waiting list backlog. It is suggested that there will be a return to compliance by Oct 2018. Are we really confident this is possible given the situation and demand going forward?

Page 43. Stranded Patients. Having spent a day shadowing the Discharge Matron Danny, I can only applaud the results that have been achieved in this area by the introduction of the Discharge Hub and Ward Co-ordinators. I know there is further work planned.

Page 62, Audit of Wandsworth Call Bell. The comments against this seem woolly in the extreme. The audit was done but what the results were is not clear. We all know this can be an issue on certain wards and this appears to be glossed over.

I don't know if these comments are what you need. Use or not as you see fit.

Best Wishes

Erica Betts, 9th May 2017

Annex 2 - Statement of Directors' responsibilities in respect of the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2016 to March 2017
    - papers relating to quality reported to the board over the period April 2016 to March 2017
    - feedback from commissioners dated 05/05/2017
    - feedback from governors dated 08/04/2017, 11/04/17 and 09/05/2017
    - feedback from local Healthwatch organisations – none received
    - feedback from Overview and Scrutiny Committee – none received
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29/07/2016, 27/20/2016 and 27/04/2017
    - the 2016 national patient survey, published May 2016
    - the 2016 national staff survey, published February 2017
    - the Head of Internal Audit's annual opinion of the trust's control environment dated 15/03/2017
    - CQC inspection report dated 16/03/2016
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

26/5/17 .....Date..... .....Chairman

26/5/17 .....Date..... .....Chief Executive

Annex 3 - Independent Auditor Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Norfolk and Norwich University Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Norfolk and Norwich University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge.

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

Respective responsibilities of the directors and auditors

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

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2016/17* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17.*

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

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

- Board minutes and papers for the period April 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners;
- feedback from governors;
- feedback from local Healthwatch organisations;

- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the national patient survey;
- the national staff survey;
- Care Quality Commission Inspection, dated 16 March 2016;
- the 2016/17 Head of Internal Audit's annual opinion over the trust's control environment; and
- any other information included in our review.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Norfolk and Norwich University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Norfolk and Norwich University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Norfolk and Norwich University Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

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

KPMG LLP

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

26 May 2017

Annex 4 - Mandatory performance indicator definitions

The following indicator definitions are based on Department of Health guidance, including the 'NHS Outcomes Framework 2016/17 Technical Appendix' (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385751/NHS_Outcomes_Tech_Appendix.pdf)

Where the HSCIC Indicator Portal does not provide a detailed definition of the indicator this document continues to use older sources of indicator definitions.

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

Source of indicator definition and detailed guidance
The indicator is defined in the technical definitions that accompany Everyone counts: planning for patients 2014/15-2018/19 at www.england.nhs.uk/wpcontent/uploads/2014/01/ec-tech-def-1415-1819.pdf

Detailed rules and guidance for measuring referral to treatment (RTT) standards are at www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

Detailed descriptor
EB3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

Numerator
The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks

Denominator
The total number of patients on an incomplete pathway at the end of the reporting period

Accountability Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wpcontent/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution Measures).

Indicator format
Reported as a percentage

Source of indicator definition and detailed guidance

Source of indicator definition and detailed guidance
The indicator is defined in the technical definitions that accompany Everyone counts: planning for patients 2014/15 - 2018/19 at www.england.nhs.uk/wpcontent/uploads/2014/01/ec-tech-def-1415-1819.pdf

Detailed rules and guidance for measuring A&E attendances and emergency admissions are at www.england.nhs.uk/statistics/wpcontent/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0- Final.pdf

Additional information
Paragraph 6.8 of the NHS England guidance referred to above gives further guidance on inclusion of a type 3 unit in reported performance.

Numerator
The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

Calculated as: (Total number of unplanned A&E attendances) – (Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge)

Denominator
The total number of unplanned A&E attendances

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at:
www.england.nhs.uk/wpcontent/uploads/2013/12/5yr-strat-plann-guid-wa.pdf
(see Annex B: NHS Constitution Measures).

Indicator format
Reported as a percentage

Referral to Treatment Pathways

Source of indicator definition and detailed guidance
The indicator is defined within the document 'Technical Definitions for Commissioners' https://www.england.nhs.uk/wp-content/uploads/2015/02/6-tech-defi-comms-0215.pdf.

Detailed Descriptor:
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways, completed non-admitted pathways and incomplete pathways.

Lines Within Indicator (Units):
E.B.1: The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period, on an adjusted basis.
E.B.2: The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period.
E.B.3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.

Data Definition:
A calculation of the percentage within 18 weeks for completed adjusted admitted RTT pathways, completed non-admitted RTT pathways and incomplete RTT pathways based on referral to treatment data provided by NHS and independent sector organisations and signed off by NHS commissioners.
The definitions that apply for RTT waiting times are set out in the RTT Clock Rules Suite found here: https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks.
Guidance on recording and reporting RTT data can be found here: http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

Monitoring Frequency: Monthly

Monitoring Data Source: Consultant-led RTT Waiting Times data collection (National Statistics)

What success looks like, Direction, Milestones:
Performance will be judged against the following waiting time standards:-
· Admitted operational standard of 90% – the percentage of admitted pathways (on an adjusted basis) within 18 weeks should equal or exceed 90%
· Non-admitted operational standard of 95% – the percentage of non-admitted pathways within 18 weeks should equal or exceed 95%
· Incomplete operational standard of 92% – the percentage of incomplete pathways within 18 weeks should equal or exceed 92%

Timeframe/Baseline: Ongoing

Rationale:
The operational standards that:
- 90% of admitted patients and 95% of non-admitted patients should start treatment within a maximum of 18 weeks from referral; and,
- 92% of patients on incomplete pathways should have been waiting no more than 18 weeks from referral.

These RTT waiting time standards leave an operational tolerance to allow for patients who wait longer than 18 weeks to start their treatment because of choice or clinical exception. These circumstances can be categorised as:
- Patient choice - patients choose not to accept earliest offered reasonable appointments along their pathway or choose to delay treatments for personal or social reasons
- Co-operation - patients who do not attend appointments that they have agreed along their pathways
- Clinical exceptions - where it is not clinically appropriate to start a patient's treatment within 18 weeks

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Detailed descriptor[1]
PHQ03: Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

Data definition
All cancer two-month urgent referral to treatment wait

Numerator
Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Denominator
Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at:
www.england.nhs.uk/wpcontent/uploads/2013/12/5yr-strat-plann-guid-wa.pdf
(see Annex B: NHS Constitution Measures).

1 Cancer referral to treatment period start date is the date the acute provider receives an urgent (twoweek wait priority) referral for suspected cancer from a GP and treatment start date is the date first definitive treatment starts if the patient is subsequently diagnosed. For further detail refer to technical guidance at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131 880

Emergency re-admissions within 28 days of discharge from hospital[2]

Indicator description
Emergency re-admissions within 28 days of discharge from hospital

Indicator construction
Percentage of emergency admissions to a hospital that forms part of the trust occurring within 28 days of the last, previous discharge from a hospital that forms part of the trust

Numerator
The number of finished and unfinished continuous inpatient spells that are emergency admissions within 0 to 27 days (inclusive) of the last, previous discharge from hospital (see denominator), including those where the patient dies, but excluding the following: those with a main speciality upon re-admission coded under obstetric; and those where the re-admitting spell has a diagnosis of cancer (other than benign or in situ) or chemotherapy for cancer coded anywhere in the spell.

Denominator
The number of finished continuous inpatient spells within selected medical and surgical specialities, with a discharge date up to 31 March within the year of analysis. Day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded. Patients with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days before admission are excluded.

Indicator format
Standard percentage

More information
Further information and data can be found as part of the HSCIC indicator portal.

2 This definition is adapted from the definition for the 30 days re-admissions indicator in the NHS Outcomes Framework 2013/14: Technical Appendix. We require trusts to report 28-day emergency re-admissions rather than 30 days to be consistent with the mandated indicator requirements of the NHS (Quality Accounts) Amendment Regulations 2012 (S.I. 2012/3081).

Minimising delayed transfer of care

Detailed descriptor
The number of delayed transfers of care per 100,000 population (all adults, aged 18 plus).

Data definition
Commissioner numerator_01: Number of Delayed Transfers of Care of acute and non-acute adult patients (aged 18+ years)
Commissioner denominator _02: Current Office for National Statistics resident population projection for the relevant year, aged 18 years or more
Provider numerator_03: Number of patients (acute and non-acute, aged 18 and over) whose transfer of care was delayed, averaged over the quarter. The average of the three monthly SitRep figures is used as the numerator.
Provider denominator_04: Average number of occupied beds[3]

Details of the indicator
A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.
A patient is ready for transfer when:
[a] a clinical decision has been made that the patient is ready for transfer AND
[b] a multidisciplinary team decision has been made that the patient is ready for transfer AND
[c] the patient is safe to discharge/transfer.
To be effective, the measure must apply to acute beds, and to non-acute and mental health beds. If one category of beds is excluded, the risk is that patients will be relocated to one of the 'excluded' beds rather than be discharged.

Accountability
The ambition is to maintain the lowest possible rate of delayed transfers of care.
Good performance is demonstrated by a consistently low rate over time, and/or by a decreasing rate. Poor performance is characterised by a high rate, and/or by an increase in rate.

Detailed guidance and data
Further guidance and the reported SitRep data on the monthly delayed transfers of care can be found on the NHS England website.[4]

3 In the quarter open overnight.
4 /www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

C. difficile[5]

Detailed descriptor
Number of Clostridium difficile (C. difficile) infections, as defined below, for patients aged two or over on the date the specimen was taken.

Data definition
A C. difficile infection is defined as a case where the patient shows clinical symptoms of C. difficile infection, and using the local trust C. difficile infections diagnostic algorithm (in line with Department of Health guidance), is assessed as a positive case. Positive diagnosis on the same patient more than 28 days apart should be reported as separate infections, irrespective of the number of specimens taken in the intervening period, or where they were taken. In constructing the C. difficile objectives, use was made of rates based both on population sizes and numbers of occupied bed days. Sources and definitions used are:
For acute trusts: The sum of episode durations for episodes finishing in 2010/11 where the patient was aged two or over at the end of the episode from Hospital Episode Statistics (HES).

Basis for accountability
Acute provider trusts are accountable for all C. difficile infection cases for which the trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one). To illustrate:
• admission day; • admission day + 1; • admission day + 2; and
• admission day + 3 – specimens taken on this day or later are trust apportioned.

Accountability
The approach used to calculate the C. difficile objectives requires organisations with higher baseline rates (acute trusts and primary care organisations) to make the greatest improvements in order to reduce variation in performance between organisations. It also seeks to maintain standards in the best performing organisations. Appropriate objective figures have been calculated centrally for each primary care organisation and each acute trust based on a formula which, if the objectives are met, will collectively result in a further national reduction in cases of 26% for acute trusts and 18% for primary care organisations, whilst also reducing the variation in population and bed day rates between organisations.

Timeframe/baseline
The baseline period is the 12 months, from October 2010 to September 2011. This means that objectives have been set according to performance in this period.

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5 The QA Regulations requires the C. difficile indicator to be expressed as a rate per 100,000 bed days. If C. difficile is selected as one of the mandated indicators to be subject to a limited assurance report, the NHS foundation trust must also disclose the number of cases in the quality report, as it is only this element of the indicator that we intend auditors to subject to testing.

Percentage of patient safety incidents resulting in severe harm or death[6]

Indicator description

Patient safety incidents (PSIs) reported to the *National Reporting and Learning Service (NRLS),* where degree of harm is recorded as 'severe harm' or 'death', as a percentage of all patient safety incidents reported.

Indicator construction

Numerator: The number of patient safety incidents recorded as causing severe harm /death as described above.

The 'degree of harm' for PSIs is defined as follows;

'severe' – the patient has been permanently harmed as a result of the PSI, and

'death' – the PSI has resulted in the death of the patient.

Denominator: The number of patient safety incidents reported to the *National Reporting and Learning Service (NRLS).*

Indicator format:

Standard percentage.

6 This definition is adapted from the definition for the 30days readmissions indicator in the NHS Outcomes Framework 2012/13: Technical Appendix

Financial Statements

FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 MARCH 2017

Contents

KPMG

Independent auditor's report

to the Council of Governors of Norfolk and Norwich University Hospitals NHS Foundation Trust only

Opinions and conclusions arising from our audit

1. Our opinion on the financial statements is unmodified

We have audited the financial statements of Norfolk and Norwich University Hospitals NHS Foundation Trust for the year ended 31 March 2017 set out on pages 7 to 44. In our opinion:

- the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2017 and of the Trust's income and expenditure for the year then ended;
- the financial statements have been properly prepared in accordance with the Department of Health's Group Accounting Manual 2016/17.

Overview	
KPMG LLP first appointed for 2016/17	
Materiality Financial statements taken as a whole	£11.3m 2% of income from operations
For accruals, deferred income and provisions	£6.7m as this is a first year audit
Risks of material misstatement	
Risks	Valuation of land and buildings
	Recognition of NHS and non-NHS income
	Going concern

2. Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements, the risks of material misstatement that had the greatest effect on our audit, in decreasing order of audit significance, were as follows:

	The risk	Our response
Property, plant and equipment Property, plant and equipment: £234 million; 2016/16: £284 million) – of which £214 million; 2016/16: £263 million relate to land and buildings. *Refer to note 1.6 (accounting policy) and note 15 (financial disclosures).*	**Valuation of land and buildings:** Land and buildings are required to be held at fair value. The Trust's main land and buildings relate to a hospital built under the Public Finance Initiative (PFI) at Colney Lane, Norwich. 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. In 2016, the Trust's land and buildings were revalued by the Trust's external valuer, Boshier & Co. In 2017, the director's obtained a letter from Boshier & Co that indicated a decrease in property value indices which the Trust has applied and recognised as an impairment of £60 million. In addition, the Trust obtained an interim valuation of its PFI hospital which in accordance with the Department of Health's GAM reflects the recovery of VAT that would be expected on a fully managed and serviced PFI. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied.	Our procedures included: — **External valuer:** We assessed the qualifications and experience of Boshier & Co, to ensure they were appropriately experienced and qualified to undertake the valuation; — **PFI Valuation:** We checked that the valuation provided by the external valuer was prepared in line with our expectations based on our knowledge of the client and experience of the industry in which it operates. We checked that the estate base data provided to the valuer, was consistent with the estate records held by the Trust; and — **Remaining estate:** We checked the impairment calculation had correctly applied the indices provided by the external valuer.
NHS and non-NHS income and receivables Income: £664 million; 2016/16: £642 million. Current receivables: £22 million; 2016/16: £24 million. *Refer to note 1.3 (accounting policy) and notes 3, 4 and 18 (financial disclosures).*	**Recognition of NHS and non-NHS income:** £480 million (86%) of the Trust's income came from commissioners (Clinical Commissioning Groups (CCGs) and NHS England). The majority of this income is contracted on an annual basis, however actual achievement is based on completing the planned level of activity. 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. Contractual arrangements between the Trust and commissioners set out processes for agreeing disputes. An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances from each party in transactions and variances over £250,000 are required to be reported to the National Audit Office to inform the audit of the Department of Health consolidated accounts. The Trust reported income of £81m from other activities, primarily education and training, research and development, or other activities. There is a greater risk that the income has not been recognised under the accruals basis, and instead on a cash basis.	Our procedures included: — **Contract agreement:** We confirmed that signed contracts were in place for the largest commissioners of the Trust; — **Agreement of balances:** We obtained the outcome of the agreement of balances exercise with other NHS bodies. Where there were mismatches over £250,000 we sought explanations and supporting evidence from the director's of the level of income they were entitled to. In particular, we challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rational for the accounting treatments adopted. In doing so, we discussed the status of differences, reviewed correspondence with commissioners, and whether the matter had been referred to NHS England for local dispute resolution; and — **Other income:** We tested a sample of income from other activities to supporting documentation and/or cash receipts.
Going Concern *Refer to note 1.*	**Going concern:** Under guidance from the Department of Health the financial statements 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 and funding:** We obtained the financial plans for 2017/18 and 2018/19 and ascertained the expected future funding support required from the Department of Health and confirmed that this had been secured; — **Future income:** We obtained copies of signed contracts from the Trusts largest commissioners for 2017-19 and agreed these to the financial plans for 2017/18 and 2018/19; and — **Board paper on Going Concern:** We critically assessed the Trust's Board paper on Going Concern and the assumptions and sensitivities within this to ensure that the Going Concern basis and related disclosures within the financial statements were appropriate.

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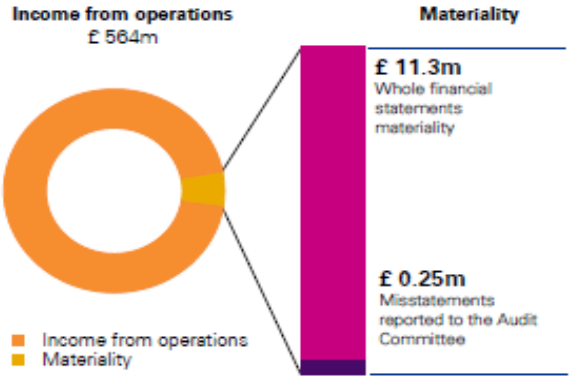
3. Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £11.3 million, determined with reference to a benchmark of income from operations (of which it represents approximately 2%). We consider income from operations to be more stable than a surplus-related benchmark. As this is a first year audit, we applied a lower materiality of £6.7 million to accruals, deferred income and provisions.

We report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £260,000, in addition to other identified misstatements that warrant reporting on qualitative grounds.



4. Our opinion on other matters prescribed by the Code of Audit Practice is unmodified

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2016/17; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5. We have nothing to report in respect of the matters on which we are required to report by exception

We are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the Annual Report and financial statements taken as a whole is fair, balanced and understandable; or
- the Audit Committee's commentary of the Annual Report does not appropriately address matters communicated by us to the Audit Committee.

Under the Code of Audit Practice we are required to report to you if, in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17, 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.

In addition we are required 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 respect of the above responsibilities.

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6. Other matters on which we report by exception – adequacy of arrangements to secure value for money

Under the Code of Practice we are required to report to you if we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

Our review of the Trust's arrangements identified the following issues:

- Since April 2016 the Trust has agreed legally binding steps, known as "enforcement undertakings", with Monitor (now NHS Improvement) to reduce its waiting times for A&E, routine operations and cancer care patients. Monitor also added an additional condition on the Trust's licence, requiring improvement in the effectiveness of the Trust's Board and governance arrangements. At the date of this report, the enforcement undertakings and conditions placed on the Trust's licence remain in force.
- In March 2016, the Care Quality Commission rated the Trust overall as "requires improvement" following its full inspection of the Trust. The Trust is currently awaiting the results of a CQC re-inspection performed in March 2017.
- In August 2016 NHS Improvement placed the Trust in Financial Special Measures (FSM). In February 2017 NHS Improvement took the Trust out of FSM as the Trust successfully met the criteria to exit financial measures.
- The Trust incurred a deficit of £24.9 million in 2016/17.

As a result of these matters, we are unable to satisfy ourselves that Norfolk and Norwich University Hospitals NHS Foundation Trust made proper arrangements to secure, economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

7. We have completed our audit

We certify that we have completed the audit of the accounts of Norfolk and Norwich University Hospitals 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.

Scope and responsibilities

As described more fully in the Statement of Accounting Officer's Responsibilities the accounting officer is responsible for the preparation of financial statements that give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors. A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its 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 its 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 its 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, as to whether the Trust has 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. Based on our risk assessment, we undertook such work as we considered necessary.

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. 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 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.

S Beavis

Stephanie Beavis
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
Dragonfly House, 2 Guilders Way, Norwich, Norfolk, NR3 1UB

26 May 2017

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Foreword to the Accounts

These financial statements, for the year ended 31 March 2017, have been prepared by the Norfolk and Norwich University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed.....

Mark Davies
Chief Executive

Date: 26 May 2017

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2017

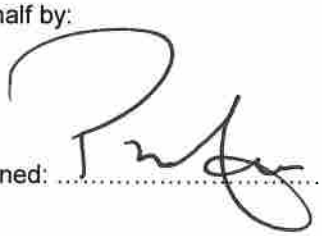
STATEMENT OF COMPREHENSIVE INCOME	Note	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Operating income	3	483,257	451,737
Other operating income	4	80,829	90,487
Operating expenses	6	(558,911)	(534,644)
OPERATING SURPLUS		**5,175**	**7,580**
FINANCE INCOME AND EXPENSES			
Finance income	12	60	231
Finance expense - financial liabilities, including unwinding of discount on provisions	14	(28,625)	(27,876)
PDC Dividends payable	28	(1,470)	(1,869)
NET FINANCE COSTS		**(30,035)**	**(29,514)**
(DEFICIT) FOR THE YEAR		**(24,860)**	**(21,934)**
Other comprehensive income			
Revaluation (Losses) on property, plant and equipment	15	(49,655)	(1,930)
TOTAL COMPREHENSIVE (EXPENSE) FOR THE YEAR		**(74,515)**	**(23,864)**

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2017

STATEMENT OF FINANCIAL POSITION	Note	31 March 2017 £'000	31 March 2016 £'000
Non-current assets			
Property, plant and equipment	15	234,212	283,708
Trade and other receivables	18	64,502	63,870
Total non-current assets		**298,714**	**347,578**
Current assets			
Inventories	17	8,404	8,434
Trade and other receivables	18	21,901	23,568
Cash and cash equivalents	19	15,510	31,494
Total current assets		**45,815**	**63,496**
Current liabilities			
Trade and other payables	20	(62,469)	(55,729)
Other liabilities	22	(14,942)	(24,512)
Borrowings	21	(3,149)	(3,522)
Provisions	25	(328)	(861)
Total current liabilities		**(80,888)**	**(84,624)**
Total assets less current liabilities		**263,641**	**326,450**
Non-current liabilities			
Trade and other payables	20	(331)	(815)
Other liabilities	22	(1,328)	(2,433)
Borrowings	21	(212,704)	(199,411)
Provisions	25	(2,842)	(2,852)
Total non-current liabilities		**(217,205)**	**(205,511)**
Total assets employed		**46,436**	**120,939**
Financed by (taxpayers' equity)			
Public dividend capital		25,117	25,105
Revaluation reserve		15,025	65,621
Income and expenditure reserve		6,294	30,213
Total taxpayers' equity		**46,436**	**120,939**

The financial statements on pages 7 to 44 were approved by the Board on 26th May 2017 and signed on its behalf by:



Signed: .....(Chief Executive) Date: 26 May 2017

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total Taxpayers' Equity
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016	**25,105**	**65,621**	**30,213**	**120,939**
Deficit for the year	0	0	(24,860)	**(24,860)**
Other transfers between reserves	0	(941)	941	**0**
Revaluations	0	(49,655)	0	**(49,655)**
Public dividend capital received	12	0	0	**12**
Taxpayers' equity at 31 March 2017	**25,117**	**15,025**	**6,294**	**46,436**

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2016

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total Taxpayers' Equity
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2015	**25,090**	**67,918**	**51,780**	**144,788**
Deficit for the year	0	0	(21,934)	**(21,934)**
Other transfers between reserves	0	(367)	367	**0**
Revaluations	0	(1,930)	0	**(1,930)**
Public dividend capital received	15	0	0	**15**
Taxpayers' equity at 31 March 2016	**25,105**	**65,621**	**30,213**	**120,939**

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2017

	Note	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Cash flows from operating activities			
Operating surplus		5,175	7,580
Operating surplus		**5,175**	**7,580**
Non-cash income and expense:			
Depreciation	6	12,161	13,843
Loss on disposal of non-current assets		26	63
Non-cash donations credited to income		(170)	(492)
Decrease/(Increase) in receivables and other assets		2,647	(3,212)
Decrease/(Increase) in inventories		30	(190)
(Decrease) in payables and other liabilities		(3,830)	(12,516)
(Decrease) in provisions		(550)	(1,175)
Net cash generated from operations		**15,489**	**3,901**
Cash flows from investing activities			
Interest received	12	60	231
Purchase of property, plant, equipment and investment property		(13,372)	(13,291)
Sales of property, plant, equipment and investment property		56	9
Net cash used in investing activities		**(13,256)**	**(13,051)**
Cash flows from financing activities			
Public dividend capital received		12	15
Movement on loans from the Department of Health		16,000	0
Capital element of finance lease rental payments		(162)	(172)
Capital element of PFI, LIFT and other service concession payments		(3,360)	(3,541)
Interest paid on finance lease liabilities		(27)	(18)
Interest paid on PFI, LIFT and other service concession obligations		(28,562)	(27,824)
PDC dividend paid		(2,118)	(1,954)
Net cash used in financing activities		**(18,217)**	**(33,494)**
(Decrease) in cash and cash equivalents	19	(15,984)	(42,644)
Cash and Cash equivalents at start of the year	19	31,494	74,138
Cash and Cash equivalents at 31 March	19	**15,510**	**31,494**

The accompanying notes form an integral part of the Financial Statements

NOTES TO THE ACCOUNTS

1. Accounting Policies

Basis of Preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Going Concern

The Trust is forecasting a surplus of £3.6 million for 2017/18 following a reported deficit of £24.9 million in 2016/17 and a deficit of £21.9 million in 2015/16. The forecast surplus for 2017/18 is based on a number of assumptions, including the delivery of cost savings of £30.8 million. The Trust's forecast cash position as at 31 March 2018 is £14.5 million which assumes that the balance of the loan agreed with the Department of Health of £5.2m is received in April 2017, which it has been. Accordingly there is no uncertainty surrounding the required revenue support from the Department of Health. The forecast does assume a capital loan of £5.8 million to fund capital expenditure, which will be incurred in year. The Capital Loan has not been confirmed and in the event that it is delayed we consider that we can manage the timing difference through capital planning.

As part of reviewing the financial sustainability of the organisation, the Trust has considered the scale of the financial challenges facing the Trust over the next 12 month period, in particular the revenue cash support required. The funds required under our forecast plan are fully secured and received however, it is recognised that the plan contains demanding cost improvement targets and the commissioning landscape is and remains challenging. The directors have considered this risk and based on past experience and the vital role the hospital plays are confident that should additional support be required this would be made available. Our expectation is informed by the anticipated continuation of the provision of service in the future, as evidenced by inclusion of financial provision for that service in published documents. Contracts for Service, being the NHS Standard Contract 2017/19 have been signed with the Trust's main Commissioners.

Accordingly, after making enquiries, the directors have a reasonable expectation that the Norfolk and Norwich University Hospitals NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trust continues to adopt the going concern basis in preparing the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.1.1 Subsidiaries

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits.

1.1.2 Consolidation

The NHS foundation trust is the corporate trustee to Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

Prior to 2013/14, the FT ARM permitted the NHS foundation trust not to consolidate the charitable fund. Since 2013/14 the Trust has chosen not to consolidate the charitable fund on the basis it is not material.

1.2 Critical accounting judgements and key sources of estimation uncertainty

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

1.2.1 Critical judgements in applying accounting policies

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

1. Accounting Policies (Continued)

1.2.1 Critical judgements in applying accounting policies (continued)

An assessment of the Trust's PFI schemes was made as part of the IFRS transition in the 2009/10 accounts, and it was determined that the PFI scheme in respect of the main Hospital building should be accounted for as an on statement of position asset under IFRIC 12. This required judgements to be made in order to determine the required accounting treatment. The key judgements were to initially value the hospital at the cost of construction, to attribute an asset life of 70 years and to identify the components of the hospital subject to lifecycle maintenance, that should be accounted for separately. The annual contribution to lifecycle maintenance is treated as a non current prepayment until it is capitalised consistent with the operators schedule for replacement.

An interim valuation of the PFI hospital was performed by David Boshier as at 31 March 2017. Prior to this the last full market valuation of land and building assets was carried out by David Boshier (MRICS) of Boshier & Company Chartered Surveyors RICS and was applied on 31 March 2015 . The Trust has applied updated indices to the valuation and adjusted the carrying value for the other specialised buildings at 31 March 2017.

1.2.2 Key sources of estimation uncertainty

No key assumptions concerning the future have had to be made and there are no key sources of estimation uncertainty at the end of the reporting period. Therefore there is no significant risk of a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Estimations as to the recoverability of receivables and the valuation of inventories have been made in determining carrying amounts of those assets. Variation is not expected to be significant.

Judgement has also been used to determine the carrying value of provisions, deferral of income and accruals.

An estimate has also been used to determine total future obligations under PFI contracts as disclosed in note 24.2, in relation to future rates of inflation. This estimate does not affect the carrying value of liabilities in the Statement of Financial Position at 31 March 2017 or 31 March 2016, or the amounts charged through the Statement of Comprehensive Income.

Valuation of property has been made using BCIS indices and is updated regularly. Plant and equipment are valued at depreciated cost as described in notes 1.6 and 1.7. using esimated useful economic lives.

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. Income relating to patient care spells that are part-completed at the year end is apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay. Application of performance related fines by commissioners are accounted for in the period to which the fine relates.

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

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pensions Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.4 Employee Benefits

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 accounts to the extent that employees are permitted to carry-forward leave into the following period.

1.4.2 Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

1. Accounting Policies (Continued)

1.4.2 Retirement benefit costs (Continued)

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.

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.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5k; or
- Collectively, a number of items have a cost of at least £5k and individually have a cost of more than £0.25k, 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.

1.6.1 Valuation

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

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

- Land and non-specialised buildings and dwellings– market value for existing use
- Specialised buildings – depreciated replacement cost using the modern equivalent asset method

The Trust commissioned a revaluation of its estate as at 31 March 2015 and it was conducted by Mr David Boshier MRICS, of Boshier & Company Chartered Surveyors RICS. The revaluation basis for specialised building was for a Modern Equivalent Asset (MEA) on an existing site basis. Specialised buildings are valued on a Depreciated Replacement Cost basis.
Since then an interim valuation of the PFI Hospital Building was commissioned as at 31 March 2017 and conducted by Mr David Boshier MRICS. The basis of valuation was the same, however the valuation of the PFI asset was excluding VAT, to better reflect the cost of when the asset would be replaced by a PFI operator.
In between revaluations, consideration is given to market trends, supported by a review of the impact of applying nationally published and recognised indices, to assess whether an interim revaluation is required. The BCIS indices were used for this purpose in 2016/17, with the exception of the PFI Hospital assets as set out above.

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

Prior to 31 March 2008, plant and machinery, transport equipment, information technology and furniture and fittings were valued at replacement cost, as assessed by indexation and depreciation of historic cost. This ceased at 1 April 2008 when the nationally published indices were withdrawn. The carrying value of existing assets at that date are being written off over their remaining useful lives and new assets are carried at depreciated historic cost as this is not considered to be materially different from fair value.

1. Accounting Policies (Continued)

1.6.2 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'.

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.

1.7 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 and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

1.8 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.
The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.9 De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:
• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

• the sale must be highly probable i.e.:

- management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

1. Accounting Policies (Continued)

1.9 De-recognition (Continued)

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.10 Leases

1.10.1 Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

1.10.2 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.

1.10.3 The Trust as lessee

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

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

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

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

1.10.4 The Trust as lessor

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

1. Accounting Policies (Continued)

1.11 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as "on-Statement of Financial Position" by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment at their fair value, together with an equivalent PFI finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to 'Finance Costs' in the Statement of Comprehensive Income.

1.11.1 PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and is expensed in the Statement of Comprehensive Income. It is detailed in note 14 as a contingent finance cost.

1.11.2 Lifecycle replacement

Components of the asset scheduled to be replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. This charge is used to establish a prepayment to fund future replacement.

1.11.3 Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

1.11.4 Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.12 Off Statement of Financial Position PFI transactions

Where a PFI scheme fails to meet the requirements of IFRIC 12, it is accounted for off Statement of Financial Position as an operating lease.

1. Accounting Policies (Continued)

1.13 Inventories

Inventories are valued at the lower of cost and net realisable value using a first in first out basis. This is considered to be a reasonable approximation to fair value due to the high turnover of inventories. Provision is made, for slow moving, obsolete and defective inventories.

1.14 Cash and cash equivalents

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

1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

1.16 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 25 but is not recognised in the Trust's accounts.

1.17 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHSLA 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.

1.18 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 32, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 32 where an inflow of economic benefits is probable.

1.19 Financial instruments and financial liabilities

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

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.

1. Accounting Policies (Continued)

1.19.1 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.
Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.19.2 Classification and measurement

Financial assets are categorised as loans and receivables, whilst financial liabilities are classified as 'other financial liabilities'.

1.19.3 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.

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.

The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

1.19.4 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 profit and loss' 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.

A provision is made when there is uncertainty around the recoverability of a financial asset. At the point that it is determined that the amounts are unlikely to be recovered, the impairment is charged directly to the asset.

1.20 Financial liabilities

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

1.20.1 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.

1. Accounting Policies (Continued)

1.21 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Foreign currencies

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

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM. See note 30 to the accounts.

1.24 Public Dividend Capital (PDC) and PDC dividend

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 utilised 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, (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 of the audit of the annual accounts.

1.25 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on a cash basis with the exception of provisions for future losses.

1. Accounting Policies (Continued)

1.26 Accounting standards that have been issued but have not yet been adopted

IFRS 9 - ***Financial Instruments*** IFRS 9 reduced the number of classification categories and provided a clearer rationale for measuring financial assets. It also applied a single impairment method to all financial assets not measure at fair value and aligned the measurement attributes of financial assets with the way the entity manages its financial assets and their contractual cash flow characteristics. There is also guidance included for when part of a financial asset could be considered for derecognition. The derecognition principles should be applied to a part of a financial asset only if that part contained no risk or reward relating to the part not being considered for derecognition.	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 14 - ***Regulatory Deferral Accounts*** IFRS 14 Regulatory Deferral Accounts specifies the reporting requirements for regulatory deferral account balances that arise when an entity provides goods or services to customers at a price or rate that is subject to rate regulation.	Not yet EU-Endorsed* Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH group Bodies
IFRS 15 - ***Revenue from Contracts with Customers*** IFRS 15 establishes principles for reporting useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from an entity's contracts with customers. It is anticipated that additional disclosures around contracts will need to be made including performance related income contracts with the commissioners. However, no significant impact upon actual revenue recognition is expected. Depending on the type of arrangements entered into the future, assets and/or impairment losses may be recognised and disclosed	Application required for account periods beginning on or after 1 January 2018, but not yet adopted by the Frem: early adoption is not therefore permitted.
IFRS 16 - ***Leases*** IFRS 16 sets out the principles for the recognition, measurement, presentation and disclosure of leases for both parties to a contract, ie the customer ('lessee') and the supplier ('lessor').	Application required for account periods beginning on or after 1 January 2019, but not yet adopted by the Frem: early adoption is not therefore permitted.

* The European Financial Reporting Advisory Group recommended in October 2015 that the standard should not be endorsed as it is unlikely to be adopted by many EU countries.

1. Accounting Policies (Continued)

1.27 Accounting standards that have been early-adopted

No new accounting standards or revisions to existing standards have been early-adopted in 2016/17.

1.28 Research and development

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

1.29 Corporation Tax

The Trust does not fall within the scope of Corporation Tax for the year ended 31 March 2017, neither did it for the year ended 31 March 2016.

1.30 Charitable Funds

The Trust is Corporate Trustee to Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund, a Charity registered with the Charities Commission (Charity No 1048170).

The main purpose of the charitable funds held on trust is to apply income for any charitable purposes relating to the National Health Service wholly or mainly for the services provided by the Norfolk and Norwich University Hospitals NHS Foundation Trust.

At the 31st March 2017, the Charitable funds reserves stood at £11,391k (2015/16: £9,914k) and it had a surplus of income after expenditure in the year of £1,477k (2015/16: £994k).

1.31 Interests in Joint Operations

The Trust has a 58% interest in a joint operation for the provision of pathology services in Norfolk known as the Eastern Pathology Alliance EPA. The arrangement has been effective from 1st November 2013, and has not involved the establishment of a separate entity.

Accordingly, the Trust's share of operating income and expenditure is included in these accounts.

2. Operating segments

Segmental reporting is required to reflect the content and form of information that is supplied to the Chief Operating Decision Maker. In the case of the Trust, this has been determined to be the Executive Directors.

The Executive Directors receive segmental information for expenditure. Segments are defined as the Trust's divisions, as identified in the following table which also describes the service that each provides. The Services division deals with areas such as the commissioning of catering, portering and cleaning, as well as support functions. During the year there was a restructure of the Trust's divisions and as a result, the comparatives have been realigned without change in overall total.

Income and assets are not reported by division, so are not analysed in the data below. Details of income by source is provided in note 3.1. The Trust's main source of income is from within the UK for the provision of healthcare services.

2016/17:

	Medicine	Clinical Support	Surgery and Cromer	Women, Children and Sexual Health	Emergency	Services	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pay	79,397	57,312	94,942	34,654	28,043	19,560	313,908
Non Pay	78,657	30,618	38,895	7,203	2,748	51,981	210,102
Total	**158,054**	**87,930**	**133,837**	**41,857**	**30,791**	**71,541**	**524,010**

2015/16 :

	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pay	76,319	55,673	90,098	33,505	26,704	19,113	301,412
Non Pay	71,693	27,847	35,506	6,789	3,509	50,976	196,320
Total	**148,012**	**83,520**	**125,604**	**40,294**	**30,213**	**70,089**	**497,732**

Reconciliation - Pay

	2016/17	2015/16
	£'000	£'000
Employee Expenses - Executive directors (note 6)	1,156	1,155
Employee Expenses - Non-executive directors (note 6)	134	135
Employee Expenses - Staff (note 6)	312,618	300,096
VSS & Redundancy (note 6)	0	26
Total	**313,908**	**301,412**

Reconciliation - Non Pay

	£'000	£'000
Operating Expenses (note 6)	558,911	534,644
Less: Pay (see above)	(313,908)	(301,412)
Less: Depreciation (note 6)	(12,161)	(13,843)
Less: Consortium payments (note 6)	(16,764)	(17,699)
Less: Loss on disposal (note 6)	(26)	(63)
Less: Research and development (note 6)	(5,950)	(5,307)
Total	**210,102**	**196,320**

3. Operating income

3.1 Income from activities

	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
NHS Foundation Trusts	14	13
NHS Trusts	82	141
CCGs and NHS England	479,707	445,646
Local Authorities	(5)	0
NHS Other	72	2,041
Non-NHS: Private patients	1,631	1,770
Non-NHS: Overseas patients (non-reciprocal)	229	335
NHS injury scheme (formerly RTA)	1,047	1,258
Non-NHS: Other	480	533
Total income from activities	**483,257**	**451,737**

Substantially all income from activities comes from mandatory services.
NHS injury scheme income is subject to a provision for impairment of receivables of 22.94% (2015/16: 21.99%) to reflect expected rates of collection.
Overseas patients (non-reciprocal) income is amounts received by the Trust, where the overseas patient is liable for the cost. This occurs when there is not a national reciprocal arrangement with the country that the patient is a national of.

Substantially all income arises in the UK. There are four main customers of the Trust who each account for over 19% of its income from activities. They are NHS England (21.6%) and NHS South Norfolk CCG (22.6%) and NHS Norwich CCG (21.9%) and NHS North Norfolk CCG (19.5%).

3.2 Income from activities by category

	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Elective income	90,477	83,195
Non elective income	123,138	119,017
Outpatient income	81,477	75,741
A & E income	14,274	15,976
Other NHS clinical income	170,984	154,445
Private patient income (including overseas visitors)	1,860	2,105
Other non-protected clinical income	1,047	1,258
Total income from activities	**483,257**	**451,737**

3.3 Overseas Visitors (patient charged direct by the Trust)

	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Income recognised this year	229	335
Cash payments received in year (all years)	114	184
Amounts added to provision for impairment of receivables (all years)	(52)	105
Amounts written off in-year (all years)	125	41

3.4 Income from Commissioner Requested Services

Operating income includes income from Commissioner Requested Services as follows:

	Year ended 31 March 2017	Year ended 31 March 2016
Commissioner Requested Services	480,917	449,099
Non-Commissioner Requested Services	2,340	2,638
	483,257	**451,737**

4. Other operating income

	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Research and development	5,907	5,003
Education and training	20,608	19,990
Other		
Staff recharges	12,855	13,414
Car parking	2,576	2,414
Pharmacy sales	1,265	1,234
Clinical tests	339	520
Clinical excellence awards	1,204	1,499
Grossing up consortium arrangements	16,764	17,699
Other income	19,311	28,714
Total other operating income	**80,829**	**90,487**

5. Total operating income

Income is from the supply of services.

6. Operating Expenses

	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Services from NHS trusts	30	(49)
Employee expenses - executive directors	1,156	1,155
Employee expenses - non-executive directors	134	135
Employee expenses - staff	312,618	300,096
Supplies and services - clinical	64,114	61,227
Supplies and services - general	20,778	15,887
Establishment	7,812	7,855
Research and development	5,950	5,307
Transport	2,065	2,132
Premises	23,583	26,686
Increase/(Decrease) in provision for impairment of receivables	469	(195)
Increase in other provisions	-	505
Change in provisions discount rate(s)	236	-
Inventories written down	107	193
Drug costs	438	435
Inventories consumed	71,135	65,118
Rentals under operating leases	1,887	1,734
Depreciation on property, plant and equipment	12,161	13,843
Audit fees payable to the external auditor*		
audit services- statutory audit	78	85
other auditor remuneration (external auditor only)	-	77
Clinical negligence	8,335	7,124
Loss on disposal of non-current assets	26	63
Legal fees	30	(164)
Consultancy costs	4,672	2,613
Internal audit	134	63
Training, courses and conferences	690	1,002
Car parking & security	829	661
Redundancy	-	26
Insurance	79	64
Other services, eg external payroll	1,003	704
Grossing up consortium arrangements	16,764	17,699
Losses, ex gratia & special payments	11	14
Other	1,587	2,549
Total operating expenses	**558,911**	**534,644**

* The engagement letter signed on 13th January 2017 states that the liability of KPMG LLP, its members, partners and staff (whether contract, negligence or otherwise) in respect of services provided in connection with or arising out of the audit shall in no circumstances exceed £1,000k in the aggregate in respect of all such services.

6.1 Auditor's Remuneration

	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Audit Fees- statutory audit	78	85
Assurance services	0	77
TOTAL	**78**	**162**

The Trust's auditors, KPMG LLP (2015/16 PwC LLP), also audit the associated charity (Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund) for a fee of £6k (2015/16 £6k).

7. Operating leases

7.1 As lessee

Payments recognised as an expense	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Minimum lease payments	1,887	1,734
Total	**1,887**	**1,734**

Total future aggregate minimum lease payments	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Payable:		
Not later than one year	1,291	1,273
Between one and five years	4,487	4,310
After 5 years	15,065	14,911
Total	**20,843**	**20,494**

7.2 As lessor

The Trust leases the retail units at its Colney Lane site to a third party. The contract is for a period of 30 years and was entered into in 2002.

Rentals, recognised as other operating income	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Rents recognised as income in the year	87	87
Contingent rents recognised as income in the year	101	91
Total	**188**	**178**

Total future aggregate minimum lease payments	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Receivable:		
Not later than one year	87	87
Between one and five years	350	350
After 5 years	875	962
Total	**1,312**	**1,399**

8. Employee costs and numbers

8.1 Employee costs

	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Salaries and wages	241,371	232,217
Social security costs	22,708	17,134
Employer's contributions to NHS pensions	29,429	27,842
Termination benefits	-	26
Agency/contract staff	20,266	24,058
Total	**313,774**	**301,277**

Above total excludes costs of non-executive directors.
Details on the remuneration of key management personnel can be found in note 29.

8.2 Monthly average number of people employed

	Year ended 31 March 2017 Number	Year ended 31 March 2016 Number
Medical and dental	913	867
Administration and estates	473	472
Healthcare assistants and other support staff	2,258	2,091
Nursing, midwifery and health visiting staff	1,886	1,879
Nursing, midwifery and health visiting learners	11	9
Scientific, therapeutic and technical staff	452	432
Healthcare science staff	421	403
Agency and contract staff	249	251
Bank staff	305	261
Total	**6,968**	**6,665**

The above numbers are based on whole-time equivalents.

8.3 Staff exit packages

Staff exit packages for the year ended 31 March 2017

There were no new staff exit packages in the year ended 31 March 2017. The packages relating to the prior year are stated below.

Staff exit packages for the year ended 31 March 2016

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10k	-	2	2
£10k - £25k	-	5	5
£25k - £50k	-	2	2
£50k - £100k	-	1	1
£100k - £150k	-	1	1
£150k - £200k	-	1	1
	0	**12**	**12**

Of the 12 non compulsory departures in the year ended 31 March 2016, 3 being mutually agreed resignations (MARS) totalling £397k, and 9 being voluntary redundancies totalling £155k. Total cost of exit packages for all staff including senior executives is £552k.

9. Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. 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 their 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 appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation was carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

c) Scheme provisions

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

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

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

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

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

9. Pension costs (continued)

c) Scheme provisions (continued)

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

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

10. Retirements due to ill-health

During 2016/17 there were 10 (2015/16: 5) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements are £684k (2015/16: £379k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

11. Better Payment Practice Code

11.1 Better Payment Practice Code - measure of compliance	Year ended 31 March 2017		Year ended 31 March 2016	
	Number	£'000	Number	£'000
Total Non-NHS trade invoices paid in the year	147,746	263,275	134,209	254,974
Total Non-NHS trade invoices paid within target	123,529	228,918	110,920	226,157
Percentage of Non-NHS trade invoices paid within target	84%	87%	83%	89%
Total NHS trade invoices paid in the year	3,041	36,152	3,415	43,622
Total NHS trade invoices paid within target	2,240	24,538	2,872	39,000
Percentage of NHS trade invoices paid within target	74%	68%	84%	89%

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

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

The Trust made payments of £nil under this legislation in the year (2015/16: £nil)

12. Finance income

	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Interest receivable on bank deposits	60	231
Total	**60**	**231**

13. Other gains and losses

	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
(Loss) on disposal of land, property, plant and equipment	(26)	(63)
Total	**(26)**	**(63)**

14. Finance expense - financial liabilities including unwinding of discount on provisions

	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Interim Revenue Support Facility Cost - Dept. of Health	29	0
Finance leases	27	18
Finance Costs in PFI obligations		
- Main finance costs	17,596	17,878
- Contingent finance costs	10,966	9,946
Unwinding of discount on provisions	7	34
Total	**28,625**	**27,876**

15. Property, plant and equipment

	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2016	**11,710**	**253,432**	**77,870**	**107**	**14,278**	**884**	**358,281**
Additions - purchased	0	8,617	2,831	0	338	4	**11,790**
Additions - leased	0	0	442	0	0	0	**442**
Additions - donated	0	34	136	0	0	0	**170**
Revaluation	0	(56,395)	0	0	0	0	**(56,395)**
Disposals	0	0	(2,955)	(53)	(63)	(27)	**(3,098)**
Cost or valuation at 31 March 2017	**11,710**	**205,688**	**78,324**	**54**	**14,553**	**861**	**311,190**
Accumulated depreciation at 1 April 2016	**0**	**2,399**	**60,313**	**101**	**10,937**	**822**	**74,572**
Provided during the year	0	7,411	3,528	1	1,179	42	**12,161**
Revaluation Eliminated	0	(6,740)	0	0	0	0	**(6,740)**
Disposals	0	0	(2,877)	(53)	(59)	(26)	**(3,015)**
Accumulated depreciation at 31 March 2017	**0**	**3,070**	**60,964**	**49**	**12,057**	**838**	**76,978**
Net book value							
NBV - Owned at 31 March 2017	11,710	29,504	13,538	5	2,449	21	**57,227**
NBV - Finance lease at 31 March 2017	0	0	726	0	0	0	**726**
NBV - PFI at 31 March 2017	0	163,134	388	0	0	0	**163,522**
NBV - Donated at 31 March 2017	0	9,980	2,708	0	47	2	**12,737**
NBV total at 31 March 2017	**11,710**	**202,618**	**17,360**	**5**	**2,496**	**23**	**234,212**
Net book value							
NBV - Owned at 31 March 2016	11,710	32,581	12,876	6	3,271	57	**60,501**
NBV - Finance lease at 31 March 2016	0	0	437	0	0	0	**437**
NBV - PFI at 31 March 2016	0	208,195	1,165	0	0	0	**209,360**
NBV - Donated at 31 March 2016	0	10,257	3,079	0	70	4	**13,410**
NBV total at 31 March 2016	**11,710**	**251,033**	**17,557**	**6**	**3,341**	**61**	**283,708**

Land, buildings and dwellings are all deemed to fall within the definition of protected assets.

The revaluation loss of £49,655k on Land and Buildings has been presented in the table above in accordance with the requirements of IAS 16
The accumulated depreciation on the relevant assets has been eliminated, in the sum of £6,740k.
The cost or valuation has been adjusted to reflect the revalued amount of the assets being a reduction to buildings of £56,395k
The net impact of this presentation of the revaluation is a decrease to the net book value of land and buildings at 31.3.2017 by £49,655k.

15. Property, plant and equipment (continued)

	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2015	**11,710**	**261,148**	**75,014**	**187**	**14,528**	**916**	**363,503**
Additions - purchased	0	1,534	5,770	0	947	6	**8,257**
Additions - leased	0	0	0	0	0	0	**0**
Additions - donated	0	0	442	0	50	0	**492**
Revaluation	0	(9,250)	0	0	0	0	**(9,250)**
Disposals	0	0	(3,356)	(80)	(1,247)	(38)	**(4,721)**
Cost or valuation at 31 March 2016	**11,710**	**253,432**	**77,870**	**107**	**14,278**	**884**	**358,281**
Accumulated depreciation at 1 April 2015	**0**	**1,915**	**58,874**	**179**	**10,923**	**808**	**72,699**
Provided during the year	0	7,803	4,727	2	1,258	52	**13,842**
Revaluation Eliminated	0	(7,320)	0	0	0	**0**	**(7,320)**
Disposals	0	0	(3,288)	(80)	(1,244)	(38)	**(4,650)**
Accumulated depreciation at 31 March 2016	**0**	**2,398**	**60,313**	**101**	**10,937**	**822**	**74,571**
Net book value							
NBV - Owned at 31 March 2016	11,710	32,581	12,876	6	3,271	57	**60,501**
NBV - Finance lease at 31 March 2016	0	0	437	0	0	0	**437**
NBV - PFI at 31 March 2016	0	208,195	1,165	0	0	0	**209,360**
NBV - Donated at 31 March 2016	0	10,257	3,079	0	70	4	**13,410**
NBV total at 31 March 2016	**11,710**	**251,033**	**17,557**	**6**	**3,341**	**61**	**283,708**
Net book value							
NBV - Owned at 1 April 2015	11,710	32,586	10,080	8	3,568	101	**58,053**
NBV - Finance lease at 1 April 2015	0	0	604	0	0	0	**604**
NBV - PFI at 1 April 2015	0	216,145	1,942	0	0	0	**218,087**
NBV - Donated at 1 April 2015	0	10,502	3,514	0	37	7	**14,060**
NBV total at 1 April 2015	**11,710**	**259,233**	**16,140**	**8**	**3,605**	**108**	**290,804**

Land, buildings and dwellings are all deemed to fall within the definition of protected assets.

The revaluation loss of £1,930k on Land and Buildings has been presented in the table above in accordance with the requirements of IAS 16
The accumulated depreciation on the relevant assets has been eliminated, in the sum of £7,320k.
The cost or valuation has been adjusted to reflect the revalued amount of the assets being a reduction to buildings of £9,250k
The net impact of this presentation of the revaluation is a decrease to the net book value of land and buildings at 31.3.2016 by £1,930k.

15. Property, plant and equipment (continued)

During the year assets to the value of £170k (2016: £492k) were purchased using Charitable Funds donated to the Trust.

Plant and Equipment mainly consists of low value equipment with short asset lives. It is therefore considered that Depreciated Historic Cost is appropriate to be used as a proxy for Depreciated Replacement Cost and for Fair Value.

For 2016/17 and 2015/16 the Trust undertook an exercise, where it obtained the BCIS indices and applied them to its specialised buildings estate, in order to identify any change in value. The BCIS index for East Anglia showed a reduction of 0.8% in both years which has been applied to the Estate with the exception of the PFI Hospital Building, which is set out below.
An interim valuation of the PFI Hospital Building was commissioned as at 31 March 2017, on the same basis as the existing valuation with the exception of VAT. The interim valuation has excluded VAT to better reflect the cost of when the asset would be replaced by a PFI operator. This has resulted in a reduction in value of £49,578k. This together with the impact of the change in index on the other estate assets has resulted in a total revaluation of a reduction in value of £49,655k. This has satisfied the Trust that its land and buildings, which are held for the long term, are held at fair value.

For 2014/15 the Trust's Land and Buildings were subject to an IFRS compliant revaluation as at 31 March 2015. This was performed by David Boshier (MRICS) of Boshier & Company Chartered Surveyors RICS.

Details of the methodology and valuer used can be found in note 1.6.

The economic lives of the depreciable items of property, plant and equipment is disclosed in the table below:

	Minimum Life (years)	Maximum Life (years)
Buildings excluding dwellings	2	82
Plant and machinery	1	32
Transport equipment	7	10
Information technology	1	10
Furniture & fittings	5	32

Assets under construction are not depreciated until they are brought into use.
Land is not depreciated.

16. Capital commitments

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

	31 March 2017 £'000	31 March 2016 £'000
Property, Plant and Equipment	9,045	11,014
Total	**9,045**	**11,014**

17. Inventories

17.1. Inventories

	31 March 2017 £'000	31 March 2016 £'000
Drugs	2,333	2,652
Consumables	6,071	5,782
Total	**8,404**	**8,434**

17.2 Inventories recognised in expenses

	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Inventories recognised as an expense in the year	121,185	113,500
Write-down of inventories (including losses)	107	193
Total	**121,292**	**113,693**

18. Trade and other receivables

18.1 Trade and other receivables

	31 March 2017		31 March 2016	
	Current £'000	Non - Current £'000	Current £'000	Non - Current £'000
Trade receivables due from NHS bodies	18,405	0	14,871	0
Provision for impaired receivables	(2,586)	0	(2,320)	0
Prepayments (non-PFI)	2,566	1,150	2,968	1,265
PFI prepayments:				
Lifecycle replacements	0	62,205	0	61,241
Accrued income	133	0	97	0
PDC dividend receivable	880	0	232	0
VAT receivable	1,701	0	3,037	0
Other receivables	802	1,147	4,683	1,364
Total	**21,901**	**64,502**	**23,568**	**63,870**

The significant majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

18.2 Provision for impairment of receivables

	31 March 2017 £'000	31 March 2016 £'000
At 1 April as previously stated	**2,320**	**2,590**
Increase in provision	719	269
Amounts utilised	(203)	(75)
Unused amounts reversed	(250)	(464)
At 31 March	**2,586**	**2,320**

18.3 Analysis of impaired receivables

Ageing of impaired receivables	31 March 2017 Other receivables £000	31 March 2016 (restated) Other receivables £000
0 - 30 days	0	2
30-60 Days	9	5
60-90 days	3	9
90- 180 days	67	77
Over 180 days	497	512
Total	**576**	**605**
Ageing of non-impaired receivables past their due date		
0 - 30 days	13,914	1,430
30-60 Days	2,197	10,128
60-90 days	648	548
90- 180 days	1,174	1,422
Over 180 days	2,218	2,936
Total	**20,151**	**16,464**

19. Cash and cash equivalents

	Year ended 31 March 2017 £'000	Year ended 31 March 2016 £'000
Balance at 1 April	31,494	74,138
Net change in year	(15,984)	(42,644)
Balance at 31 March	**15,510**	**31,494**
Comprising:		
Cash at commercial banks and in hand	108	121
Cash with the Government Banking Service	15,402	31,373
Cash and cash equivalents as in statement of financial position and statement of cash flows	**15,510**	**31,494**

20. Trade and other payables

	31 March 2017 Current £'000	31 March 2017 Non-current £'000	31 March 2016 Current £'000	31 March 2016 Non-current £'000
NHS trade payables	5,921	0	3,310	0
Amounts due to other related parties	4,142	0	3,917	0
Capital payables	877	0	1,495	0
Social security costs	6,277	0	5,583	0
Other payables	15,006	0	12,490	0
Accruals	30,246	331	28,934	815
Total	**62,469**	**331**	**55,729**	**815**

Included in Amounts due to other related parties at 31 March 2017 is £4,142k (31 March 2016: £3,917k) of outstanding pension contributions.

21. Borrowings

	31 March 2017 Current £'000	31 March 2017 Non-current £'000	31 March 2016 Current £'000	31 March 2016 Non-current £'000
Interim Revenue Support Facility - Dept. of Health	0	16,000	0	0
Obligations under finance leases	168	608	162	335
Obligations under Private Finance Initiative contracts	2,981	196,096	3,360	199,076
Total	**3,149**	**212,704**	**3,522**	**199,411**

Details of the PFI schemes comprising the liabilities detailed above can be found in note 24.

22. Other liabilities

	31 March 2017 Current £'000	31 March 2017 Non-current £'000	31 March 2016 Current £'000	31 March 2016 Non-current £'000
Deferred Income	14,942	1,328	24,512	2,433
Total	**14,942**	**1,328**	**24,512**	**2,433**

23. Finance lease obligations

	31 March 2017 Minimum Lease Payments £'000	31 March 2017 PV of Minimum Lease Payments £'000	31 March 2016 Minimum Lease Payments £'000	31 March 2016 PV of Minimum Lease Payments £'000
Gross lease liabilities				
of which liabilities are due				
- not later than one year;	190	190	190	190
- later than one year and not later than five years;	653	653	758	758
- later than five years.	0	0	79	79
Finance charges allocated to future periods	(67)	(67)	(530)	(530)
Net lease liabilities	**776**	**776**	**497**	**497**
Split into:				
- not later than one year;	168	168	162	162
- later than one year and not later than five years;	608	608	273	273
- later than five years.	0	0	62	62
Net lease liabilities	**776**	**776**	**497**	**497**

24. Private Finance Initiative contracts

24.1 PFI schemes on-Statement of Financial Position

(i) New Hospital

On 9 January 1998 the Trust concluded contracts under the Private Finance Initiative (PFI) with Octagon Healthcare Limited for the construction of a new 809 bed hospital and the provision of hospital related services. In addition, and as a consequence of revised patient activity projections, the Trust entered into a contract variation with Octagon Healthcare Limited to extend the new hospital by a further 144 beds. This contract variation was approved by the Department of Health and was signed on 14 July 2000.

The PFI scheme was approved by the NHS Executive and HM Treasury as being better value for money than the public sector comparator. Under IFRIC 12, the PFI scheme is deemed to be on Statement of Financial Position, meaning that the hospital is treated as an asset of the Trust, that is being acquired through a finance lease. The payments to Octagon in respect of it have therefore been analysed into finance lease charges and service charges. The accounting treatment of the PFI scheme is detailed in accounting policy 1.11.

The service element of the contract was £19,600k (2015/16: £20,200k), with contingent rent being £11,000k (2015/16: £9,900k).

The estimated value of the scheme at inception was £222,600k. Payments under the scheme commenced on 15 August 2001. In 2003/04 the Trust entered into and concluded a refinancing arrangement with Octagon Healthcare Ltd on the investment in the hospital. This resulted in an extension of the minimum term of the scheme from 30 to 35 years and a reduction in the annual charge of £3,500k per annum.

(ii) Radiotherapy

In October 2002, the Trust entered into a PFI agreement for the provision of radiotherapy services. The duration of the contract is 15 years with an estimated capital value of £7,100k. It has been assessed as being on Statement of Financial Position under IFRS, meaning that it is treated as a finance lease, with the assets being treated as assets of the Trust.

The contract includes a maintenance agreement, with the cost for 2016/17 being £500k (2015/16: £500k).

During 2013-14 a variation to this contract was agreed in order to finance an additional linear accelerator for radiotherapy services. The duration of the extension is 4.25 years with an estimated capital value of £1,200k. The extension to the contract includes a maintenance agreement, with the cost for 2016/17 being £100k (2015/16: £100k).

24.2 PFI schemes on-Statement of Financial Position (on-SoFP)

Total obligations for on-statement of financial position PFI contracts are:

	31 March 2017 £000	31 March 2016 £000
Gross PFI, LIFT or other service concession liabilities	**985,533**	**1,013,222**
Of which liabilities are due		
- not later than one year;	39,206	38,766
- later than one year and not later than five years;	166,521	161,158
- later than five years.	779,806	813,298
Lifecycle Maintenance expenditure	(89,236)	(96,546)
Finance charges allocated to future periods	(697,220)	(714,240)
Net PFI, liabilities	**199,077**	**202,436**
- not later than one year;	2,981	3,360
- later than one year and not later than five years;	13,728	11,738
- later than five years.	182,368	187,338
	199,077	**202,436**

Gross PFI liabilities includes £89,236k (2015/16: £96,546k) in respect of lifecycle maintenance expenditure on the hospital PFI scheme. These are payments to replace components of the hospital infrastructure throughout the course of the PFI agreement.

Finance charges include both interest payable and contingent rent payable. Contingent rent is variable dependent on the future rate of inflation using the Retail Prices Index (RPI). The Trust has assessed the future rate of RPI with regard to historical trends and current forward-looking estimates.

24.3 The Trust is committed to make the following payments for on-SoFP PFI obligations during the next year in which the commitment expires:

	31 March 2017 £'000	31 March 2016 £'000
Within one year	565	0
2nd to 5th years (inclusive)	0	1,138
16th to 20th years (inclusive)	38,641	0
21st to 25th years (inclusive)	0	37,628
Total	**39,206**	**38,766**

24.4 The Trust is committed to make the following payments in respect of the service element of the On-SoFP PFIs.

	31 March 2017 £'000	31 March 2016 £'000
- not later than one year;	20,670	21,434
- later than one year and not later than five years;	85,578	88,530
- later than five years.	400,312	446,459
Total	**506,560**	**556,423**

25. Provisions

	Current 31 March 2017 £'000	Non-current 31 March 2017 £'000	Current 31 March 2016 £'000	Non-current 31 March 2016 £'000
Pensions relating to other staff	210	2,842	229	2,852
Legal claims	96	0	80	0
VSS & Redundancy	22	0	552	0
Total	**328**	**2,842**	**861**	**2,852**

	Pensions relating to other staff £'000	Legal claims £'000	VSS & Redundancy £'000	Total £'000
At 1 April 2016	3,081	80	552	**3,713**
Change in the discount rate	236	0	0	**236**
Arising during the year	60	44	0	**104**
Utilised during the year	(213)	(28)	(79)	**(320)**
Reversed unused	(119)	0	(451)	**(570)**
Unwinding of discount	7	0	0	**7**
At 31 March 2017	**3,052**	**96**	**22**	**3,170**
Expected timing of cash flows:				
Within one year	210	96	22	**328**
Between one and five years	882	0	0	**882**
After five years	1,960	0	0	**1,960**
	3,052	**96**	**22**	**3,170**

Pensions relating to other staff covers liabilities in respect of former staff members. Due to the nature of the obligation (pension related) there is uncertainty over the expected timing of cash flows, duration and magnitude.

Legal claims include Employer's Liability and Public Liability claims. Incidents occurring after 1 April 1999 are covered by the NHS Litigation Authority Liabilities to Third Parties Scheme.

The NHS Litigation Authority holds provisions at 31 March 2017 of £150,908k (31 March 2016; £116,273k) in respect of clinical negligence liabilities of the Trust.

25. Provisions (continued)

2015/16

	Pensions relating to other staff £'000	Legal claims £'000	VSS, redundancy and other £'000	Total £'000
At 1 April 2015	2,736	80	2,038	**4,854**
Arising during the year	485	20	261	**766**
Utilised during the year	(174)	(20)	(10)	**(204)**
Reversed unused	0	0	(1,737)	**(1,737)**
Unwinding of discount	34	0	0	**34**
At 31 March 2016	**3,081**	**80**	**552**	**3,713**
Expected timing of cash flows:				
Within one year	229	80	552	**861**
Between one and five years	939	0	0	**939**
After five years	1,913	0	0	**1,913**
	3,081	**80**	**552**	**3,713**

Included within provisions reversed unused of £1,737k is £1,570k for holiday pay provision (being untaken leave at the year end). This was reclassified as an accrual in 2015/16 and reflected in Note 20.

26. Financial Instruments

26.1 Financial assets by category	31 March 2017		31 March 2016	
	Total £'000	Loans and receivables £'000	Total £'000	Loans and receivables £'000
Assets as per SoFP				
Trade and other receivables excluding non financial assets	24,198	24,198	26,197	26,197
Cash and cash equivalents (at bank and in hand)	15,510	15,510	31,494	31,494
Total at 31 March	**39,708**	**39,708**	**57,691**	**57,691**

The net book value of the financial assets is equivalent to fair value, by virtue of the balances being deemed as current.

26.2 Financial liabilities by category	31 March 2017		31 March 2016	
	Total £'000	Other financial liabilities £'000	Total £'000	Other financial liabilities £'000
Liabilities as per SoFP				
Borrowings excluding Finance lease and PFI liabilities (at 31 March 2017)	16,000	16,000	0	0
Obligations under finance leases	776	776	497	497
Obligations under Private Finance Initiative contracts	199,077	199,077	202,436	202,436
Trade and other payables excluding non financial liabilities	62,800	62,800	56,544	56,544
Provisions under contract	3,170	3,170	3,713	3,713
Total at 31 March	**281,823**	**281,823**	**263,190**	**263,190**

The net book value of the financial liabilities is equivalent to fair value, as they are either current, relate to PFI obligations, or are already discounted using HM Treasury's discount rate of 0.24% (2015/16: 1.37%) in real terms.

26.3 Maturity of Financial Liabilities	31 March 2017 £'000	31 March 2016 £'000
In one year or less	65,947	60,112
In more than one year but not more than two years	3,178	3,893
In more than two years but not more than five years	27,489	9,934
In more than five years	185,209	189,251
Total	**281,823**	**263,190**

26.3 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the 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 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 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 Trust's internal auditors.

26.3.1 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.

26.3.2 Interest rate risk

The Trust has borrowings in the form of PFI arrangements and a Finance Lease. For both types of borrowings, the interest rate is fixed, resulting in a low level of associated risk. Contingent rent does apply to the largest PFI scheme, as it is indexed through a twice yearly application of RPI. There is therefore an interest rate risk associated with that, though it is deemed to be low due to its comparative size and current market conditions.

26.3.3 Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the Trade and Other Receivables note.

The Trust's Treasury Management Policy has clear criteria, is updated regularly and advice is taken from it's investment advisers so as to ensure that there is a very low level of risk associated with cash and any deposits with financial institutions.

26.3.4 Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, 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.

27. Events after the reporting year

There have been no events after the reporting year that have had a major impact on these accounts.

28. Capital cost absorption rate

The Trust incurs a charge on the balance of any funding received from the government. This is in the form of a PDC dividend charge that is broadly calculated as 3.5% of the Trust's average net relevant assets. In 2016/17 this equated to a £1,470k charge (£1,869k in 2015/16).

29. Related party transactions

The Norfolk and Norwich University Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Foundation Trust.

The Department of Health is regarded as a related party. During the year the Norfolk and Norwich University Hospitals NHS Foundation Trust has had a significant number of transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These are summarised below:

Related Party Transactions	**Income Year ended 31 March 2017 £'000**	**Expenditure Year ended 31 March 2017 £'000**	**Income Year ended 31 March 2016 £'000**	**Expenditure Year ended 31 March 2016 £'000**
Value of transactions with other related parties				
- Department of Health	22,040	3	22,588	3
- Other NHS Bodies	520,874	38,052	490,073	38,539
- Charitable Funds	36	0	35	0
- Other	1,168	61,094	1,094	55,735

Related Party Balances	**Receivables 31 March 2017 £'000**	**Payables 31 March 2017 £'000**	**Receivables 31 March 2016 £'000**	**Payables 31 March 2016 £'000**
Value of balances (other than salary) with related parties in relation to doubtful debts	(1,756)	0	(2,225)	0
Value of balances with other related parties				
Department of Health	960	0	232	0
Other NHS Bodies	18,272	5,896	15,055	5,224
Charitable Funds	2	0	4	0
Other	1,890	10,746	3,210	10,181

Remuneration of Key Management Personnel

The following table analyses the remuneration of key management personnel (deemed to be the Board of Directors) in accordance with IAS 24.

	Year ended 31 March 2017 £'000	**Year ended 31 March 2016 £'000**
Short term employee benefits (pay)	1,045	1,086
Post-employment benefits (employers pension contribution)	116	109

The highest paid Director in 2016/17 received remuneration of £227k, not including pension related benefits, for their services as Chief Executive. In 2015/16 the highest paid Director received remuneration of £202k, not including pension related benefits, for their services as Chief Executive.

Further details on remuneration of the Board of Directors can be found in the Remuneration Report.

In addition, the Trust had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions were with HM Revenue & Customs in respect of the deduction and payment of PAYE and with South Norfolk Council in respect of rates.

The Trust has also received revenue and capital payments from the Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund, the Corporate Trustee of which is the Trust. These payments are outlined below.

29. Related party transactions (continued)

The services of the Norfolk and Norwich University Hospitals NHS Foundation Trust have benefited from payments of £113k (2015/16: £39k) from charitable funds.

During the year assets to the value of £170k (2015/16: £492k) were purchased using Charitable Funds donated to the Foundation Trust, of which £108k (2015/16: £376k) came from the Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has recharged the sum of £36k (2015/16: £35k) to the Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund for the provision of the administration and management of the charity.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has received payments of £260k (2015/16: £322k) from the Eastern Academic Health Science Network. The Chief Executive Officer is a member of the board of this network.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has made payments of £329k (2015/16: £318k) to Norwich Research Partners LLP. The Chief Executive Officer and a Non-Executive director are members of the board of this organisation.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has made payments of £2,406k (2015/16:£3,930k) to the University of East Anglia. A Non-Executive director is the Vice-Chancellor of this organisation.

30. Third Party Assets

The Trust held £6k (2015/16: £17k) cash at bank and in hand at 31 March 2017 which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

31. Losses and Special Payments

There were 2,326 cases of losses and special payments totalling £268k paid during the year (2015/16: 1,968 cases totalling £283k).

	31 March 2017		31 March 2016	
	Number	£'000	Number	£'000
Losses				
Cash losses (including overpayments, physical losses, unvouched payments and theft)	2	1	14	9
Bad debts and claims abandoned (excluding cases between FT and other NHS bodies)	2,262	149	1,903	67
Stores losses (including damage to buildings and other properties as a result of theft, criminal damage and neglect)	3	107	3	193
Special Payments				
Ex gratia payments	59	11	48	14
	2,326	**268**	**1,968**	**283**

These amounts are recorded on an accruals basis but excludes provisions for future losses.

32. Contingent Assets and Contingent Liabilities

There are no contingent assets or contingent liabilities.

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