The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Annual Report

2016/17

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The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Performance Report

2016/17

Contents

Overview

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

Statement from the Chief Executive

Throughout the past year the Trust has worked hard to sustain its improvement trajectory despite an increasingly challenging operating environment. The Board's corporate objectives remain:

1. To deliver safe services
2. To deliver the best possible experience for patients and staff
3. To deliver the most effective outcomes
4. To deliver a well-led, capable and motivated workforce
5. To be efficient and make best use of available resources.

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

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

- The introduction of a midwifery led pathway and the reinstatement of the Trust's home birth service. This has been accompanied by the introduction of electronic patient records for maternity
- The continued development and improvement of the Trust's estate, including the completion of two new laparoscopic theatres, the introduction of Trust-wide WIFI, the opening of the new breast unit and the installation of the first of two new CT scanners
- The introduction of red bag and deconditioning initiatives to improve the quality of care for our frail and elderly patients
- The opening of our refurbished stroke unit. The hospital has since received an A rating for its stroke care

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

- Continue to implement the recommendations arising from the regulator's Contingency Planning process looking at the health economy of West Norfolk
- Develop and begin implementation of the Norfolk and Waveney Sustainability and Transformation Plan (STP)
- Continue to collaborate through the Norfolk Provider Partnership, which has seen the CEOs of the three Norfolk Hospitals and Norfolk Community Health and Care agree a memorandum of understanding to find the best solutions, in order to mutually share problems
- Establish the local A&E Delivery Board with the Trust CEO as its chair.

Other achievements of note having included:

- A strong performance against the four-hour emergency access target over the winter, despite an exceptionally challenging period
- Significant improvements in our flu vaccination rates amongst staff
- The maintenance of a substantially improved position in our fight against Norovirus, with few bays and even fewer wards closed than over the previous winter.

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

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

It has been a notable disappointment that despite having achieved its budgetary commitments for the previous two financial years, this year the Trust did not meet the deficit target it initially agreed. That said, the fiscal control systems now in place give us confidence that we are able to remain in control of the financial elements of our business in the future to deliver on our promises and value for money services.

At the end of the 2016/17 financial year Dorothy Hosein left as the Trust CEO after two and a half successful years. I took up the post of Trust CEO in May 2017. There have also been several changes to the Executive team. Edward Libbey remains in post as Trust Chair supported by a strong team of non-executive directors.

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

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

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

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

Jon Green – Chief Executive
Date: 23/5/2017

Purpose and activities of the foundation trust

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

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

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

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

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

A brief history of the foundation trust

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

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

A re-inspection by the CQC in July 2014 found that improvements had been made in consent to care and treatment, care and welfare of patients, nutrition and hydration, incident reporting, respecting and involving service users, dealing with complaints, keeping records, and co-operating with other providers. However, our services remained non-compliant with the regulations on staffing, support for workers, safeguarding and medicines management and so the Trust remained in 'special measures'.

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

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

Monitor, which has since become NHS Improvement, subsequently removed the Trust from 'special measures' in August 2015 and, after a challenging few years, the Trust is now on a sustained improvement trajectory.

Key issues and risks in delivering the Trust's objectives

The Board has agreed its Corporate Objectives as:

1. To deliver safe services
2. To deliver the best possible experience for patients and staff
3. To deliver the most effective outcomes
4. To deliver a well-led, capable and motivated workforce
5. To be efficient and make best use of available resources.

The principal risks to the delivery of its objectives have been articulated through the Board Assurance Framework.

Principal risks to the delivery of the Trust's Strategic Objectives have been identified as follows:

- Patients do not receive quality care because safety, outcome and/or experience does not meet our expected standards
- Unable to maintain Trust financial viability without significant deterioration in service quality
- Unable to develop effective partnerships that lead to transformative care pathways for patients
- Failure to develop appropriate workforce capacity and capability that reflects a culture of excellence
- Unable to maintain, replace, develop (or dispose of) the Trust's physical infrastructure, including IT and Estate to ensure that they remain fit for the future needs of the Trust
- Unable to retain and/or build and embed leadership capability at all levels within the Trust

The Board has monitored its position in respect of these principal risks at each public Board meeting throughout 2016/17 and has identified its key risks as financial sustainability, workforce and estate.

Going concern

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

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

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

The Board considered its 'Going Concern' position at its meeting in March 2017 and after consideration of risks and uncertainties agreed that:

'The use of the going concern basis is appropriate but there are material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a going concern. Nevertheless after making enquiries, and considering the reality of the uncertainty materialising, the Directors have a reasonable expectation that the Trust will have access to adequate cash resources to continue in

operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts.

Performance analysis

Financial Performance

In 2016/17 the Trust set a deficit budget of £5.3m, which included £6.5m income from the Department of Health Sustainability & Transformation (S&T) Fund.

The delivery of this deficit budget was a significant challenge for the Trust, particularly against the backdrop of increased activity and the difficulties of recruiting and retaining key members of clinical staff.

At the end of December 2016 the Trust reported a year to date loss of £14m and it was apparent that the Trust would no longer qualify for the S&T fund income and achieve the original £5.3m deficit.

In close consultation with the Regulator the Trust revised the 2016/17 financial projections and committed to achieve a control total deficit of £18.3m or less. In order to achieve this revised target, a financial recovery plan was developed to manage the quarter four financial performance (January 2017 to March 2017).

The Trust achieved the revised control target deficit of £18.3m, despite the significant operational pressure of additional emergency activity over the winter period.

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

NHS Clinical Revenue	2015/16 Activity no.	2015/16 Revenue £'000	2016/17 Activity no.	2016/17 Revenue £'000	Activity Variance no.	Activity Variance %	Revenue Variance £'000	Revenue Variance %
A&E	**59,902**	£6,931	**62,319**	£7,469	**2,273**	3.8%	**£538**	7.8%
Elective Inpatients	**4,862**	£11,113	**5,548**	£12,013	**686**	14.1%	**£900**	8.1%
Elective Excess Bed Days	**967**	£205	**697**	£155	**(270)**	(27.9%)	**(£50)**	(24.4%)
Daycases	**33,820**	£18,156	**32,605**	£17,835	**(1,215)**	(3.6%)	**(£321)**	(1.8%)
Non-elective Inpatients	**33,193**	£52,781	**35,926**	£57,979	**2,733**	8.2%	**£5,198**	9.9%
Non-elective Excess Bed Days	**11,497**	£2,440	**11,434**	£2,438	**(63)**	(0.5%)	**(£2)**	(0.1%)
Emergency Threshold Cap	**280,721**	(£2,091)		(£2,810)			**(£719)**	34.4%
Outpatients	**280,721**	£29,945	**291,297**	£32,311	**10,576**	3.8%	**£2,366**	7.9%
Other Clinical Income		£37,101		£37,308			**£207**	0.6%
Total NHS Clinical Revenue		**£156,581**		**£164,698**			**£8,117**	**5.2%**
Private Patient Income		£857		£780			**(£77)**	(9.0%)
Other Clinical Income *		£1,506		£433			**(£1,073)**	(71.3%)
Total Income from activities		**£158,944**		**£165,911**			**£6,967**	**4.4%**

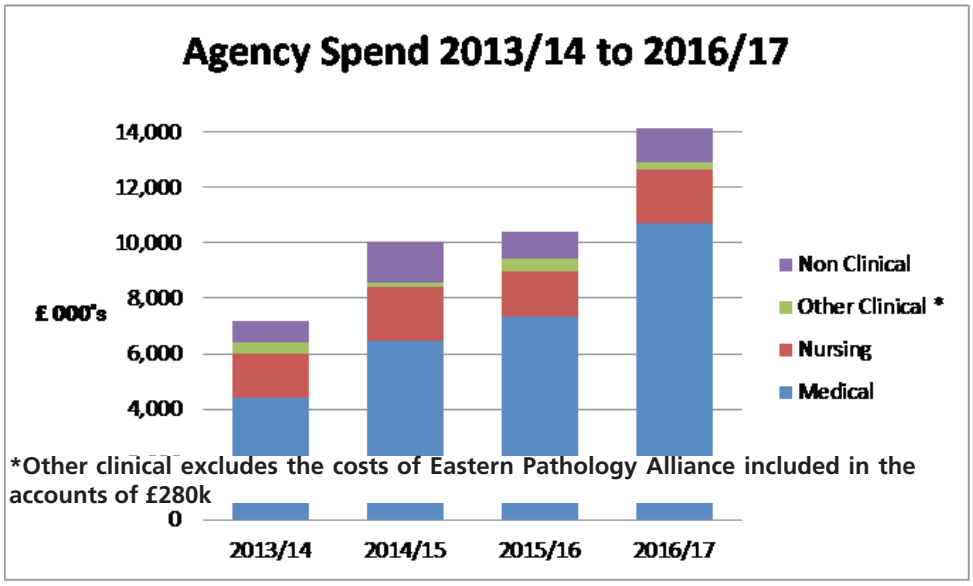
* In 2015/16 £1m of capital - revenue transfer is included.

Overall for 2016/17 clinical income (excluding pass-through drugs and Sustanability and Transformation Funding) was £1m above plan. The trend of above demographic growth in A&E attendances and in-patient admissions continued throughout 2016/17.

Over-achievement of the Trust's income plan was offset by an overspend on expenditure, which is a combination of under-delivery of planned efficiencies and additional costs to support additional activity e.g. staffing costs for additional escalation beds.

The cost of agency staffing remains a significant challenge to the Trust, with expenditure in 2016/17 totalling £14.1m. This is an increase of £3.8m on 2015/16 and £4.1m above the £10m expectation set by the Regulator.

As can be seen from the graph below, the cost of medical agency staff remains the consistent area of cost increase as the Trust has a number of vacancies in difficult to recruit to areas. These are also the areas experiencing the year on year increase in demand. The Trust continues to try and minimise expenditure through implementation of Department of Health led cost control measures, but a workforce strategy and plans to address recruitment and retention to specific posts remain a priority for clinical and financial sustainability.



*** Other clinical excludes the costs of EPA included in the accounts of £280k.**

The Trust delivered £3.9m of efficiency savings, which is about 2% of turnover. The Trust received the £25.2m of cash support from the Department of Health, which also supported £8m of capital investment on the following infrastructure schemes:

- Modernisation of the Trust's operating theatres
- Installation of replacement CT scanner
- Continuation of the Trust's ward refurbishment programme
- Complete the installation of wireless IT infrastructure
- Modernisation of maternity patient information system
- Replacement and modernisation of medical equipment
- Updating and replacement of Trust IT hardware
- Undertaking essential estate backlog maintenance

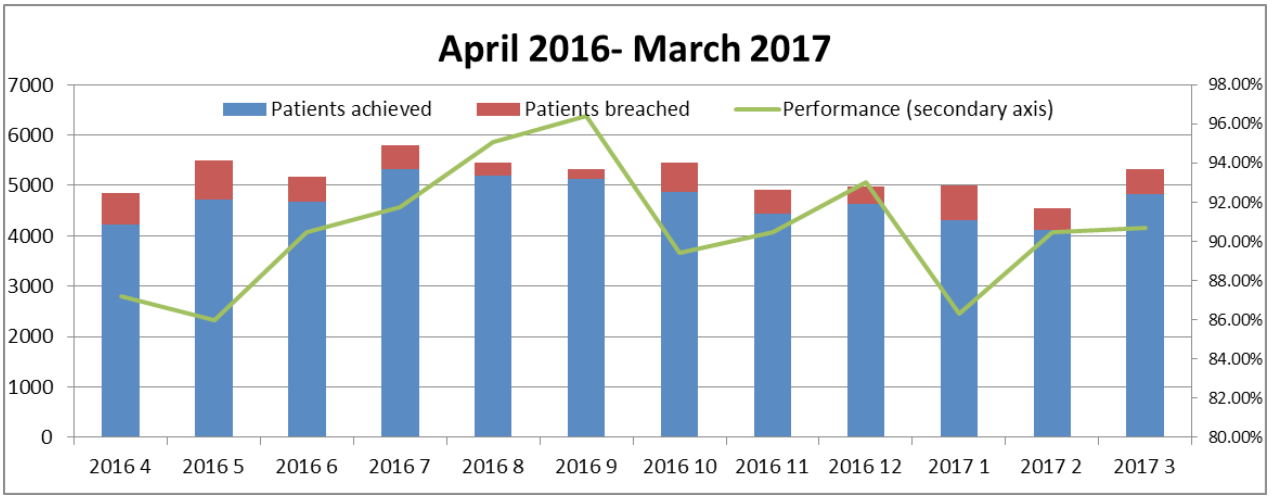
As at the 31 March 2017 the Trust has received over £65m of Department of Health loans. The Trust remains in a financially unsustainable position and continues to work with partner organisations, as it develops long term strategies and service transformation plans that can return the overall health economy to a clinical and financially sustainable position.

Operational Performance

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

Accident and Emergency 4 hour access target

The Trust has had another year of unprecedented A&E demand. Across the year the Trust saw an additional 2,425 patients in 2016/17 compared to 2015/16. Against this challenging backdrop the Trust has performed well against the four-hour target and has often been one of the top performing A&E Trusts in the country. While the Trust has minimised internally controllable delays, there does remain an ongoing challenge with ensuring patients who no longer require hospital care are discharged to appropriate care settings. The Trust continues to work with its system partners to both minimise delays in discharging patients to appropriate care settings and to help inform demand management schemes that may help to control demand.



Month	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
Patients Achieved 4 hour standard	4231	4725	4678	5326	5185	5134	4877
Patients Breached 4 hour standard	622	769	494	480	270	191	578
% achievement of standard	87.18%	86.00%	90.45%	91.73%	95.05%	96.41%	89.40%

Month	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	16/17
Patients Achieved 4 hour standard	4446	4628	4312	4120	4824	56486
Patients Breached 4 hour standard	467	348	684	433	496	5832
% achievement of standard	90.49%	93.01%	86.31%	90.49%	90.68%	90.64%

Ambulance Handover

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

	0-15 Minutes	15-30 Minutes	30 - 1 Hour	1 Hour +	Grand Total
April EEAST*	902	605	85	58	**1650**
May EEAST	850	501	48	37	**1436**

June EEAST	830	560	116	49	**1555**
July EEAST	880	589	197	54	**1720**
August EEAST	726	730	85	14	**1555**
September EEAST	710	796	34	21	**1561**
October EEAST	531	823	171	77	**1602**
November EEAST	473	883	97	47	**1500**
December EEAST	540	983	102	33	**1658**
January EEAST	423	850	241	147	**1661**
February EEAST	331	851	191	84	**1457**
March EEAST	334	954	266	145	**1699**

* EEAST = East of England Ambulance Service Trust

The Trust remains committed to improving this position and delivering a better patient experience. This will require similar actions to those highlighted under the 4 hour access target, with some of the most challenging actions supporting flow through the whole health and social care system.

Cancer access targets

While the Trust has consistently met the 14 day and 31 day standards, the 62 day standard has been more challenging. The Trust undertook several significant pieces of work during 2016/17, such as streamlining cancer pathways, reinvigorating the patient tracking list meetings and working with our histopathology supplier to secure a good service for our patients.

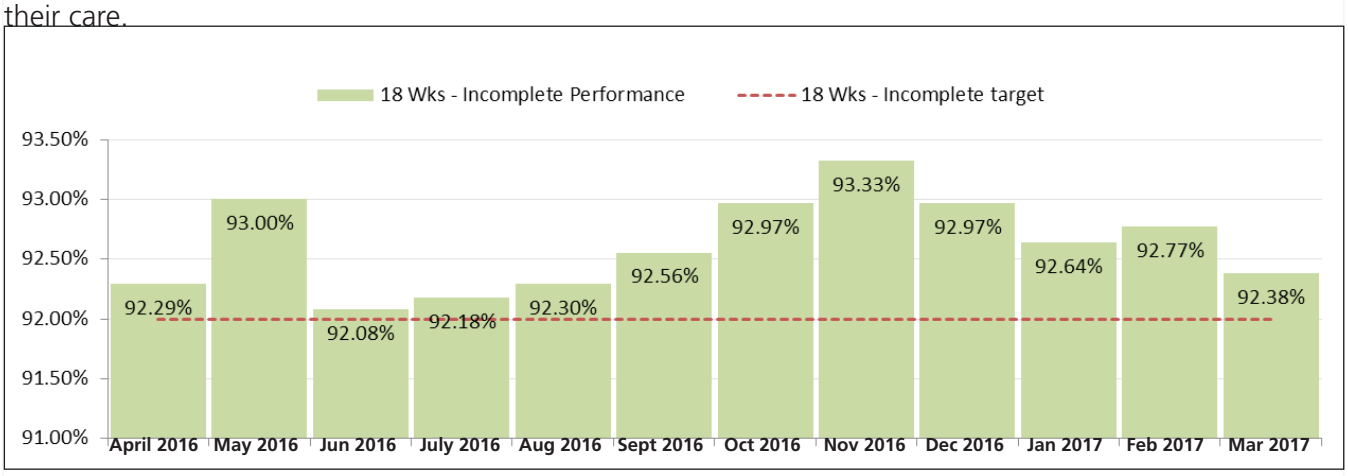
	Target	Q1	Q2	Q3	Q4*
2 week wait	93.00%	97.90%	97.80%	96.64%	96.21%
31 days	96.00%	99.67%	99.08%	99.48%	98.94%
62 days	85.00%	83.04%	83.33%	82.79%	82.89%

* Q4 is currently a forecast

The Trust aims to continue developing its cancer pathways to ensure all cancer patients are seen as quickly as possible appropriate to their condition.

Eighteen Week Referral to Treatment Time

Delivering strong elective care performance alongside our emergency care is a priority for the Trust. We are proud that we have continued to deliver elective care treatment within the time expected by the national target. Over 92% of our patients waiting for treatment have waited for less than 18 weeks. This is one of the strongest performances in the region and ensures that patients of our hospital do not wait too long for their care.



The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Accountability Report

2016/17

Contents

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

Jon Green – Chief Executive
Date: 23/5/2017

Directors' report

How our hospital is governed

What is a Foundation Trust?

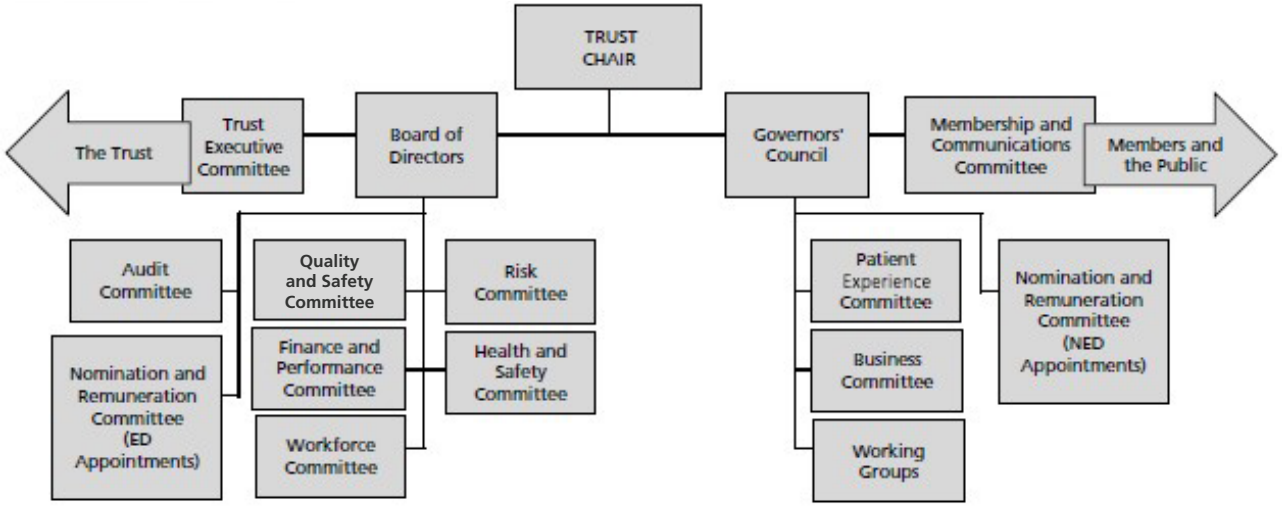
A Foundation Trust is a Public Benefit Corporation. This means that:

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

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

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

The Queen Elizabeth Hospital, King's Lynn Governance Structure at 2 May 2017



Key
ED = Executive Director
NED = Non-Executive Director

Edward Libbey – Chair

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

David Thomason – Vice Chair

David recently retired from the post of Deputy Chief Executive, Executive Director for Resources, at the Borough Council of Kings Lynn and West Norfolk. He is a qualified accountant and was a member of the Chartered Institute of Public Finance and Accountancy (CIPFA). As well as his role as Vice Chair, David chairs the Finance and Performance Committee and is the Senior Independent Director (SID).

Ian Pinches

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

John Rees

Dr John Rees is a former Director of Public Health and has been a Board Member at two health authorities and a primary care trust (PCT) in Norfolk. He has also been a Trustee at West Norfolk Voluntary & Community Action, Age Concern and MIND. John chairs the Trust's Quality Committee.

Maureen Carson

Maureen is a registered nurse who has worked as a midwife and Health Visitor, as well as a manager, senior manager and Executive Director for a number of years.

She lives in Norfolk and worked in the NHS for over 30 years before working independently. She is also a CQC inspector and trustee of the Polycystic Kidney Disease (PKD) charity. Maureen chairs the Workforce Committee.

Ian Harvey

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

Jon Green – Chief Executive

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

David Stonehouse – Finance Director and Deputy Chief Executive

David knows the West Norfolk healthcare economy well after starting as a finance trainee at the West Norfolk and Wisbech Health Authority in 1988. He has undertaken several roles in commissioning services across the county. He became Finance Director in July 2011 and took on the role of Deputy Chief Executive in 2014.

Nick Lyons – Medical Director

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

Emma Hardwick – Interim Director of Nursing

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

Ciara Moore – Chief Operating Officer

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

Jon Wade – Director of Strategy and IT

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

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

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

Statutory statements

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

- So far as the directors are aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware
- The directors have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information
- The Trust can confirm that it has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance
- The Trust has made no political donations to any individual, body or organisation in the 2016/17 financial year
- Our Trust is committed to working with all of our supplier partners fairly and professionally. One way that we do this is by working to the Better Payment Practice Code. We aim to pay at least 95% of invoices within the agreed terms, unless there is a dispute or for other reasons. For most of our partners, this would be within 30 days of the date of invoice or receipt of goods & services. However, in some cases this may not be the case due to lack of adequate supplier information.

The Trust's performance for 2016/17 is shown in the following table

	Number	£
NHS Suppliers		
Total invoices paid to target	316	£3.6
Total invoices paid in year	1,225	£11.3
% paid within target	26%	34%
Non NHS Suppliers		
Total invoices paid to target	12,484	£21.8
Total invoices paid in year	49,207	£72.9
% paid within target	25%	30%
Combined		
Total invoices paid to target	12,800	£25.6
Total invoices paid in year	50,432	£84.2
% paid within target	25%	30%

The poor performance in 2016/17 is driven by the timing of receipts and the requirement for loan funding.

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

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

Enhanced quality governance reporting

The Trust has adopted and continues to embed robust quality governance arrangements and structures to ensure a standardised approach to understanding and improving its delivery of quality services for patients. This includes effective:

- Accountability, leadership and oversight
- Reporting
- Assessment
- Monitoring
- Scrutiny
- Challenge
- Risk management and escalation
- Learning
- Assurance from ward to Board, with an incorporated feedback process.

At its last inspection in 2015, the CQC rated the Trust as 'Good' in its 'Well-Led Domain', which assesses the Trust against the following good practice:

- Inspiring vision – developing a compelling vision and narrative
- Governance – ensuring clear accountabilities and effective processes to measure performance and address concerns
- Leadership, culture and values – developing open and transparent cultures focused on improving quality
- Staff and patient engagement – focusing on engaging all staff and valuing patients' views and experience
- Learning and innovation – focusing on continuous learning, innovation and improvement.

The Trust is preparing for its first regulatory 'Well-led Framework for Governance' external review in 2017/18 and in 2016/17, undertook a self-assessment against the 'Well-led Framework for Governance' criteria. The regulatory definition of a 'well-led' organisation is one where the leadership, management and governance ensure the delivery of sustainable high quality person-centred care, support learning and innovation, and promote an open and fair culture.

The 'Well-Led Framework for Governance' review methodology is based on Monitor's Quality Governance Framework domains of:

- Strategy
  - Does quality drive the Trust's strategy?
  - Is the Board sufficiently aware of the potential risks to quality?
- Capabilities and Culture
  - Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?
  - Does the Board promote a quality focused culture throughout the Trust?
- Processes and Structures
  - Are there clear roles and responsibilities in relation to quality governance?
  - Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?
  - Does the Board actively engage patients, staff and other key stakeholders on quality?
- Measurement
  - Is appropriate quality information being analysed and challenged?
  - Is the Board assured of the robustness of quality information?
  - Is quality information being used effectively?

The Trust's 2016/17 self-assessment employed a non-executive director and lead governor peer review as part of its rigorous evidence-based methodology. An action plan to address identified gaps is in development and will be rolled out in 2017/18.

Information showing how the Trust's quality governance arrangements and assurance mechanisms demonstrate its level of compliance with the Quality Governance Framework is set out in the Annual Governance Statement, the Quality Report, the Performance and Governance sections of this annual report.

The Board believes there to be no material inconsistencies arising from the Trust's approach to quality governance and the Annual Governance Statement, statements made by the Board in relation to the Risk Assessment Framework on an annual and quarterly basis or the CQC's report after its inspection in June 2015.

Remuneration report

Foundation Trust Remuneration Report

The remuneration report has been audited.

Annual Statement on Remuneration

In accordance with the Regulator's Code of Governance, The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust has two Nomination and Remuneration Committees, dealing with the remuneration of the non-executive directors (NEDs) and executive directors (EDs) respectively. Director membership and meeting attendance in respect of the Nomination and Remuneration Committee is set out in the governance section 'Board of Directors' 2016/17 table'.

The Nomination and Remuneration Committee (NED appointments) is a governor committee, making recommendations in respect of non-executive director remuneration to the Governors' Council (the Governors' Council is not permitted to delegate any of its powers to a committee). The committee is chaired by the Trust Chair (unless the committee is considering the remuneration of the Trust Chair). Non-executive director remuneration is benchmarked using NHS Providers' annual survey analysis, and, as a reflection of spending restraint in the NHS and the very low pay awards made to staff subject to Agenda for Change in the organisation in recent years, there have been no changes to the remuneration of the non-executive directors or the Trust Chair in 2016/17.

The Nomination and Remuneration Committee (ED appointments) is a committee of the Board, with delegated authority to approve the terms and conditions, including the remuneration of the executive directors. The members of the committee are the non-executive directors and the CEO (unless the committee is considering the remuneration of the CEO), chaired by the Trust Chair. Executive remuneration is benchmarked using NHS Providers' annual survey analysis, on appointment and annually. As a reflection of spending restraint in the NHS, and, the very low pay awards made to staff subject to Agenda for Change in the organisation in recent years, the Nomination and Remuneration Committee (ED appointments) have made no changes to executive director remuneration in 2016/17.

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

Edward Libbey - Trust Chair and Chair of the Remuneration Committee
Date: 23/5/2017

Senior Managers' Remuneration Policy

The Trust has an Executive Director Pay Policy in place.

The Chief Executive undertakes the appraisals of the executive directors and the Chair undertakes the Chief Executive's appraisal, making an assessment of overall performance against annually agreed objectives.
The Trust had no 'Performance–Related Pay' incentives in place in 2016/17 for executive directors or other very senior managers.

The Trust had two executive directors earning more than £142,500, in post in 2016/17. Both directors were appointed and remuneration agreed before the June 2015 guidance from the Department of Health (DoH)

was published, requiring trusts to seek the views of ministers via NHS Improvement before making executive / VSM appointments with a higher salary than the Prime Minister (£142,500), with justification. All executive salaries are within the benchmarked range for foundation trusts.

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

- Proposed Very Senior Manager (VSM) remuneration of more than £142,500
- Board members, including interims should be 'on-payroll', except in exceptional, short-term cases
- Where there are exceptional, short term cases - interim daily rates paid should not normally exceed what would be paid to substantive appointees
- 'Retire and Return' – VSMs, particularly those leading organisations receiving additional tax payer support, should not be better off by taking their pension and returning almost immediately, to work for the NHS
- The new redundancy terms for NHS staff in England (within section 16 of Agenda for Change) should apply to all newly appointed VSMs (unless they are on statutory redundancy terms)
- Senior staff should not be leaving on significantly better compensation packages than more junior colleagues The approval process for management consultancy costs
- 'Fit and Proper Person' test – All Board level appointments to be subject to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19 – 'Fit and Proper Person' test
- Revised tax guidance responsibilities from April 2017
- Employment or engagement following NHS Redundancy

Very Senior Managers (VSM)

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

Non-executive and governor expenses

Expenses are reimbursed to both directors and governors in accordance with the Trust's policies. Aggregate non-executive director expenses for 2016/17 were £9,541.82. Aggregate governor expenses were £7,575.25.

Service Contract Obligations

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

Remuneration Committee

Details of the membership and attendance at the Nomination and Remuneration Committees (EDs) can be found in the Governance Section of the Annual Report table, 'The Board of Directors and Supporting Executive Portfolio Holders - in 2016/17'.

Remuneration Received

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

Details of remuneration and audited information

Details of Directors' remuneration for the period ended 31 March 2017 is set out in the Remuneration tables.

The median remuneration of the reporting entity's staff. This is based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) as at the reporting date

The calculation uses the basic salary of each employee, part time staff have had their salary grossed up to their full time equivalent salary. The banded remuneration of the highest paid director, calculated for comparison purposes on a full time basis at The Queen Elizabeth Hospital, Kings Lynn, NHS Foundation Trust in the financial year 2016/17 was £270,000-£275,000 (2015/16 - £175,000-£180,000); this was 12.46 (2015/16 – 7.87) times the median remuneration of the workforce, which was £21,909. In 2016/17, no members of the workforce received remuneration in excess of the highest paid director. Remuneration ranged from £1,552 to £273,000.

This information is presented in this way to:

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

Fair Pay multiple		
	2016/17	**2015/16**
	£	**£**
Midpoint of banded remuneration of highest paid director - full year effect	273,000	175,000
Median total remuneration	21,909	22,236
Ratio	12.46	7.87

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

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

The highest paid director of the Trust in 2016/17 was the Interim Chief Operating Officer whilst in 2015/16 it was the Chief Executive.

The banded remuneration of the highest paid director is calculated for comparison purposes on a full time basis on pay at year end.

Foundation Trust Directors Remuneration Report

		1st April 2016 to 31st March 2017			
Salaries and allowances		**(a) Salary**	**(b) Expenses payments (taxable)**	**(c) Performance pay and bonuses**	**(d) Long term performance pay and bonuses**
		Bands of £5,000	**To nearest £100**	**Bands of £5,000**	**Bands of £5,000**
Edward Libbey	Chairman	50-55			
Heather Farley (to 13/09/15)	Non-executive				
Ian Pinches	Non-executive	10-15			
Joss Trout (to 30/09/15)	Non-executive				
John Rees	Non-executive	10-15			
Lisa Gamble (to 30/11/15)	Non-executive				
Maureen Carson	Non-executive	10-15			
David Thomason	Non-executive	10-15			
Ian Harvey	Non-executive	10-15			
Dorothy Hosein	Chief Executive	180-185			
Catherine Morgan (to 20/01/2017)	Director of Nursing	95-100			
David Stonehouse	Finance Director	125-130	8,100		
Beverly Watson (to 16/09/2016)	Medical Director	75-80			
Jonathan Wade (from 21/11/2016)	Director of Strategy and Transformation	35-40			
Timothy Petterson (from 11/07/2016 to 31/03/2017)	Medical Director	300-305			
Karen Croker (from 03/10/2016)	Chief Operating Officer	140-145			
Ciara Moore (from 13/03/2017)	Chief Operating Officer	5-10			
Sandy Spencer from 06/06/2016 to 06/09/2016)	Chief Operating Officer	80-85			
Emma Hardwick (from 16/01/2017)	Director of Nursing	25-30			
Patricia Dunmore (from 23/07/2015 to 27/05/2016)	Chief Operating Officer	40-45			
Clare Badenhorst (from 11/01/16 to 06/03/16)	Director of Operations and Service Support				
Gerald Dryden (to 30/07/15)	Director of HR				
Clive Walsh (from 07/04/15 to 22/07/15)	Chief Operating Officer				

1st April 2016 to 31st March 2017		1st April 2015 to 31st March 2016					
(e) All pension-related benefits	**(f) TOTAL (a to e)**	(a) Salary	(b) Expense payments (taxable)	(c) Performance pay and bonuses	(d) Long term performance pay and bonuses	(e) All pension-related benefits	(f) TOTAL (a to e)
Bands of £2,500	**Bands of £5,000**	Bands of £5,000	To nearest £100	Bands of £5,000	Bands of £5,000	Bands of £2,500	Bands of £5,000
	50-55	50-55					50-55
		5-10					5-10
	10-15	10-15					10-15
		5-10					5-10
	10-15	10-15					10-15
		5-10					5-10
	10-15	5-10					5-10
	10-15	5-10					5-10
	10-15	0-5					0-5
0-2.5	180-185	180-185				0-2.5	180-185
42.5-45	135-140	115-120				30-32.5	145-150
27.5-30	160-165	125-130	7,400			27.5-30	155-160
0	75-80	170-175				87.5-90	260-265
115-117.5	150-155						
	300-305						
	140-145						
25-27.5	30-35						
	80-85						
	25-30						
	40-45	145-150					145-150
		20-25					20-25
		70-75				52.5-55	125-130
		105-110					105-110

Off-payroll
Prior year only
Left in year
Secondment

Foundation Trust Directors Remuneration Report

		Pension Benefits	
Pension Benefits		**(a) Real increase in pension at pension age**	**(b) Real increase in pension lump sum at pension age**
		Bands of £2,500	Bands of £2,500
Beverly Watson (to 02/09/2016)	Medical Director	0	0
Cathrine Morgan (to 20/01/2017)	Director of Nursing	0-2.5	5-7.5
Ciara Moore (from 13/03/2017)	Chief Operating Officer	0-2.5	2.5-5
David Stonehouse	Finance Director	0-2.5	0-2.5
Jon Wade (from 05/12/2016)	Director of Strategy and Transformation	5-7.5	7.5-10

Pension Benefits					
(c) Total accrued pension at pension age as at 31 March 2017	**(d) Lump sum at pension age related to accrued pension at 31 March 2017**	**(e) Cash equivalent transfer value at 1 April 2016**	**(f) Real increase in Cash Equivalent Transfer Value**	**(g) Cash Equivalent Transfer Value at 31 March 2017**	**(h) Employer's contribution to stakeholder pension**
Bands of £5,000	Bands of £5,000	£000	£000	£000	£000
170-175	130-135	994	0	0	11
135-140	100-105	509	44	563	13
50-55	35-40	203	1	229	1
170-175	125-130	723	45	768	18
45-50	30-35	105	17	158	5

Left in year

Staff report

Our Staff

The Trust is one of the largest employers in the West Norfolk area, employing 3,241 staff as at 31 March 2017. The Trust aims to be the 'employer of choice', with a range of benefits and incentives and also by offering new and existing staff support to develop through an investment in 'growing-your-own' workforce strategies as an important part of the Trust's plans to ensure a sustainable future workforce.

An analysis of average staff numbers (whole time equivalent)

	31 Mar 17			31 Mar 16
	Permanent	Other	Total	Total
	wte	wte	wte	wte
Medical and dental	305	0	305	315
Ambulance staff	2	0	2	1
Administration and estates	555	0	555	533
Healthcare assistants and other support staff	270	0	270	269
Nursing, midwifery and health visiting staff	1,241	0	1,241	1,204
Nursing, midwifery and health visiting learners	3	0	3	3
Scientific, therapeutic and technical staff	309	0	309	299
Healthcare science staff	58	0	58	49
Social care staff	0	0	0	0
Agency and contract staff	0	91	91	65
Bank staff	146	0	146	140
Total average numbers	**2,889**	**91**	**2,980**	**2,878**

Staff Gender

A breakdown of staff by gender as at 31 March 2017 is included in the table below: of the number of male and female:

As at 31st March 2017 Staff breakdown by gender

Category	Female	Male	Total
Exec	2	2	4
Non Execs	1	5	6
Senior Manager	33	29	62
Other	2490	680	3170
Grand Total	2526	715	3241

Staff Costs

It is recognised that staff costs is the largest area of Trust spend and that costs have increased over the last year to ensure high quality safe patient care. There will be a focus during 2017/18 on developing workforce and recruitment strategies to ensure a sustainable affordable workforce with the aim of reducing the reliance on agency workers and reducing costs.

	31 Mar 17			31 Mar 16		
	Permanent	Other	Total	Permanent	Other	Total
	£000	£000	£000	£000	£000	£000
Salaries and wages	99,873	0	**99,873**	95,695	1,026	**96,721**
Social security costs	8,973	346	**9,316**	7,092	263	**7,355**
Employer's contributions to NHS pensions	10,677	411	**11,088**	10,345	384	**10,729**
Termination benefits	41	0	**41**	108	0	**108**
Agency/contract staff	0	14,438	**14,438**	0	10,381	**10,381**
Total Staff Costs	**119,564**	**15,195**	**134,759**	**113,240**	**12,054**	**125,294**

Staff Engagement

The aim is to ensure an excellent quality experience for staff working at the Trust that will support staff retention and the delivery of high quality patient care. By developing an engaged, enabled and empowered workforce, which is well-led and supported, the Trust can ensure its staff are getting the best possible experience, and in turn patients are getting the best care. Motivated and involved staff are at the forefront of enabling the Trust to know what is working well and how we can better improve our services for the benefit of patients and the public.

The Trust encourages open and honest communication throughout the organisation. It is acknowledged that research consistently shows that high levels of staff engagement in the NHS have a positive impact on quality, cost and, most importantly, on the patient experience and the Trust plans to review staff engagement mechanisms and use the appointment of the Trust Freedom to Speak Up Guardian to improve staff engagement further.

Trust Values

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

Values in Action Awards

Between April 2016 and March 2017, 176 members of staff have received these values awards. The breakdown of the awards is as follows:

24 - Compassion
8 - Courage
18 - Curiosity
90 - Pride
36 - Responsibility

Long Service Awards

The Trust recognises staff long service and the following numbers of staff received an award presented by the Chief Executive and Trust Chair for reaching 40, 30, 20 or 10 years' long service from 1 January 2016 to 31 December 2016.

40 years : 1 staff
30 years : 12 staff
20 years : 30 staff
10 years : 66 staff

Supporting Managers to Support their Staff

This one day workshop, first introduced in 2015, continued to be offered regularly throughout 2016 enabling 70 managers the opportunity to improve their understanding and application of Trust policies. The scenario and group learning approach facilitated by HR Business Partners continues to receive very positive ratings with managers commenting on a sense of improved confidence in maintaining a positive work environment. Further regular sessions are planned throughout 2017 to help embed and maintain the support created to date.

Leadership Development

Accelerating challenges in healthcare have made it imperative that front line clinicians, particularly nurses and midwives, have the leadership capability to drive radical service redesign and improvement. The ability to influence and lead change at the front line is now central to delivering this agenda at all levels within the hospital.

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

The second phase of a nursing and leadership development programme completed during 2016 with a prime purpose of increasing understanding of the context for change with enhanced cohesive and productive teamwork. The evaluation results demonstrate significant improvement in awareness and confidence relating to change and teamwork from the ward managers and an improved awareness and confidence from the matrons. The overriding theme in the final evaluation process from all participants was the importance of being together to learn, share and develop. It is proposed that five action learning sets will be facilitated during 2017 to enable a self-sustaining model for learning and development for nurse leaders within the hospital.

The Trust will be participating in a Systems Leadership programme sponsored by Health Education England from May 2017 to March 2018 aimed at developing leadership skills in working across boundaries. The programme will be delivered through Five cohorts across each participating locality (West Norfolk, Central Norfolk, Great Yarmouth & Waveney, East Suffolk & North East Essex and West Suffolk). Delegates will work collaboratively on an integration related project to improve their systems leadership competencies

across four domains; individual effectiveness, relationships and connectivity, innovation and improvement and learning capability building. Programme review will be March 2018.

Lifelong Learning

Lifelong Learning is a partnership programme between the Trust and our recognised trade unions; it aims to give staff learning opportunities to help with confidence and encourage access to personal development. The opportunities do not necessarily relate to work, with classes including wellbeing activities such as Pilates, yoga, dancing and sewing as well as continuing support for dementia awareness sessions. The approach to partnership working in setting up Lifelong Learning and the development of a dedicated centre (The Inspire Centre) onsite at the hospital has been recognised nationally and the Trust has been shortlisted for the HPMA (Healthcare People Management Association) Excellence Award. The final announcement and presentation will be in June 2017.

Staff Sickness Absence

Sickness absence remains a concern for the organisation. The Trust's average percentage was 5.06% in 2016. Monthly meetings are held with managers to discuss departmental sickness and agree action plans. Individual cases are being managed through the Managing Attendance Policy with the support of Human Resources and Occupational Health.

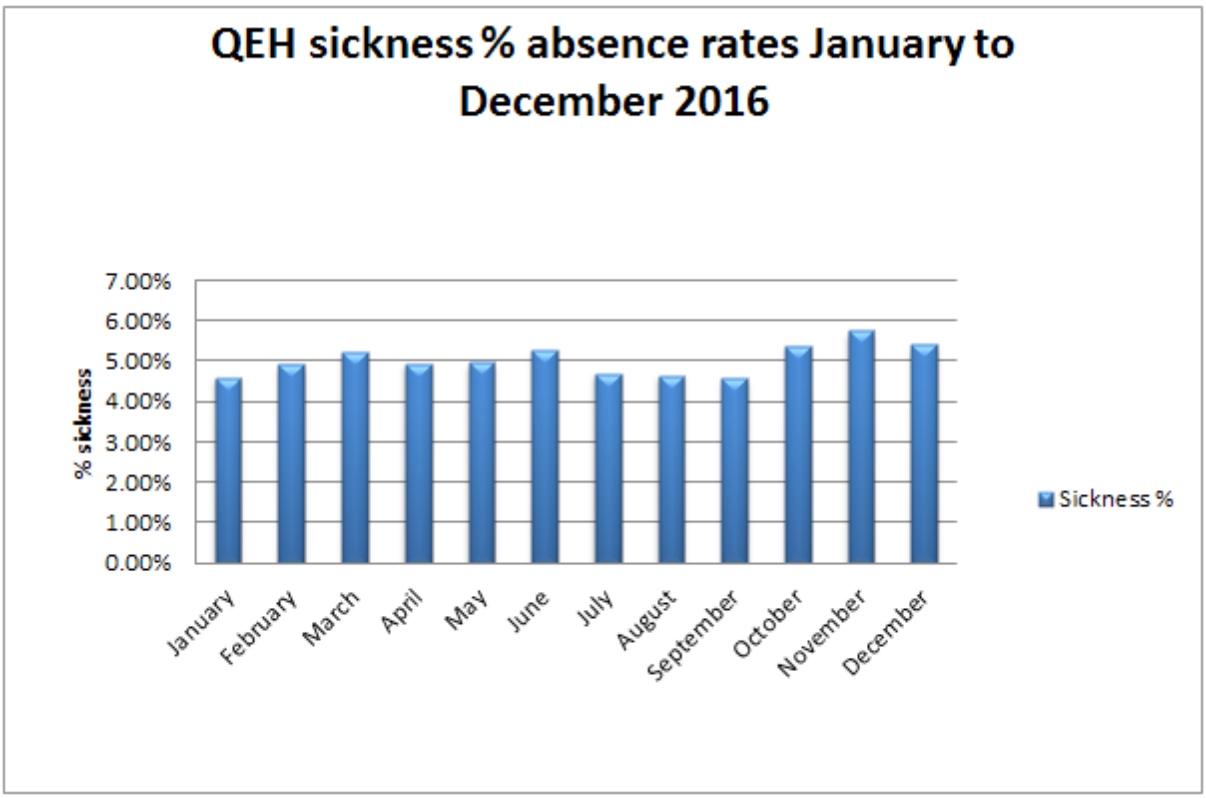
The table below shows sickness absence figures for the calendar year 2016.

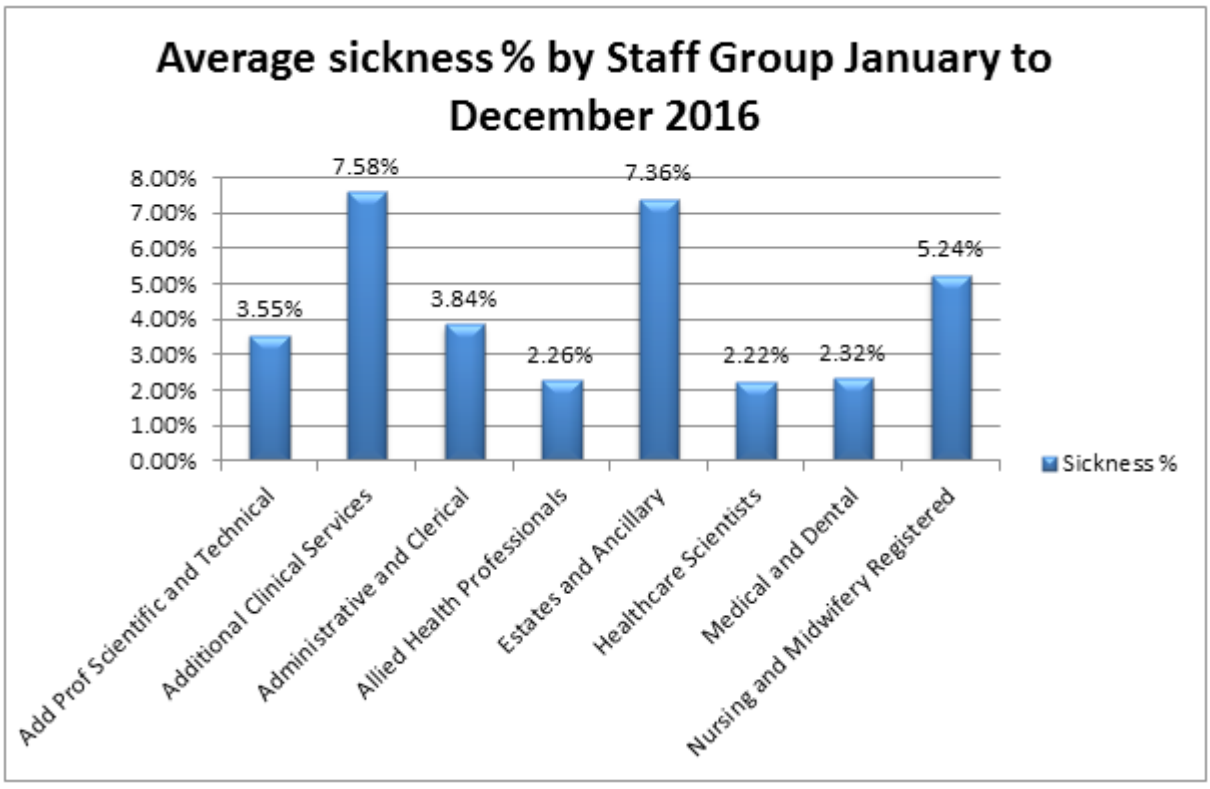
Average FTE 2016	FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence	Average Sickness % 2016
2,738	31,199	11.4	999,345	50,611	5.06%

Since April 2016, the Trust has continued using Firstcare who provide a 24/7 absence reporting line, giving staff access to immediate and on-going advice from a registered nurse.

This has supported improvement in sickness absence reporting, with managers receiving real time notifications and alerts.

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


QEH sickness % absence rates January to December 2016
% sickness
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
January
February
March
April
May
June
July
August
September
October
November
December
Sickness %


Average sickness % by Staff Group January to December 2016
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
3.55%
7.58%
3.84%
2.26%
7.36%
2.22%
2.32%
5.24%
Add Prof Scientific and Technical
Additional Clinical Services
Administrative and Clerical
Allied Health Professionals
Estates and Ancillary
Healthcare Scientists
Medical and Dental
Nursing and Midwifery Registered
Sickness %

Staff Policies

Staff policies and actions applied during the financial year:

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

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

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

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

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

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

All policies are assessed for equality prior to being implemented.

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

The Recruitment and Selection Policy states that the Trust will make every effort, when employees become disabled, to make sure they stay in employment. The Trust also has a Diversity and Equality of Opportunity Policy which states that the Trust will ensure that all people are treated fairly, with dignity and respect, irrespective of their gender, race, age, disability, sexual orientation, marital status, religion, belief, ethnic or national origin.

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

In line with the Managing Attendance Policy, where an employee becomes permanently incapable of undertaking their normal contractual duties the Trust will consider making reasonable adjustments to the duties of their job, subject to the needs of the service, or finding suitable alternative employment elsewhere within the Trust.

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

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

As above, it is within the Recruitment and Selection Policy for the Trust that if a disabled individual meets the essential criteria for a post there is the guarantee of an interview. For interview situations reasonable adjustments are made to ensure that individuals who attend have the resources and facilities that meet their needs.

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

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

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

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

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

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

Monthly Joint Staff Consultative Committee (JSCC) meetings take place and consultations are a standing agenda item. Transformational projects are also discussed at the Transformation Committee and Trust Executive Committee meetings, both of which have staff side representation.

The Chief Executive highlights areas of change within the organisation through his blog and QEH team brief sessions.

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

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

Monthly performance meetings take place with the divisional management teams and Executive Directors. 'The Knowledge' publication outlines Trust performance in key areas.

Individual staff surveys have been circulated to staff to ensure compliance with key protocols (i.e. implementation of new absence system, Firstcare).

Information on health and safety performance and occupational health

Health and Safety

The organisation has continued its work in this financial year to improve and sustain the governance of health and safety across the Trust. This has included closer working with Estates, Facilities and Occupational Health services. The Health & Safety Committee receives comprehensive reports that include staff incident trends and analysis. Where deficits are identified, remedial action plans are put in place.

There were a total of 17 RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reports made during the period 1 April 2016 to 31 March 2017.

Quality Improvement Programmes this year have included:

- Continuing development of the Trust's electronic web-based system for the safe management of Control of Substances Hazardous to Health (COSHH). The Trust database of assessments continues to develop and expand
- Continuing the development of the network of health and safety confident and competent staff across the Trust and at all levels from senior managers to local risk champions. This includes the introduction of training sessions as part of the risk champions meetings
- Involvement in groups such as falls and bariatric steering groups, and closer working with patient safety
- On-going monitoring of health and safety folders in all departments via scheduled H&S audits. This provides assurance that the folders are being used, and generic risk assessments are completed to support safe working practice
- Appointment of a substantive, full time fire officer from July 2016, and subsequent improvements to fire safety throughout the Trust, with the view to holding another live fire evacuation exercise in conjunction with the local fire service in summer 2017.

Occupational Health

Some 429 Management Referrals were made to Occupational Health for staff in 2016/17, which is consistent with the previous year (428). Also, 72 members of staff self-referred to Occupational Health, which is a decrease from the 93 in the previous year.

From January 2017 the process for data collection was modified to capture categories of referral. Between January and March 2017 Management Referrals for musculo-skeletal health issues were 29% of the total received in this period, and for mental health issues 24%. These percentages could be higher, as the process for capturing this data has been modified further for this year to capture underlying reasons where referrals were categorised generally (such as short or long-term sickness absence) or where information was incomplete. An OH data system, which would provide more complex data, is currently being considered.

The Occupational Health Physiotherapist received 433 new referrals, which was a slight increase on the previous year (406). The service continues to be appreciated by staff.

Numbers of staff undertaking mandatory Manual Handling training (Core Induction and Updates) was 674 for patient handling and 685 for non-patient handling. Non-mandatory training / support was provided for bariatric care, for volunteers using wheelchairs, for doctors and for using specialist equipment.

Improving staff health and wellbeing and the influenza vaccine campaign were part of a new Health and Wellbeing Commissioning for Quality and Innovation (CQUIN) this year, which is described in the Quality Report.

Information on policies and procedures for countering fraud and corruption

In conjunction with the Local Counter Fraud Specialist, policies are reviewed and audits undertaken as appropriate. An amendment was made to the Managing Attendance Policy to reflect measures introduced for 'employees undertaking secondary employment'. A local counter-fraud risk assessment was also undertaken and a subsequent action plan developed to ensure this was incorporated into relevant policies and procedures. These included the following actions:

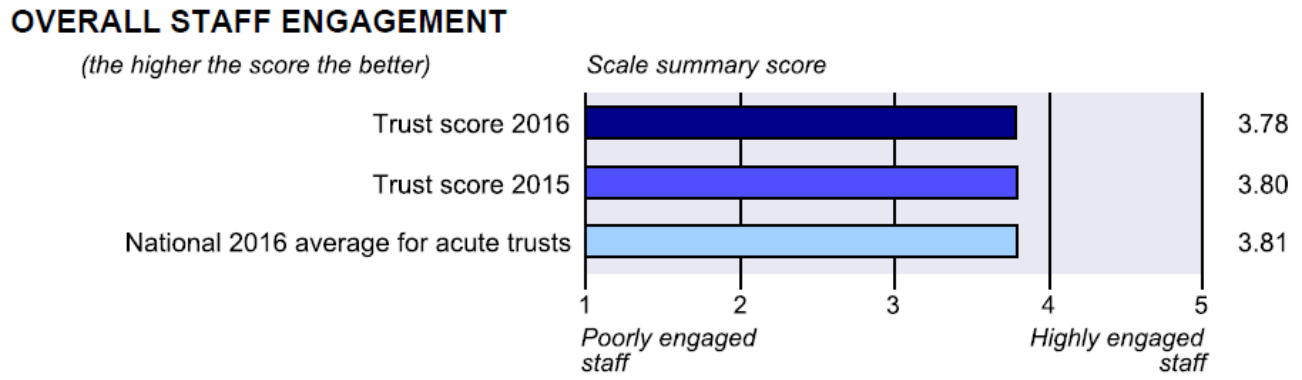
- Developing a Charitable Funds Policy – which has now been implemented
- Requiring staff in a position to influence purchasing decisions to sign a declaration of interests, including a nil return
- Auditing of HR files to ensure correct documentation is held
- Updating interview packs and Recruitment Policy to require panel members to declare any personal relationships with candidates
- Maintaining a policy review spread sheet detailing all review dates
- Referring to appropriate policies to include reference to the Anti-Fraud and Anti-Bribery Act
- Implementing of e-Rostering, which monitors annual leave
- Completing review of Secondary Employment Policy

Staff Survey 2016

The Trust Staff Survey 2016 was provided to 3,073 staff to complete, 1,376 surveys were completed, providing a response rate of 45%. The Staff Survey 2015 was provided to a random sample of 800 staff; 416 staff at the Trust took part in the Staff Survey 2015, a response rate of 53%. There was no significant change between the Trust Staff Survey Results for 2015 and 2016.

Staff Survey 2016 – Results

The figure below shows how The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.78 was below (worse than) average when compared with trusts of a similar type.



The table below shows how The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2015 survey.

	Change since 2015 survey	Ranking, compared with all acute trusts
Overall staff engagement	No change	Below (worse than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment	No change	Below (worse than) average
KF4. Staff motivation to work	No change	Above (better than) average
KF7. Staff ability to contribute towards improvements at work	No change	Average

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

Overall	2016		2015		
	Trust	**National Average**	Trust	National Average	**% Increase / decrease**
Response rate	45%	44%	53%	42%	8% decrease
Top 5 ranking scores					
KF24. Percentage of staff / colleagues reporting most recent experience of violence	73%	67%	62%	53%	11% increase
KF27. Percentage of staff/ colleagues reporting most recent experience of harassment, bullying or abuse	49%	45%	46%	37%	3% increase

KF11. Percentage of staff appraised in last 12 months	90%	87%	85%	86%	5% increase
KF2. Staff satisfaction with the quality of work and care they are able to deliver (Sliding scale 1 -5)	4.01	3.96	3.95	3.93	0.06 increase
KF4. Staff motivation at work	3.97	3.94	3.97	3.94	no change
Bottom 5 ranking scores					
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	21%	15%	19%	14%	2% increase
KF6. Percentage of staff reporting good communication between senior management and staff	24%	33%	28%	32%	4% decrease
KF31. Staff confidence and security in reporting unsafe clinical practice	3.55	3.65	3.63	3.62	0.08% decrease
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	32%	27%	32%	28%	no change
KF12. Quality of appraisals (Sliding scale 1 -5)	2.94	3.11	2.93	3.05	0.01% increase

KF numbers relate to key findings in National Staff Survey report.

Ranking Description	Key Finding areas 2016	Key Finding areas 2015
Best 20%	2 areas	3 areas
Better than average	8 areas	4 areas
Average	5 areas	12 areas
Worst than average	8 areas	8 areas
Worst 20%	9 areas	5 areas
Total	**32 areas**	**32 areas**

Largest Local Changes since the 2015 Survey

Where staff experience has improved

- KF18. Percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves.
- KF11. Percentage of staff appraised in last 12 months.

Development of Action Plans

It is recognised that the Staff Survey 2016 results showed that improvement is needed in a number of areas. The results of the Trust NHS Staff Survey 2016 are being communicated within the organisation in different ways. Action plans for areas requiring improvement will be developed with progress being monitored and reported on with the involvement of the Freedom to Speak Up Guardian and staff. In addition, there is a need to consider and to take forward best practice with regard to workforce initiatives and to explore what initiatives have worked well in other Trusts with above average staff survey scores compared to other acute Trusts and to implement any changes required to make a positive impact on staff experience at the Trust.

Staff Friends and Family Test

The Trust is committed to improving the engagement of staff with the Staff Friends and Family Test during 2016/17. Further analysis of staff feedback and development of action plans will take plan with a renewed emphasis on providing responses to staff on positive actions and changes made due to feedback received.

During each quarter, provider organisations are asked to rate the Trust against two key questions:

Question 1
Would you recommend your Trust to friends and family as a place to come for treatment?
Question 2
Would you recommend your Trust to friends and family as a place to work?

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

Staff Response Rate

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

Expenditure on Consultancy

The Trust made two payments in 2016/17 totalling £464,000. These were £448,000 for Emergency Care Transformation project, and £16,000 for an Acute Medicine Implementation Report.

(The supplier for both projects was Transformation Nous Limited).

Exit Packages

The exit packages within this disclosure were made under local arrangements

Exit Package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Departures where special payments have been made
<£10,000	1	12	13	10
£10,001 - £25,000	0	2	2	1
£25,001 - 50,000	0	0	0	
£50,001 - £100,000	0	0	0	
£100,001 - £150,000	0	0	0	
£150,001 - £200,000	0	0	0	
>£200,000	0	0	0	
Total number of exit packages by type	**1**	**14**	**15**	**11**
Total Resource cost (£)	**£7,000**	**£69,000**	**£76,000**	**£50,000**

Exit Packages: other (non-compulsory) departure payments	2016/17		2015/16	
	Payments Agreed	Total Value	Payments Agreed	Total Value
	Number	£000	Number	£000
Mutually agreed resignations (MARS) contractual costs			1	10
Contractual payments in lieu of notice	3	19	5	98
Non--contractual payments requiring HMT approval	11	50		
Total	**14**	**69**	**6**	**108**

Reporting high paid off-payroll arrangements

All off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than six months	2016/17 Number of engagements
	Number
No. of existing engagements as of 31 March 2017	25
Of which:	
Number that have existed for less than one year at the time of reporting	14
Number that have existed for between one and two years at the time of reporting	7
Number that have existed for between two and three years at the time of reporting	4
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0
Confirmation:	
The Trust can confirm that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	

For all new engagements, or those that reached six months in duration between 1 April 2016 and 31 March 2017	2016/17 Number of engagements
	Number
Number of new engagements, or those that reached six months in duration between 1 April 2016 and 31 March 2017	24
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	24
Number for whom assurance has been requested	24
Of which:	
Number for whom assurance has been received	24
Number for whom assurance has not been received *	0
Number that have been terminated as a result of assurance not being received	0

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017	2016/17 Number of engagements
	Number
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	4
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". The figure should include both off-payroll and on-payroll engagements	4

Disclosures set out in the NHS Foundation Trust Code of Governance

Compliance with the NHS Foundation Trust Code of Governance

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

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

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

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

At 31 March 2017, the Board of Directors declares compliance with the provisions of **The Code of Governance, Schedule A1 (Statutory Requirements)**

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

Provision	Provision summary	Supporting Explanation
A.1.1	This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	The Trust has in place an Engagement Policy, which describes how Governors may engage with the Board of Directors when they have concerns about the performance of the Board of Directors, compliance with the Licence Conditions or the welfare of the Trust. The Trust also has in place a 'Dispute Resolution Procedure', to deal with disputes relating to the Trust's constitution. Summary statements outlining how the Board and Governors' Council operate, including a summary of the types of decisions taken, are set out in the Annual Report, in 'The role of the Board of Directors' and 'The role of the Governors' Council' respectively.
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	See table – 'The Board of Directors in 2016/17'.

A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	See table - 'The Governors' Council composition in 2016/17'.
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	In respect of the criteria set out in The Code of Governance, all non-executive directors are judged to be independent in character and judgement. No relationships or circumstances have been identified that are likely to affect, or could appear to affect, directors' judgement.
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	See Board of Directors' Biographies. The Board is substantively appointed from April 2017, with the exception of the Interim Director of Nursing. This post will be appointed to substantively in 2017.
B. 1. 10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	See 'Committees of the Governors' Council - The Nomination and Remuneration Committee (Non-Executive Director appointments).
B. 3. 1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	The Trust Chair has no commitments likely to impact on his work with the Trust.
B. 5. 6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Governors canvass the opinion of the Trust's members and the public in a variety of ways, including through engagement with Healthwatch Norfolk and the Patient Participation Groups of the GP surgeries within the Trust's catchment area. The Trust's appointed Governors represent the views of a range of local strategic partners.

B. 6. 1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Board and Director performance evaluation methodologies employed include: • Self-assessment (after each Board meeting) • ED appraisal • NED appraisal (involving the Governors) In 2016/17, the Board self-certified compliance with: • general condition 6 of the NHS provider licence • corporate governance statement, AHSCs and training of governors. See also 'Evaluating the Board's Performance'. The Trust is preparing for its first regulatory 'Well-led Framework for Governance' external review in 2017/18 and in 2016/17, undertook a self-assessment against the 'Well-led Framework for Governance' criteria.
B. 6. 2	Where an external facilitator is used for reviews of governance, they should be identified and a statement made as to whether they have any other connection with the trust.	RSM (the Trust's Internal Auditor) has undertaken a preliminary review of the Trust's Financial Governance in 2016/17.
C. 1. 1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	See sections on: • 'The Directors' Report' • 'The Audit Committee and External Audit' • 'The Annual Governance Statement'
C. 2. 1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	See: 'The Annual Governance Statement'.
C. 2. 2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	See 'The Audit Committee and External Audit'.
C. 3. 5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	After a tender exercise, the Governors' Council reappointed KPMG as the Trust's external Auditor

C. 3. 9	A separate section of the annual report should describe the work of the committee in discharging its responsibilities. The report should include: • The significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed • An explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted, and • If the external auditor provides non- audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	See 'The Audit Committee and External Audit'; and 'The Independent Auditor's Report to the Governors' Council'.
D. 1. 3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable
E. 1. 5	The Board of Directors should state in the annual report the steps they have taken to ensure that the members of the Board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS Foundation Trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	See 'The Role of the Board of Directors'.
E. 1. 6	The Board of Directors should monitor how representative the NHS foundation trust's membership is, and the level and effectiveness of member engagement and report on this in the annual report.	See 'The Membership Strategy' and 'Current Foundation Trust Public Membership'.

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

Provision	Provision summary	Supporting Explanation
A. 1. 3	The board of directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.	Annual Report and on website.
B. 1. 4	A description of each director's expertise and experience, with a clear statement about the board of director's balance, completeness and appropriateness.	Annual Report and on website.

B. 2. 10	The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.	On request and in Annual Report – 'Committees of the Governors' Council'.
B. 3. 2	The terms and conditions of appointment of non- executive directors.	On request and in Annual Report.
C. 3. 2	The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference.	On request and in Annual Report – 'The Audit Committee and External Audit'.
D. 2. 1	The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board of directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the NHS foundation trust.	On request and in the Annual Report – 'Committees of the Governors' Council'. No remuneration consultants have been appointed during 2016/17.
E. 1. 1	The board of directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.	On request.
E. 1. 4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website.	Website and Annual Report – 'Contacting the Governors'.

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

	Provision	Information
A4	B. 7. 1	In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that after formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. *No non-executive directors reappointed in 2016/17*
A5	B. 7. 2	The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information. *Details of governors re-elected in 2016/17 are included in the Governors' Council table*

In respect of **The Code of Governance, Schedule A6 (Provisions requiring a compliance statement or explanation where the Trust has departed from the Code),** the Board declares compliance with all provisions as at 31 March 2017.

The Board of Directors

The Board of Directors has, during 2016/17, met in public on six occasions. The Board has also met in private where its debate has considered commercially sensitive and/or involved confidential issues. The Board meets in workshop settings to undertake strategic planning and development activities.

As at 31 March 2017, the Board of Directors was made up of the Chair, five non-executive directors and four voting executive directors. The four voting executive board positions at 31 March were: the Chief Executive; the Director of Finance; the Medical Director and the Director of Nursing. The meetings of the Board of Directors have been supported by executive portfolio holders.

The Role of the Board of Directors

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

Some of the responsibilities of the Board of Directors

- To ensure that the Trust meets its statutory duties and complies with its terms of authorisation and its constitution
- To ensure that the organisation's policy framework is developed in accordance with the rights, pledges and responsibilities contained in the NHS Constitution
- To provide leadership for the organisation in respect of agreed organisational values and standards of conduct, in accordance with accepted standards of behaviour in public life, which include the principles of selflessness, integrity, objectivity, openness, honesty and leadership (Nolan)
- To establish a robust performance management framework and support the Executive team in meeting the organisation's performance targets; monitoring the performance of the Trust and ensuring that the Executive Directors manage the Trust within the resources available, in such a way as to:

  – ensure the quality and safety of healthcare services
  – plan for continuous improvement
  – protect the health and safety of Trust employees and all others to whom the Trust owes a duty of care
  – use Trust resources efficiently and effectively
  – promote the prevention and control of Healthcare Associated Infection
  – comply with all relevant regulatory, legal and code of conduct requirements
  – maintain high standards of ethical behaviour, corporate governance and personal conduct in the business of the Trust
  – maintain the high reputation of the Trust both with reference to local stakeholders and the wider community

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

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

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

The Chair, the Vice Chair and the Senior Independent Officer

In a Foundation Trust, the Trust Chair chairs both the Board of Directors and the Governors' Council. The Queen Elizabeth Hospital's constitution makes provision for the Board's appointment of a Senior Independent Director, who has particular duties regarding working with the Governors' Council and the Board of Directors

to address any issues where it is inappropriate for the Chair to do so. The Trust's Senior Independent Director was appointed by the Board in 2016. The appointment was supported by the Governors' Council. The Governors' Council appointed the Trust's Vice Chair in February 2016.

In 2016/17, the Trust Chair has had no other significant commitments that have had an adverse impact on the role of Chair of the Foundation Trust.

Register of Directors' Interests

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

Delegation and the Committees of the Board of Directors

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

Committees reporting and accountable to the Board of Directors at 31 March 2017:

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

The Audit Committee and External Audit

The Audit Committee met five times during 2016/17. Its purpose is to maintain oversight of the adequacy of the control environment of the Trust, including those controls related to financial reporting procedures and quality. This work involves the monitoring of the effectiveness of internal controls and risk management processes. The Audit Committee approves strategies and plans for countering fraud and receives reports from the Trust's NHS Protect representative at each meeting. The Chair of the Audit Committee is a qualified accountant.

The Audit Committee approves the Internal Audit work programme and monitors the effectiveness of the Internal Audit function. The committee also receives and considers reports and opinion from both internal and external auditors. RSM provided the Trust's Internal Audit function in 2016/17. The Internal Auditors audit a range of both financial and quality controls at the Trust and provide levels of assurance accordingly.

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

The Trust's external auditor for the period covered by this Annual Report was KPMG. KPMG was re-appointed in 2016/17 as the Trust's external auditors by the Governors' Council after a transparent process, overseen by a group of governors, appointed by the full Council.

KPMG has provided additional non-audit services in 2016/17 at a cost of £52,650 + VAT. The work involved:

- high-level review of the cost improvement plans, transformation programme, grip and controls, cash flow management and VAT recovery
- identifying opportunities to improve performance against 2016/17 control total.

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

Evaluating the Board's Performance

The Board of Directors uses a number of methods to evaluate the performance of the Board and its committees. In 2016/17, performance evaluation methodologies employed include:

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

In 2016/17, the Board self-certified its compliance with:

- general condition 6 of the NHS Provider Licence
- corporate governance statement, AHSCs and training of governors.

The Trust is preparing for its first regulatory 'Well-led Framework for Governance' external review in 2017/18, and in 2016/17 undertook a self-assessment against the Well-led Framework for Governance criteria.

The Constitution

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

Director 1st April 2016 - 31st March 2017	Date of end of current NED terms of office	Audit Committee five meetings		Nomination and Remuneration Committee (ED Appointments) three meetings		Meetings attended out of 12 Board of Director (Ordinary) Meetings	Meetings attended out of 6 Governors' Council Meetings
Edward Libbey Non-Executive Director (NED) Trust Chair From 1 July 2014	July 2017			Chair	6/6	12/12	5/6
Ian Pinches – NED Chair of Audit Committee and Charitable Funds Committee – From 12 November 2012	Dec 2018	Chair	5/5	✓	6/6	11/12	5/6
John Rees – NED Chair of Quality Committee From 8 September 2014	Sept 2017	✓	3/5	✓	6/6	11/12	6/6
David Thomason – NED Chair of Finance & Performance Committee From 3 August 2015	Sept 2018	✓	4/5	✓	6/6	11/12	4/6
Maureen Carson – NED Chair of Workforce Committee From 7 September 2015	Sept 2018			✓	5/6	11/12	5/6
Ian Harvey – NED From 4 January 2016	Jan 2019			✓	5/6	10/12	4/6
Dorothy Hosein Chief Executive Officer (CEO) From 20 October 2014			5/5	✓	4/5	12/12 (1 sub)	6/6
David Stonehouse Director of Finance, Deputy CEO Voting Executive Director		✓	4/5			12/12 (5 sub)	3/6
Tim Petterson Interim Medical Director From 11 June 2016 To 31 March 2017						6/9	1/4
Karen Croker Interim Chief Operating Officer From 3 October 2016 To 31 March 2017						6/6	0/2
Jon Wade Director of Sustainability and I. T. From 21 November 2016						4/4	1/2
Emma Hardwick Interim Director of Nursing From 16 January 2017						3/3	0/1
Ciara Moore Chief Operating Officer From 15 March 2017						1/1	0/0
Beverly Watson Medical Director Voting Executive Director From 4 June 2014 To September 16 2016						4/4	3/3

Catherine Morgan Director of Nursing Voting Executive Director From 18 June 2014 To Jan 13 2016						9/9 (1 sub)	3/5
Sandy Spencer Interim Chief Operating Officer From 6 June 2016 To 6 September 2016						0/3	1/2
Patricia Dunmore Interim Chief Operating Officer From 23 July 2015 To 27 May 2016						0/1	0/1
Key: ✓= Committee member		No longer serving on the Board of Directors					

The Role of the Governors' Council

The Governors' Council:

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

Statutory duties for governors:

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

Governors:

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

Advice and training for governors:

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

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

At 31 March 2017, there were 30 governor seats on The Governors' Council of The Queen Elizabeth Hospital. The Governors' Council is made up as follows:

Sixteen Elected Public Governors

- 9 from West Norfolk
- 2 from Breckland, North Norfolk (and the Rest of England)
- 3 from Northern Cambridgeshire
- 2 from South-East Lincolnshire (1 vacant seat).

Six Elected Staff Governors

- 3 Clinical
- 3 Non-Clinical.

Eight Appointed Governors

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

2016/17 Election report

In January 2017 the Trust held elections in all constituencies: Breckland, North Norfolk and Rest of England, Cambridgeshire, South East Lincolnshire, West Norfolk, Staff Clinical and Staff Non-Clinical. Governor elections were held in accordance with the election rules set out in the Trust's Constitution, to enable members to elect candidates to the vacancies on the Governors' Council. The election was independently overseen by Electoral Reform Services. West Norfolk and Staff Non-Clinical constituencies were contested and the candidates from the other areas automatically became members as follows:

Constituency/Area	Governors to Elect	Contested?		Name	Term
Public Constituency					
Breckland, North Norfolk & Rest of England	2	No		Clive Monk Patricia Tickner	3 yrs 2 yrs
Cambridgeshire	2	No		Malcolm Bruce Betty Lewis	3 yrs
South East Lincolnshire	1	No		June Chadwick	3 yrs

Constituency/Area	Governors to Elect	Contested - Yes nominations	Turnout %	Name	Term
Public Constituency					
West Norfolk	5	8	15. 9%	Jonathan Dossetor Esmé Corner Penny Hipkin Steve Clark Barrie Taylor	3 yrs
Staff Constituency					
Staff Non-Clinical	1	2	16. 5%	David Coe	3 yrs
Staff Clinical	1	2	8. 6%	Julie Calton	3 yrs

Meetings of the Governors' Council

The Governors' Council has met formally in public, six times during 2016 - 17 (excluding the Annual Members' Meeting) and met at one extraordinary meeting.

The dates and venues for the Governors' Council meetings in 2017 can be found on the QEH website in the Governors' Council section. Alternatively, members can contact the Foundation Trust Office on 01553

613142 or email FT. Membership@qehkl.nhs.uk for details.

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

Committees of the Governors' Council

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

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

In 2016/17, the Committee continued to work to increase the public membership and to address some areas of under-representation in the public membership profile, through targeted recruitment. Once again successful collaboration with the College of West Anglia enabled wider representation of younger people. Regular membership recruitment took place within the Trust's Outpatient Department.

To assist with communicating with members and the wider public, the Committee has nominated members to participate on the editorial panel of the Trust's newsletter 'Trust Matters' and has developed an engagement strategy that includes a successful and well-attended programme of healthcare events for members.

The Nomination and Remuneration Committee (Non-Executive Director appointments) – to make recommendations to the Governors' Council regarding the appointment and remuneration of non-executive directors. The Terms of Reference for this committee have been drawn up in alignment with the Code of Governance and 'Your Statutory Duties – A Reference Guide for NHS FT Governors'. The committee making recommendations to the Governors' Council in respect of NED appointments is chaired by the Trust Chair (except when considering the appointment or remuneration of the Chair) and is comprised of governors.

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

The Patient Experience Committee has undertaken a wide range of activities throughout 2016/17:

- Involvement in PLACE (Patient Lead Assessments of the Environment) inspection / additional ward and department inspections
- Nursing Interview panel work
- Engagement with Norfolk Healthwatch
- Involvement in Mock CQC Inspections
- Liaison with Matrons and Leads across all specialties / wards
- Review of patient experience information drawn from a variety of sources.

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

Constitution Working Group – This Committee reviews the Trust's Constitution and makes recommendations for change, as necessary.

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

- Relationships and formal liaison with West Norfolk Patient Partnership and affiliated GP Patient

Participation Groups
- Development of relationships with South East Lincolnshire Patient Participation Groups
- West Norfolk Association Meetings
- Governors' Council Meetings
- PLACE Inspection(s)
- Healthcare Events
- Surveys.

Contacting the Governors

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

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

The Governors' Council composition in 2016/17

Constituency	Name	Current Term / Period remaining - Years	Governors' Council Meetings attendance	Nomination and Remuneration Committee Member	Membership & Communications Committee member	Patient Experience Committee Member	Business Committee Member
West Norfolk (9)	Robin Broke (re-elected Feb 2016) 3rd term	3/2	5/7	✓			
	Steve Clark (re-elected Feb 2017) 2nd term	3/3	5/7	✓		✓	✓
	Simon Clarke (elected Feb 2016) 1st term	3/2	4/7				✓
	Esmé Corner OBE (re-elected Feb 2017) (Lead Governor) 3rd term	3/3	7/7	✓	✓	Chair	✓
	Jonathan Dossetor (re-elected Feb 2017) 3rd term	3/3	7/7		Chair	✓	
	Penny Hipkin (re-elected Feb 2017) 3rd term	3/3	6/7	✓	✓	✓	
	Robert Outred (elected Feb 2016) 1st term	3/2	7/7		✓	✓	
	Peter Tasker (elected Feb 2016) 1st term	3/2	6/7			✓	
	Barrie Taylor (re-elected Feb 2017) 3rd term	3/3	5/7			✓	
Cambridgeshire (3)	Jenny Brodie (Feb 2016) 2nd term	3/2	4/7			✓	✓
	Malcolm Bruce (Feb 2017) 1st term	3/3	2/2		✓	✓	
	Betty Lewis (Feb 2017) 3rd term	3/3	7/7		✓	✓	
	Kevin Kanolty (re-elected Feb 2014)	3/0	0/7	✓			✓
Breckland* North Norfolk & Rest of England (2)	Clive Monk (Feb 2017) 2nd term	3/3	7/7	✓		✓	✓
	Patricia Tickner (Feb 2017) 1st term	2/2	2/2		✓	✓	
	Xavier Navarre (Feb 2016) resigned 01/17	3/2	5/5				
SE Lincolnshire (2)	June Chadwick (2017) 1st term	3/3	1/2			✓	
	Aimee Hicks (February 2016) 1st term	3/2	4/7			✓	
Staff Clinical (3)	Mark Abbott (February 2016) 1st term	3/2	6/7			✓	
	Julie Calton (re-elected Feb 2017) 2nd term	3/3	6/7	✓		✓	
	Nigel Tarratt (Feb 2016) 2nd term	3/2	6/7		✓	✓	
Staff Non-Clinical (3)	Darren Barber (elected Feb 2016) 1st term	3/2	5/7		✓		
	Sophia Buckingham (elected Feb 2016) 1st term	3/2	6/7				✓
	Dave Coe (re-elected Feb 2017) 3rd term	3/3	7/7	✓			✓

Constituency	Name	Current Term / Period remaining - Years	Governors' Council Meetings attendance	Nomination and Remuneration Committee Member	Membership & Communications Committee member	Patient Experience Committee Member	Business Committee Member
Eight Appointed Governors							
Borough Council King's Lynn & West Norfolk	Paul Kunes – from May 2015	3/2	5/7				✓
Breckland	Ian Sherwood – from May 2016	3/3	3/6				
	Peter Wilkinson from May 2015 (to May 2016)	3/0	1/1				
College of West Anglia	Ann Compton – From Feb 2017	3/3	0/0				
College of West Anglia	Andrew Gedge – from March 2014 (to Feb 2017)	3/0	0/7				
Freebridge Community Housing	Ray Johnson – from February 2014	3/0	5/7				Chair
Norfolk County Council	Jim Perkins – from June 2015	3/2	6/7	✓			
West Norfolk CCG	Hilary De Lyon – from February 2014	3/0	5/7	✓			
West Norfolk Carers	Jane Evans – from February 2015	3/1	5/7		✓	✓	
UEA	Paul Dansie – from April 2016	3/2	2/7				
Key:	**Governors no longer serving on the Governor's Council as at 31 March 2017**						

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

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

Who can become a Member?

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

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

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

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

Members of Staff

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

How do I apply to become a member?

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

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

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

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

The Membership Strategy

We achieved a public membership of 7,458 by the end of 2016/17.

The QEH Public Constituency	Members 31 March 2016	Members 31 March 2017
Gender		
Male	2,934	2,960
Female	4,334	4,498
Total	**7,268**	**7,458**
Constituency		
Breckland, North Norfolk & Rest of England	1,293	1,317
Cambridgeshire	656	665
SE Lincolnshire	593	594
West Norfolk	4,726	4,882
Total	**7,268**	**7,458**
Age		
16-21	957	981
22-29	368	477
30-39	483	503
40-49	649	644
50-59	811	812
60-74	1,875	1,911
75+	1,472	1,514
Not stated	653	616
Total	**7,268**	**7,458**
Ethnicity		
White	6,793	6,974
Mixed	29	31
Asian or Asian British	64	73
Black or Black British	27	30
Other	19	19
Not stated	336	331
Total	**7,268**	**7,458**

NHS Improvement's Single Oversight Framework

Single Oversight Framework

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

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

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

The Single Oversight Framework was 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.

Segmentation

Segmentation	Description
1	No potential concerns identified across NHSI's five themes – lowest level of oversight
2	Triggering criteria of concern in one or more of the five themes – but not in breach of licence (or equivalent for NHS trusts) and/or formal licence action not needed
3	Serious issues – the provider is in actual/suspected breach of the licence (or equivalent for NHS trusts)
4	Critical issues - the provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues (e.g. including providers requiring major intervention on multiple issues to return to sustainable performance).

As of October 2016 NHS Improvement has placed The Queen Elizabeth Hospital NHS Foundation Trust in Segment 3.

The Trust is in breach of its licence and has monthly Performance Review Meetings (PRMs) with NHSI. For more information see the Annual Governance Statement.

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	4	4
	Agency Spend	3	3
Overall Score		**4**	**4**

Overall the Trust has scored a 4 for finance and use of resources which shows weak performance. Generally this can be expected from an NHS organisation which has been identified as financially unsustainable. The larger than planned deficit and the requirement for loan funding means that the Trust expected to score a 3 or 4. These scores for the Finance and Use of Resources theme are likely to continue until longer term financial sustainability is secured.

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

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

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

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

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

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

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

Jon Green – Chief Executive
Date: 23/5/2017

Annual Governance Statement

1 Scope of responsibility

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

2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

3 Capacity to handle risk

Risk Management

The Medical Director has executive responsibility for the Trust's Risk Management function, with line management responsibility for a Risk and Governance Team which oversees and supports the maintenance of the Trust's Risk Register at all levels of the organisation, and which undertakes Risk training at appropriate levels throughout the Trust for Risk Managers and Handlers. The Risk and Governance Lead also oversees the Trust's Clinical Audit function, the Trust's compliance with the Duty of Candour and the management and reporting of Serious Incidents and Never Events. An Internal Audit was also undertaken in respect of the Clinical Audit function. The audit provided an assurance level of 'green (substantial assurance), in recognition of significant process improvements since an earlier audit.

The Trust has a Risk Management Strategy in place, which provides a framework for managing risk and lays out the delegation of responsibility to executive directors, managers, clinicians and staff as appropriate. Internal Audit undertook a review of the risk management system in 2016/17 and provided an assurance level of 'amber/green' (reasonable assurance) that the controls upon which the organisation relies to manage this area are suitably designed and consistently applied. All recommendations are being addressed by the Trust and the Trust's Risk Management methodologies are kept under review to ensure they remain fit for purpose.

An executive Risk Committee, chaired by the Director of Nursing, meets monthly and reports to the Board of Directors. The Risk Committee reviews the corporate risk register high risks every month and scrutinises all divisional and departmental risk registers on a programmed rolling basis. This provides assurance to the Board and escalates concerns as appropriate. There are plans for 2017/18 for further strengthening the assurance provided to the Board by the Risk Committee.

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

The Board of Directors agrees and monitors the Board Assurance Framework and all high scoring risks on the Corporate Risk Register. The Board Assurance Framework sets out the principal risks to the delivery of the Trust's strategic objectives. Each risk has a lead Executive Director and key monitoring committee assigned to it and details of the controls in place to mitigate against the risk. Any gaps in controls are highlighted through this process, allowing management action to be taken. The Board agrees target risk ratings for all

strategic risks and assesses residual risk against its key strategic aims once assurance is received that effective internal controls and mitigations are in place.

The Internal Audit review of the Board Assurance Framework, undertaken in 2016/17, gave a 'green' assurance rating, providing substantial assurance that the controls upon which the organisation relies to manage the identified risk(s) are suitably designed, consistently applied and operating effectively.

4 The risk and control framework

The Board submitted its Corporate Governance Statement in accordance with Licence Condition 4 in 2016.

The Trust has remained in breach of its licence with healthcare regulator, NHS Improvement (NHSi) in 2016/17 and the Regulator's assessment of the Trust against the criteria of the Single Oversight Framework will be reflected in the 2017 Corporate Governance Statement.

The Board agreed to produce timely monthly, quarterly and annual submissions to NHSI in 2016/17, concerning risks to its compliance with its licence. The Trust is subject to monthly Progress Review Meetings (PRM) with the Regulator.

The Board outlined its Corporate Objectives for 2016/17:

1. To deliver safe services
2. To deliver the best possible experience for patients and staff
3. To deliver the most effective outcomes
4. To deliver a well-led, capable and motivated workforce
5. To be efficient and make best use of available resources

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

The Board has reviewed and articulated its key risks in 2016/17 through the Board Assurance Framework:

- Patients do not receive quality care because safety, outcome and/or experience does not meet our expected standards
- Unable to maintain Trust financial viability without significant deterioration in service quality
- Inability to develop effective partnerships that lead to transformative care pathways for patients
- Failure to develop appropriate workforce capacity and capability that reflects a culture of excellence
- Inability to maintain, replace, develop (or dispose of) the Trust's physical infrastructure, including IT and Estate to ensure that they remain fit for the future needs of the Trust
- Unable to retain and/or build and embed leadership capability at all levels within the Trust.

The Board has in 2016/17, also identified its top strategic risks as being those related to:

- Financial sustainability
- Workforce
- Estate

The Board has monitored its position and mitigations in respect of these principal risks throughout 2016/17. In addition, the Board considers all medium to high corporate risks with a residual risk of between 15 and 25, and their associated mitigations.

The Board had eight committees reporting to it during 2016/17, namely:

- The Quality and Patient Safety Committee
- The Finance & Performance Committee
- The Trust Executive Committee

- The Nomination and Remuneration Committee (Executive Director Appointments)
- The Audit Committee
- The Risk Committee
- The Workforce Committee
- The Health and Safety Committee.

The Board is alerted to risks identified at the committees via a Chair's Key Issues reporting methodology.

Committees reporting to the Board are required to produce an annual report, summarising their activities in the reporting year and their compliance with their terms of reference. In this way, the Board can secure assurance of the effectiveness of its committees.

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

Risk management training is provided to relevant staff and policies and related templates are available on the Trust's intranet site. Additional 'Risk Appetite' development is planned for the Board in 2017.

The Trust Executive Committee is chaired by the CEO and the membership in 2016/17 comprised the Executive Director Team, the Trust's Clinical Directors, senior nurses and senior managers. The Committee is responsible for the delivery of the Trust's business plans. The Trust Executive Committee develops, implements and reviews tactical plans, approves and recommends associated policy and monitors the performance of the organisation against its plans and key performance indicators.

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

The terms of reference of the Quality and Patient Safety Committees were amalgamated in 2016/17 to strengthen Board-level visibility of patient safety and mortality. The Quality and Patient Safety Committee monitors the delivery of the Trust's Quality objectives and reviews key quality information to provide the Board with assurance that the Trust is delivering effective, safe services and a positive patient experience. The Quality and Patient Safety Committee also undertakes detailed 'Quality Enquiries', where concerns have been raised relating to the delivery of quality services in a particular area.

The Finance & Performance Committee monitors and reviews the adequacy of the Trust's financial risk assessments, assumptions, sensitivities, mitigation plans and contingencies. It monitors the Trust's on-going financial position against the Board-approved plan and any action plans in place to recover the financial position. The Committee monitors the Trust's performance in delivering services in accordance with key access standards. It also considers and reviews the alignment of capacity and activity volumes to financial plans and service line contributions.

In 2016/17, a deterioration in performance against the Trust's financial forecast prompted the Finance and Performance Committee to commission additional recovery monitoring work from a non-executive director-led Finance Oversight Group.

The Workforce Committee oversees and monitors the Trust's workforce issues and risks relating to recruitment, retention, sickness absence management, education, training and staff satisfaction.

The Nomination and Remuneration Committee (ED appointments), oversees the recruitment of the executive directors and approves executive appointments. In 2016/17, the terms of reference for the Committee were reviewed and revised to provide for non-executive director oversight of Very Senior Manager (VSM) appointments in respect of regulatory, Department of Health and Treasury rules relating to VSM appointments,

including the requirement for VSMs to meet the criteria of the 'Fit and Proper Person' test.

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

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

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

The Trust complies with the directions issued by the Secretary of State in 2004 and the Standards for Providers: Fraud, Corruption and Bribery as set out by NHS Protect.

The Trust takes a positive stance in countering bribery and fraud against the organisation and the NHS in general and actively seeks to ensure that an appropriate, yet proportionate response is taken to allegations of fraud and bribery.

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

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

Proactive support has been provided for the Trust by the LCFS areas, including general fraud and bribery risk and prevention, The National Fraud Initiative, working whilst in receipt of sickness absence pay and scam emails.

The CQC and Quality Risk

The Trust's last Care Quality Commission (CQC) inspection was in June 2015.

The Trust was formally rated:

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

As a result of the improvements identified by the CQC between 2014 and 2015 inspections, the Trust was removed from 'Special Measures' in August 2015.

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

The Trust has introduced a Quality Improvement Group to oversee and evidence the delivery of the 'Must' and 'Should' recommendations of the CQC's inspection report and to focus the Trust on delivering services in accordance with the CQC's Fundamental Standards. A Quality Summit was held in 2016/17 to review progress.

In 2016/17, an Internal Audit was undertaken of the Trust's methodology for providing assurance to the Board in respect of CQC compliance. The internal Audit provided 'reasonable assurance' (amber/green). The Trust has assimilated the recommendations of the audit and in 2017, will be reviewing and strengthening its processes for driving quality improvements and evidencing CQC compliance. This work will include improved visibility for the Board.

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

Public and Staff

The public, including public Foundation Trust members and Healthwatch representatives, are involved in the risk management process within the Trust through their involvement in the Patient Experience Committee of the Governors' Council (PEC), mock CQC inspections and Patient-led Assessments of the Care Environment (PLACE) inspections. Service users are also involved through a number of very active service user groups and, of course, via their responses to patient satisfaction surveys.

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

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

The Governors' Council also reviews quality, operational performance and financial information and risk as part of its statutory duty to hold the Non-Executive Directors to account for the performance of the Board. The Governors' Council meets six times a year. The Governors' Council's views have been taken into account in the development of the Trust's annual plans and Quality Strategy. The Patient Experience and Business Committees of the Governors' Council review detailed quality, performance and financial risk and report back to the Governors' Council at every meeting.

Governors and NEDs have recently participated together in a workshop on 'Holding to account and questioning techniques'.

Staff are expected to provide safe clinical practice, report incidents and potential hazards, be familiar with the Trust's Risk Management Strategy and departmental risk issues, comply with all Trust policies and procedures and take reasonable care of their own safety and the safety of others. The Trust uses a Datix-web system for the reporting of incidents. All reported incidents are reviewed regularly. The 2016 Staff Survey found 92% of responders 'reporting errors, near misses or incidents witnessed in the last month' as compared to the national average of 90%.

The Trust has a well-developed Whistleblowing Policy, which aligns with the national 'Freedom to speak up: whistleblowing policy for the NHS' and a range of both internal and external arrangements are in place for staff to be able to raise concerns. All Whistleblowing cases are reported to the Board. In 2016/17, the Trust appointed a Non-Executive Director to the post of Freedom to Speak Up Guardian as an interim measure, pending the appointment of an independent post-holder. The new Freedom to Speak-Up Guardian will take up her post in May 2017.

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

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

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

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

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

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

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

The Board considered its 'Going Concern' position at its meeting in March 2017 and after consideration of risks and uncertainties agreed that:

'The use of the going concern basis is appropriate but there are material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a going concern. Nevertheless after making enquiries, and considering the reality of the uncertainty materialising, the Directors have a reasonable expectation that the Trust will have access to adequate cash resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts.'

The Trust reports on the delivery of its financial plans to NHSi in accordance with the Single Oversight Framework and is subject to monthly Progress Review Meetings (PRM) with the Regulator.

The Trust has been financially challenged in 2016/17, due in large part to agency costs required to maintain safe levels of staffing. Because of a significant deterioration in its financial position in Quarter 3, the Trust:

- Alerted the Regulator
- Secured independent specialist financial support
- Commissioned an independent audit of its financial governance arrangements
- Put in place additional non-executive director-led financial oversight.

The Trust understands that the financial challenge for 2017/18 and beyond will be significant and that delivery of its plans will require elevated levels of Cost Improvement Programme (CIP) delivery and transformational ways of working. The Trust has put in place additional controls at all levels, has developed further sources of assurance and oversight to provide high visibility for the Board and has improved its financial reporting.

The Trust is working strategically with its Sustainability and Transformation Plan (STP) and other partners to secure the sustainability of the regional and local healthcare system. This work is overseen at a high level jointly, by NHS Improvement and NHS England.

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

- Standing Financial Instructions and Scheme of Delegation
- Financial Management Policy Suite
- Anti-Fraud and Anti-Bribery Policy Suite
- Management of Conflicts of Interest and Gifts, Hospitality and Commercial Sponsorship Policy (to be revised for June 2017, in line with national policy)
- Executive management of Trust finance and activity plans
- Regulatory review of Reference Costs
- Trust response to Lord Carter review – 'Operational productivity and performance in English NHS acute hospitals'
- Cost Improvement Programme (Quality Impact Assessed)
- Service Line Reporting
- Procurement Strategy (assimilating Lord Carter recommendations).

Assurance is provided by Internal and External Audit.
Through the Internal Audit programme for 2016/17, the Trust has commissioned a range of audits to provide assurance that resources are used economically, efficiently and effectively:

- CIPS and Financial Forecasting – amber/red (partial assurance)
- Theatres IT Procurement – red (no assurance)
- Financial Systems – amber/green (reasonable assurance)
- Consultant Medical Leave and Locum Usage - green (substantial assurance)

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

6 Information governance

Information risk is managed through the Information Governance Committee, which reports to the Trust Executive Committee. The Trust has nominated a Director to fulfil the role of Senior Information Risk Owner (SIRO) and has assessed compliance with the requirements of the NHS Digital Information Governance Toolkit, and signed the annual Information Governance Assurance Statement in March 2017. It assessed itself as 'green/satisfactory' with a compliance score of 80% which is a pre-requisite of unconditional registration with the Care Quality Commission. Internal Audit also undertook a review of the systems and processes supporting the Trust's submission.

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

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

7 Annual Quality Report

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

The Trust has presented its Quality Report as part of its Annual Report and Accounts based on a range of Quality indicators that were agreed by the Board and that are monitored on a regular basis through Integrated Performance reports, including Quality and Operational performance. The Governors' Council has selected a local indicator for audit as required. The Board of Directors is satisfied that the messages within

the Quality Report accurately reflect the information that it has received on a regular basis throughout the year. The report has been shared with the Trust's commissioners, Governors, Healthwatch and Norfolk Health Overview and Scrutiny Committee, all of whom have been given the opportunity to provide formal comment for publication within the report.

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

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

The Quality Report development process is led by the Director of Nursing, with support from the informatics team.

8 Review of effectiveness

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

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

Internal Audit reviewed the Board Assurance Framework in 2016/17 giving an overall rating of 'Green' (Substantial Assurance).

During the year, 15 internal audits were conducted:

- CIPS and Financial Forecasting - amber/red (partial assurance)
- CQC - amber/green (reasonable assurance)
- Non-Purchase Order Payment Systems – amber/red (partial assurance)
- Patient Experience – Complaints – green (substantial assurance)
- Divisional Accountability – green (substantial assurance)
- Clinical Audit Process – green (substantial assurance)
- Raising Concerns & Whistleblowing – amber/green (reasonable assurance)
- Board Assurance Framework – green (substantial assurance)
- Theatres IT Procurement – red (no assurance)
- Financial Systems – amber/green (reasonable assurance)
- Consultant Medical Leave and Locum Usage – green (substantial assurance)
- Recruitment – amber/red (partial assurance)
- Risk Management – amber/green (reasonable assurance)

- IG Toolkit Fieldwork - advisory
- Maternity Dashboard – amber/green (reasonable assurance)

Robust management action plans and follow-up audits have been agreed. These will address any risks, control weaknesses and ongoing compliance issues identified in all Internal Audits. The delivery of these actions is monitored by the Audit Committee.

The Head of Internal Audit opinion for 2016/17 is as follows:

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

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

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

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

I take additional assurance from programmed, ad-hoc and commissioned external reviews. These external reviews provide me with an independent view and recommendations. In 2016/17 independent reviews have included:

- CCG review of Maternity and Children
- HEE Non-Medical Quality Improvement Performance Framework
- Major Trauma Peer Review
- Model Hospital - GIRFT - Getting it Right First Time – Orthopaedics Review
- Model Hospital - GIRFT - Getting it Right First Time – Urology Review
- Medicines and Healthcare Products Regulatory Agency (MHRA) review

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

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

The Trust is preparing for its first regulatory 'Well-led Framework for Governance' external review in 2017/18, and in 2016/17 undertook a self-assessment against the Well-led Framework for Governance criteria. The regulatory definition of a 'well-led' organisation is one where the leadership, management and governance of the organisation ensure the delivery of sustainable high quality person-centred care, support learning and innovation, and promote an open and fair culture. The review employed non-executive director and governor peer review as part of its rigorous evidence-based methodology. An action plan to address identified gaps is in development and will be rolled out in 2017/18.

9 Conclusion

I am new to the role of CEO of The Queen Elizabeth Hospital, King's Lynn, NHSFT, having taken up my post as Accounting Officer in May 2017. The opportunity afforded by the requirement for me to make an Annual Governance Statement (AGS) at this time, is helpful in that it facilitates a review of the control environment in the year just passed, at the beginning of my tenure with the Trust, which is of course primarily forward looking.

There has been one 'red' (no assurance) internal audit in the 2016/17 reporting period, in respect of 'Theatres IT Procurement'. I am pleased to note that the Head of Internal Audit Opinion reports that The Trust has responded positively to this report and is implementing the agreed actions.

My AGS review and my broader observations as newly appointed CEO and Accounting Officer lead me to conclude that while progress has been made in many areas in 2016/17, there remain significant control environment challenges for the Trust in 2017/18, relating to:

- Financial delivery, productivity/efficiency and sustainability
- Emergency pathway and operational performance sustainability
- Nurse and medical staffing sustainability and the impact of high dependency on temporary staff
- Embedding and sustaining quality improvements
- Developing a high-performing executive team and Board. At the beginning of 2017/18, the Trust has in place a recently appointed, though largely substantive, executive team. It is my intention to optimise the opportunities that this position brings.

I also understand that working with our healthcare community partners and to progress our Sustainability and Transformation Plans will present both opportunities and challenges for the Trust and that our control framework will need to be developed and more outward-facing, to ensure that we have the appropriate mechanisms in place to ensure that we meet our objectives and develop our services for the benefit of the patients and community we serve.

I take assurance from the controls and risk mitigations outlined in my Annual Governance Statement that the Trust's plans for 2017/18 will secure improvement in these areas.

Jon Green – Chief Executive
Date: 23/5/2017

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The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Quality Report

2016/17

Contents

Part 1: Statement on Quality

The Board of Directors for The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is pleased to present its Quality Report for 2016/17. This account demonstrates how the Trust has embedded the processes put in place in the previous year to improve not only the quality of the services provided to patients but also the governance arrangements through which these services are monitored and maintained.

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

- Strengthened governance and accountability within both its clinical services and the organisation as a whole
- Delivered its quality priorities for 2016/17 as set out in the final delivery year of its current Quality Strategy
- Responded to feedback and information from complaints, PALS enquiries and incidents and from views expressed in patient and staff surveys and online feedback, to ensure that areas for improvement are identified and acted upon and that lessons are learnt and shared throughout the organisation
- Monitored and improved its clinical practice through participation in clinical audit and research
- Performed in relation to its core clinical indicators and CQUIN activity
- Developed and set out its quality priorities for 2017/18.

The Trust has continued to hold to its clear ambition of 'Aiming for Excellence' in all its clinical services and throughout the organisation as a whole. This set the direction of travel for the year and enabled the organisation to focus on meeting its quality objectives and at the same time prepare for a period of transition and change. As I arrive to take up the post of Chief Executive, I am pleased to note the quality improvements the Trust achieved in 2016/17 and the appetite that the organisation has to take that ambition forward into the coming year.

In the spring of 2015 the Trust revisited and refreshed its Quality Strategy to ensure it reflected the position of the organisation at that time, was relevant and able to provide direction and focus for the following two years. The strategy was launched at the beginning of 2015/16 and has provided a framework for improvement under four clear objectives. These focused on ensuring that:

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

Under the umbrella of these overarching quality objectives the Trust identified priority areas for improvement in 2016/17:

- Reduce healthcare associated infection related to Clostridium Difficile
- Improve management of patients with sepsis
- Reduce hospital acquired pressure ulcers
- Reduce inpatient falls
- Improve Friends and Family Test (FFT) scores and maintain response rates for inpatients and the Emergency Department
- Improve patient and family experience in end of life care
- Improve pathway for urgent admissions
- Ensure effective management of medicines
- Improve the experience for mothers and their families using maternity services
- Improve staff Friends and Family Test scores.

The Trust received its last inspection visit by the Care Quality Commission (CQC) in June 2015 and exited 'Special Measures' later that year but has remained focused on improving its current rating of 'Requires Improvement'. This has been supported by its clinical and governance framework, which ensures accountability and responsibility for improvement from the operational front line through the Clinical Divisions to the Board

of Directors. During this year the governance framework has been extended and strengthened through joint governance arrangements with partnership provider organisations to support the provision of services to patients who may also present with mental health problems or have a learning disability.

The Trust has continued to see this as an on-going process of transformation leading to a sustainable position in which the Trust consistently provides an excellent service to patients. The CQC identified three areas where further improvement was required and there has been a continued focus on these services to ensure sustainable improvement:

- Obstetrics and Gynaecology services
- Outpatients
- End of Life services

During the year the Trust has maintained a Quality Improvement Group, led by an Associate Medical Director, to oversee and monitor delivery of improvements in those areas the CQC had identified as requiring further improvement and to ensure that across the organisation the Trust is continuing to deliver its service in accordance with the CQC's Fundamental Standards.

The Trust has continued to maintain its commitment to the national 'Sign up to Safety' programme and its Safety Improvement Plan for 2016/17 has focused on the four key work streams that reflected the Trust's quality priorities and have led to direct improvements in safety for the patient:

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

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

The Trust aims to be the 'employer of choice' and recognises the valuable contribution that its staff make to the care patients receive. By developing an engaged, enabled and empowered workforce, which is well-led and supported, the Trust can ensure its staff are getting the best possible experience, and in turn patients are getting the best care.

During 2016/17 the Trust has underpinned its commitment to improvement by investing in its staff and its estate. In terms of its staff this has included:

- A continued focus on recruitment, successfully appointing to a number of medical and nursing posts
- The development and implementation of a new Health and Wellbeing portal 'Just for You' and other health and wellbeing initiatives such as Yoga and Pilates classes and Staff Gym delivering on the NHS Constitution Staff pledges and improving communication and engagement
- The provision of further development opportunities for 'grow our own' through apprenticeships
- Planned for the introduction of the new Apprenticeship Levy from April 2017 to maximise the benefits to the organisation and staff
- Continued to work in partnership to provide Lifelong Learning opportunities and to develop and embed policies and practices for staff and the organisation
- Embedded the Trust's core values in the processes of recruitment, induction and appraisal
- Continued the recognition of achievement in demonstrating those values through an on-going programme of 'Values awards' and 'Long Service awards'
- Continued investment in Leadership & Management Development both internally and at regional/ national level.

In relation to our estate there is now in place a well-developed Estates Strategy and in this last year the Trust has seen:

- Refurbishment of West Raynham Stroke Ward and the West Wing corridor

- Dedication of the Peace and Hope Gardens for patients and their families in the Shouldham Ward/ Breast Unit courtyard
- Refurbishment of the Training and Resource Centre as a dedicated training area – on completion renamed as The Inspire Centre, which also includes a Unison meeting room and a Human Resources recruitment office area
- New treatment rooms in the Brancaster Unit
- Third Echo room for the Cardiorespiratory Department
- Site-wide Wi-Fi in place since July 2016
- Completion of the refurbishment programme for Theatres 5 & 6
- Refurbishment of the Specialist Doctors' mess
- New ENT treatment room
- Creation of 50 office spaces in the empty first floor pathology laboratory area, where all teams involved in Discharge and Community Support are located together
- Refurbishment of the Roxburgh Children's Centre – new floors, new treatment rooms
- Sustainable solution to the medical gases infrastructure
- Implementation of new portering software
- Implementation of Zonal Cleaning for greater supervision and response resources
- Development of The Hub Restaurant – new opening times and a focus on healthy menus.

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

- Doubling the recruitment of patients to participate in Clinical Research studies
- The Trust has met both the external target and its own stretch target in relation to the number of Clostridium Difficile cases with 22 cases during the year
- A continued reduction in hospital-acquired pressure ulcers achieving a further 36% reduction compared to the previous year
- A reduction in the number of inpatient falls to <5 per 1000 bed days
- Achieved the sepsis targets in accordance with the national CQUIN standards
- Sustained improvement in the 'level of recommendation' FFT score for inpatient and day case patients, outpatients and maternity services achieving >95% overall for the year
- A further improvement in our response times to complaints
- Improvements as part of the End of Life work stream with 90% of patients achieving their preferred place of death
- Development and introduction of the 'Abscess clinical pathway' to improve the safe management of patients presenting with an abscess and to improve their experience of care by creating a timely service that can be delivered on an outpatient / day case basis
- Introduction of a midwifery led pathway and the re-instatement of the Trust's home birth service
- Introduction of the vanguard 'Red bag' project to improve communication and sharing of vital information with Care Homes whose residents are admitted into hospital
- Introduction of the Comprehensive Geriatric Assessment and deconditioning initiatives to promote improved care and management for frail, elderly patients
- Achievement of an A rating for care by the Stroke Unit
- A strong performance against the four-hour Emergency Department target over winter, despite the challenges
- Significant improvement in uptake of flu vaccination amongst frontline staff

In addition to these achievements the Trust has launched other quality initiatives including the new Patient Experience Strategy in May 2016 and the roll-out of the Food and Drink Strategy. These include a number of interventions to improve the quality of services within the organisation that range from small qualitative projects such as improving the temperature control for cold desserts as well as longer term improvement goals such as introducing 'John's campaign' on West Newton Ward to support carer involvement in patient care.

The Trust remains committed to continuing to focus on those quality areas where further improvement needs to be embedded. This includes:

- A further focus on achieving improvements in patient flow on the clinical pathway for emergency patients, taking into consideration the increase in attendance this year. This work will focus on improvements to the admission and discharge pathway
- Improving the recommendation scores on both the patient and staff Friends and Family test by listening to feedback and responding to concerns and comments with action and change. This will be supported by the provision of a new provider for FFT services
- Developing innovative, cross-boundary approaches to support the care and management of patients who are frequent attenders so that support can be delivered in the most appropriate setting
- Continue to work in collaboration with Primary Care, Community Services and our Commissioners to improve the pathway for frail, elderly patients and to strengthen the provision of care and treatment alternatives that avoid hospital admission
- A further reduction in the number of inpatient falls and a reduction where possible in those leading to patient harm.

However, in addition to these on-going work streams the Trust will focus on new quality improvement challenges that begin to set the agenda for quality improvement going forward:

- Reduce avoidable deaths
- Improve the experience of children attending the Trust for care and treatment
- Improve the care and management of the deteriorating patient
- Ensure patients are seen by the most appropriate doctor at the right time and in the right place.

The Trust has continued to build on the work of the Contingency Planning process and to explore how qualitative improvements to health services can be developed and expanded across the whole health economy. The organisation has collaborated through the Norfolk Provider Partnership and the Sustainability and Transformation programme to begin to deliver solutions to the wider challenges faced by all healthcare providers.

The Trust has maintained its approach to quality improvement in 2016/17 both at a Board level and within individual Clinical Specialties and Divisions. This leadership will further embed these quality improvements into daily practice during the coming year and will enable current achievements to act as a foundation for the development of a new Quality Strategy to steer improvement work during the next three years. I look forward to the challenge this brings as well as the opportunities for leading the Trust to greater levels of quality improvement.

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

Jon Green – Chief Executive
Date: 23/5/2017

How the Board of Directors Monitors Quality

In 2016/17 the Trust has continued to embed and keep under review, a strengthened Quality Governance Structure (see governance structure on the next page), with clear accountabilities at all levels of the organisation from service line / divisional level right through to the Board via Board committees, including the Quality and Patient Safety Committee and Risk Committee. Assurance and Quality risk is communicated across the governance structure, using the Chair's Key Issues methodology. The Board monitors Quality performance at every meeting though its review of key Operational Performance and Quality metrics including patient satisfaction, hospital acquired infection, falls and pressure ulcers. Exception reports are prepared for the Board at every meeting to alert directors to any areas of concern and facilitate monitoring of plans in place to address those issues.

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

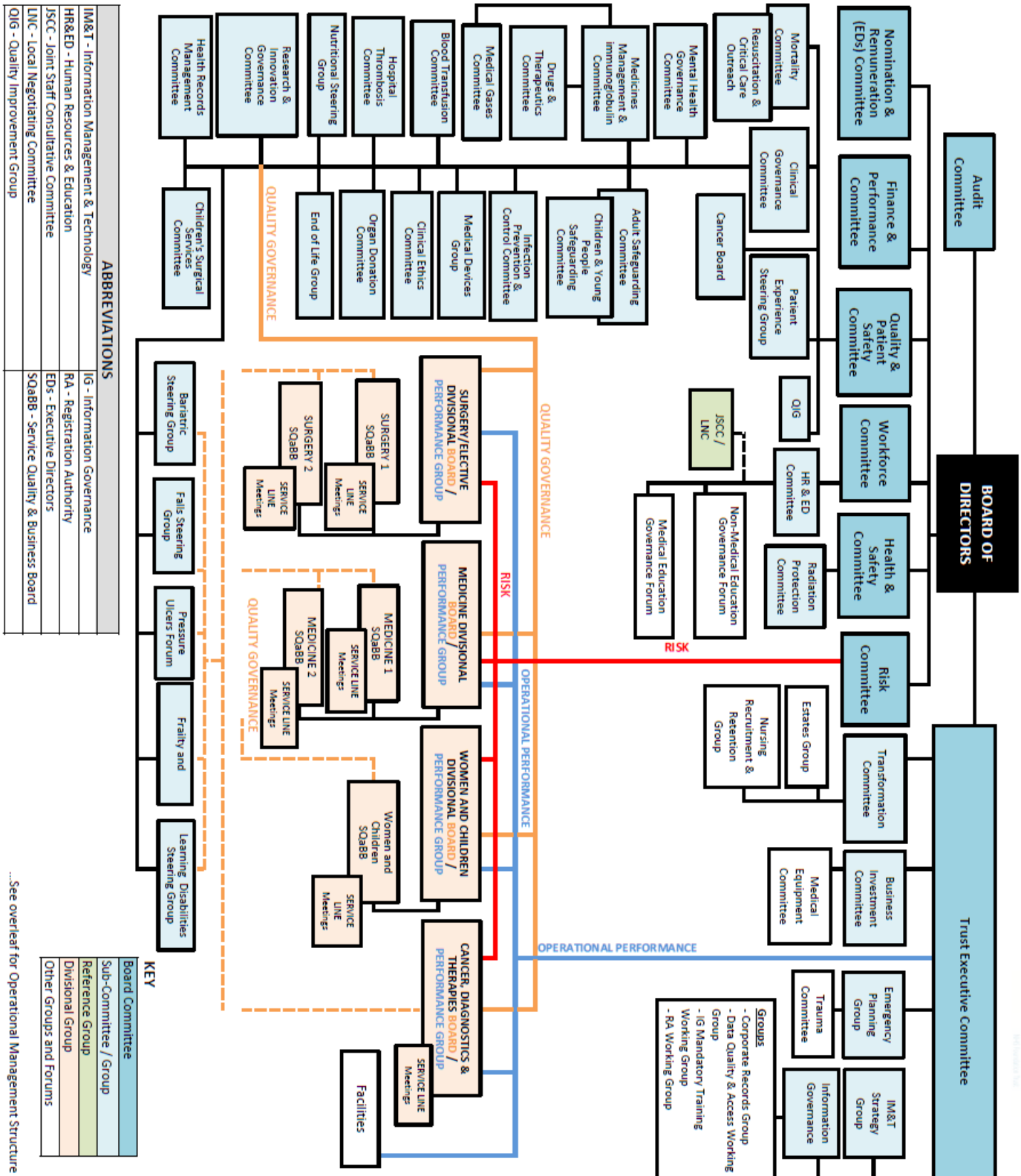
In-year development work to improve the Board's visibility of the delivery of Quality services has included:

- Strengthened oversight of Quality risk areas – terms of reference of Quality and Patient Safety Committees incorporated to improve Board-level oversight of the delivery of the Trust's Quality objectives. Patient Experience Steering Group, Cancer Board and Mortality Committee now reporting to Quality and Patient Safety Committee
- Continued embedding of Quality and Patient Safety Committee oversight methodology, including regular in-depth 'Quality Enquiries' into key Quality issues
- Continued embedding of 'Patient Stories' at public board meetings, including follow-up reports on steps taken to address previously identified issues
- 'Fifteen Steps' methodology continuing for non-executive director clinical area visit programme, with all observations captured and reported appropriately
- Dr Foster quality indicator benchmarking reports and Board / Governor workshop on Dr Foster mortality reporting and benchmarking
- Regular reporting methodology for nurse staffing levels and skills mix at Board
- Programme of scrutiny of divisional and corporate risk registers at the Risk Committee (reporting direct to the Board)
- Regular reporting of Serious Incidents and 'Lessons Learnt' at the Quality and Patient Safety Committee
- Embedding of the Quality Improvement Group, which is an action-orientated group reviewing quality, compliance with the CQC's Fundamental Standards and which commissions audit work and immediate response to address identified Quality issues
- Agreement on the Trust's refreshed Quality Strategy and Quality Priorities
- Quality Strategy Implementation progress reporting quarterly to the Quality and Patient Safety Committee
- Regulatory, accreditation and peer review out-turn reporting and subsequent action planning reporting to the Quality and Patient Safety Committee
- Board Assurance Framework reporting on Quality-related controls and sources of assurance.

The Trust is preparing for its first regulatory 'Well-led Framework for Governance' external review in 2017/18; in 2016/17, it undertook a self-assessment against the 'Well-Led Framework for Governance' criteria. The regulatory definition of a 'well-led' organisation is one where the '… leadership, management and governance of the organisation ensure the delivery of sustainable high quality person-centred care, support learning and innovation, and promote an open and fair culture'. The review employed non-executive director and governor peer review as part of its rigorous evidence-based methodology. An action plan to address identified gaps is in development and will be rolled out in 2017/18.

In 2016/17, an Internal Audit was undertaken of the Trust's methodology for providing assurance to the Board in respect of CQC compliance. The internal Audit provided 'reasonable assurance' (amber/green). The Trust has assimilated the recommendations of the audit and in 2017 will be reviewing and strengthening its processes for driving Quality improvements and evidencing CQC compliance. This work will include improved visibility for the Board.

Governance Structure



ABBREVIATIONS	
IM&T - Information Management & Technology	IG - Information Governance
HR&ED - Human Resources & Education	RA - Registration Authority
JSCC - Joint Staff Consultative Committee	EDs - Executive Directors
LNC - Local Negotiating Committee	SQaBB - Service Quality & Business Board
QIG - Quality Improvement Group	

...See overleaf for Operational Management Structure

Incident Reporting and Never Events

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

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

Incident trends

There has been one Never Event in the last financial year and, prior to this, the last reported Never Event was in August 2014. Robust systems are in place to ensure that scrutiny is applied by a senior team on a weekly basis to all moderate incidents and above in order to identify any potential adverse incidents in need of further investigation and reporting.

Patient Safety Incidents	1/4/15 to 31/3/16	1/4/16 to 31/3/17
Total number of incidents	7,236	6,142
% of incidents resulting in severe harm or death	0.44%	0.72%

A total of 46 serious incidents have been declared in the period. The table below details the serious incidents by type over the previous four years. The significant reduction in pressure ulcers reflects changes in the reporting criteria. The internal process for declaration follows robust internal guidelines and is kept under review by the Clinical Commissioning Group (CCG).

	2012/13	2013/14	2014/15	2015/16	2016/17
Pressure Ulcers	64	69	52	16	**2**
Never Events	3	0	7	0	**1**
Falls	13	10	11	9	**19**
Other Serious Incidents	6	13	18	24	**24**
Total SIs	**86**	**92**	**88**	**49**	**46**

'OTHER SERIOUS INCIDENTS' BY EVENT TYPE		
Incident Date	**STEIS Date reported externally**	**Adverse Event**
25/03/2016	19/04/2016	Cord PH < 7.15
08/04/2016	29/04/2016	Treatment/procedure - inappropriate/wrong
10/05/2016	17/05/2016	Unexpected or re-attendance
15/05/2016	24/05/2016	Failure to act on adverse symptoms
19/05/2016	28/06/2016	Wrong route for administration of medication
17/07/2016	25/07/2016	Other - Infection control incident
06/07/2016	25/08/2016	Contra-indication to the use of the medication
29/08/2016	09/09/2016	Delay/failure in acting on complication of treatment
15/09/2016	19/09/2016	Delay or failure to monitor
17/08/2016	19/09/2016	Failure to follow up
19/09/2016	21/09/2016	Failure to act on adverse test results or images
06/10/2016	10/10/2016	Treatment not clinically indicated
18/10/2016	21/10/2016	Breach of patient confidentiality
20/10/2016	27/10/2016	Breach of patient confidentiality
27/01/2017	07/02/2017	Breach of patient confidentiality
12/02/2017	14/02/2017	Failure to act on adverse symptoms
10/02/2017	22/02/2017	Delay or failure to monitor
20/02/2017	27/02/2017	Delay in diagnosis for no specified reason
21/02/2017	01/03/2017	Delay or failure to monitor
27/02/2017	03/03/2017	Never Event - Retained foreign object post-operation
28/02/2017	08/03/2017	Delay or failure to monitor
02/03/2017	08/03/2017	Failure to act on adverse symptoms
12/03/2017	16/03/2017	Failure in referral process
24/03/2017	29/03/2017	Adverse reaction when drug used as intended

Examples of Lessons Learnt from Serious Incidents

- **Information Governance incidents**
  - Confidential waste bins sited at key exit points and move towards a paperless handover system
  - Posters located on the walls and doors at all Trust exits which reminds staff to 'STOP – CHECK (their pockets) – BIN (Handover sheets in the confidential waste bins)'
  - Introduction of more robust systems for checking computer hardware prior to disposal.

- **Falls with harm**
  - Improve staff training in post-fall management. All registered nurses to have additional training with a focus on neurological observations. All registered nurses to have a competency assessment in the ability to perform neurological observations.

- **Failure to escalate clinical concerns**
  - Review of induction and orientation for both substantive and Agency staff
  - Encourage staff to escalate concerns through shift leader
  - Improved education and training in relation to patient assessment targeting Early Warning Scores
  - Access to senior clinical staff extended to next-of-kin who can refer directly to Critical Care Outreach Team if they are concerned about the care being provided on a ward.

- **Post-operative documentation**
  - Documentation of retained packs has been improved to identify those patients with intentionally retained packs and instructions on timing for removal

- Improved communication with patients discharged home following surgery
- Contact cards provided for patients at time of discharge with details of telephone numbers for advice post operatively.

- **Compliance with venous thrombo-embolism (VTE) assessments**
  - Improved staff education in relation to when VTE must be assessed and re-assessed
  - Training of staff in pre-op assessment to identify patients at risk
  - VTE assessment incorporated into the World Health Organisation (WHO) safe surgical check list.

Duty of Candour

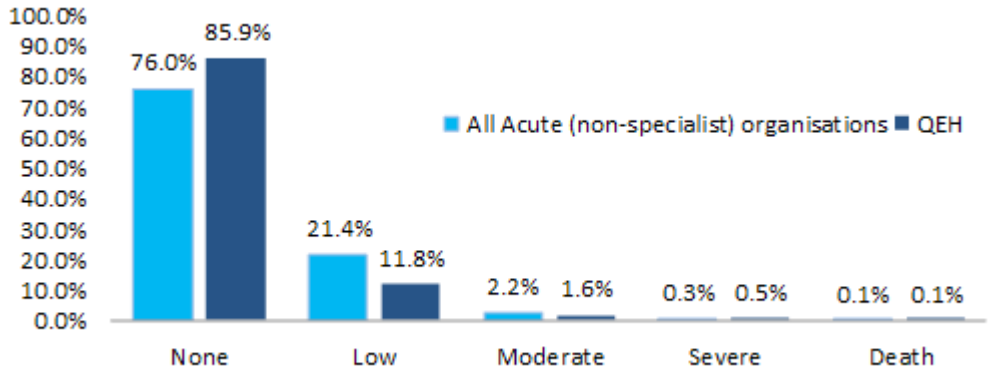
Central to national guidance for the management of serious incidents (NHS England Serious Incident Framework 2015) is the importance of working in an open, honest and transparent way where patients and their families are put at the centre of the process. This is inherently linked to the statutory guidance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

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

- A general duty to act in an open and transparent way in relation to care provided to patients
- The requirement to tell the patient (or their representative) as soon as is reasonably practicable after a notifiable patient safety incident occurs
  - Provide a full explanation of what is known at the time; provide an apology and keep a written record of the notification to the patient
  - Provide reasonable support to the patient
  - Provide the patient with a written note of the discussion, and keep copies of correspondence
  - Share the outcomes or results of any further enquiries and investigations in writing to the relevant person
- The Trust has put in place systems and processes to ensure compliance with the requirements associated with Duty of Candour (contained in regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014)
  - There are identified Duty of Candour Champions in each division who are able to facilitate the procedural implementation of Duty of Candour in line with the current Policy
  - The Trust had a Duty of Candour Campaign launch in September 2016, which included staff lanyards, posters, leaflets and training
  - Every two weeks a compliance report is circulated to all divisions for incidents for which duty of Candour applies and this is maintained and updated by the Risk and Governance department
  - There has been a sustained improvement with compliance as the process becomes embedded in practice. The current overall Trust compliance with Duty of Candour is 84.7% and is expected to reach the target of 90% once all quarter 4 incidents have been investigated and shared with the patients involved.

Monitoring is through quarterly reports to the Clinical Commissioning Group (CCG) as part of the Quality Schedule provisions.

Comparative data on number and severity of incidents from the National Reporting and Learning System NRLS (1/4/16 to 30/9/16)



QEH Incidents / Degree of Harm				
None	Low	Moderate	Severe	Death
2,312	318	42	16	2

Management of Risk

In the period of 2016/17, the implementation of an electronic risk register continued to provide a significant improvement in the visibility of all identified risks across the organisation. The system has facilitated more robust scrutiny provided by the Risk committee and Divisional Boards.

Following last year internal audit recommendations, several actions have been taken to ensure the robustness and effectiveness of the Trust's Risk Management processes, this has included:

- The development of the Risk Register Management Procedure in support of Risk Management Strategy
- Rolling out training dates and recording of attendance on the Trust ESR (electronic staff records)
- Rolling out the action plans management module in March 2017 to all risk leads in the organisation
- Development of a reporting template for all Trust areas.

The system has enabled the management teams to focus on the quality and the articulation of risks and has improved oversight of the departmental and corporate risk.

Sign up to Safety

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

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

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

- Strengthening of training on how to recognise the deteriorating patient and when to involve the 24/7 Outreach service in assessing the patient
- Introduction of a Comprehensive Geriatric Assessment tool as part of the clerking assessment of all

frail, elderly patients admitted on an unplanned medical care pathway to support better care planning
- A continued focus on early recognition of sepsis and acute kidney injury (AKI) and appropriate management of both to reduce the risk to the patient
- Establishment and monitoring of safe staffing levels using recognised assessment tools
- Strengthening of governance arrangements for the care and treatment of patients with either a concomitant learning disability or mental illness
- Review of assessment and care planning to mitigate the risk of inpatient falls with comprehensive staff training to support learning
- Review of mandatory training for nurses and the introduction of scenario training to reinforce learning
- Development of a quality dashboard for nursing metrics that is reviewed weekly at the Senior Nurses' Forum
- A focus on improving the safety and care of the bariatric patient on a planned, elective episode of care
- Introduction of Badgernet, an electronic record system for maternity care which improves the clarity of record-keeping and improves communication between professionals involved in the mother's care.

Alongside this programme the NHS Litigation Authority in early 2016 invited bids for funding for specific safety initiatives within maternity services for 2016-17 and the Trust was awarded £13,000 to invest in equipment that would support improving the management of those mothers with a large body mass index (BMI) and lead to improvements in both the safety and experience of the mother and her baby. This was invested in the purchase of the following equipment to support care:

- Bariatric wheelchair
- Weighing scales suitable for the larger mother
- Patient hoist able to accommodate a person with a large BMI
- Bariatric scanning couch.

These items of equipment have supported the delivery of safer care to mothers with a large BMI and this in turn has led to an improvement in the experience for these mothers.

Complaints and Compliments

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

The PALS Department is continuously seeking to improve the service it provides and sets itself high standards, such as ensuring that all telephone calls and emails are acknowledged within the same working day. This is measured (along with other aspects of the service) with a newly developed 'Rate our Service' Survey Monkey, which is included on all emails and on a compliment slip when information is provided in person. The PALS Department continues to promote its service by featuring on the front page of the Trust's internet site, regularly visiting the wards, occupying an accessible location in the main entrance and having a prominent position on one of the Trust's new initiatives, bedside placemats. The placemats are located on nearly all inpatient bed tables and provide guidance, contact details and information for patients and relatives. This and other new promotions have coincided with a large increase in the number of PALS contacts seen this financial year, with record breaking figures being achieved in this last quarter.

Presentations continue to be given promoting both the PALS' role and that of the Complaints Team. New staff members are guided on the need to try and resolve issues as and when they arise to ensure that a high level of patient experience is achieved and also to minimise the number of formal complaints received.

The subject codes used with the PALS department have continued to be reviewed and amended in 2016/17 to ensure that information is being logged appropriately. It is expected that during the next financial year, more subject codes will be developed to limit the use of 'general information', so that more helpful information can be drawn from the recorded data on contacts. During this financial year 4,787 PALS contacts were logged (excluding compliments):

PALS Top Subjects	
General Information	991
Travel Expenses	311
Enquiry	271
Directions within the Trust	230
Complaints Procedure	152
Access to Health Records	143
Discharge Arrangements	132
Concern	127
Inpatient Enquiry	112
Sign Post to another Organisation	109

During the financial year 1 April 2016 to 31 March 2017, the Trust received 427 formal complaints, which is a slight increase of 2% (419) when compared to 2015/16.

Local Resolution Meetings are offered as soon as a complaint is received to try and encourage complainants to come and speak with the senior staff involved in the patient's care as it is known that this is a much more beneficial way of resolving complainants' concerns. Some 49 meetings have been held, with a further 20 being offered but not accepted. As a result of any complaint, follow up actions are identified and undertaken and specific learning shared to try and prevent a recurrence of the problem. This includes sharing the outcome of complaints at relevant governance and clinical service line meetings to ensure that all staff share in the learning and not just those directly involved in the complaint.

Close relationships are maintained with the Legal Services and Risk Management Departments. The Complaints Team have the opportunity to raise any concerns that may be serious in nature with the Serious Incident Risk

Panel, which meets on a weekly basis. The relevant data is also shared with the Patient Experience Committee and Patient Experience Steering Group and is additionally summarised and included in the monthly report produced by the Patient Experience Lead for the Clinical Quality Review meeting with the commissioners.

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

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

Complaint Top Subjects	
Delay or failure to diagnose (incl. missed fracture)	29
Attitude of Medical Staff	28
Communication with patient	23
Communication with relatives/carers	22
Discharged too early	15
Delay or failure in treatment or procedure	15
Attitude of Nursing Staff/Midwives	13
Inadequate pain management	11
Appointment delay (incl. length of wait)	10

DatixWEB continues to be used as an administration tool and this service, along with a number of other aspects of the Complaints Process, was recently subject to an external audit and the department achieved 'Substantial Assurance'. The audit noted that the use of the Learning from Experience Action Plan (LEAP), which is required to be completed upon the completion of any complaint, is being fully utilised. The system continues to be a learning tool for all areas, with some areas moving to a completely paperless complaint process. The Trust again increased its average response rate, achieving a rate of 88% of complaints responded to within the set timeframe (84% in 2015/16 and 74% in 2014/15).

The way in which complaints are received continued to show an increase in the use of the internet, with 176 being received by email (117 the last financial year), 140 by post, 30 in person and 16 by telephone.

Along with the introduction of the PALS survey, the Complaints Team continued to send satisfaction questionnaires to complainants one month after completion of the complaint. At present 197 questionnaires have been sent and 50 have been returned. The questionnaires highlighted:

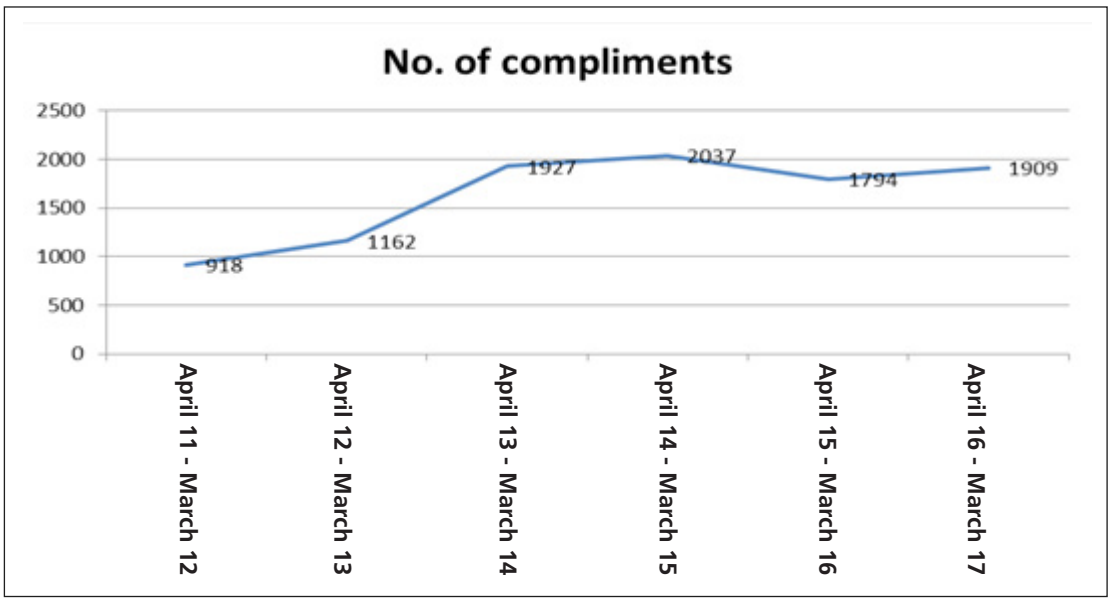
- 98% (49) confirmed that they had no problems in obtaining information on how to complain. The remaining one complainant was advised by a staff member that they can only complain over the phone but later found the department in the hospital
- 58% (29) felt that the Trust had dealt with their complaint, 2% (1) felt the complaint was partially upheld, 36% (18) felt their complaint had not been upheld and 4% (2) did not answer this question
- Within the questionnaire, the complainants are asked why they originally made the complaint and the following answers were provided:
  - to prevent others' suffering (34)
  - to be given an explanation/ information (23)
  - to be given an apology (27)
  - to have staff disciplined (11)
  - to receive compensation (5)
  - to see a change to practice (28)
  - to raise awareness (34)
- 98% (49) were easily able to understand the format and language used in the acknowledgement letter, with the remaining person reporting a literacy problem and a preference for audio communication – but

this was not requested at the time.
- 92% (46) found that we clearly explained how their complaint would be handled, with the remaining four not elaborating their answer.

The department continues to manage the process of reimbursing patients' travel expenses on a daily basis and the team processed 1,143 claims overall, equating to an average of 95 claims a month.

On occasion there are times when despite the Trust's best effort we are unable to resolve a complaint at a local level and the complainant remains dissatisfied. When this occurs, the complainant may seek guidance from the Parliamentary and Health Service Ombudsman (PSHO) to ask for an independent investigation into their complaint and financial redress. During this financial year, six complaints were referred to the PHSO with one being upheld, three being partially upheld and two currently being under investigation. Three complaints which were investigated by the PHSO during 2015/16 have now been closed, with one not being upheld and the remaining two upheld. Those complaints which were upheld or partially upheld have resulted in the development of actions plans to address the issues of concern and these have been shared with the appropriate people and organisations.

Along with feedback and concerns which are shared with the department, the PALS team also log any compliments that are shared with them, whether made in person, by email or by way of a card sent directly to the ward. When a compliment holds identifiable information, such as an address, the Chief Executive sends a personal thank you note. In 2016/17 the Trust recorded 1,909 compliments and this represents an increase in comparison to 2015/16:



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

2.1 Priorities for improvement 2016/17

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

Our key quality objectives focused on ensuring that:

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

In order to measure improvement against these four priority areas the following quality indicators were identified:

Improve patient safety and reduce harm

- Improve safety culture within the Trust and with all professional groups
- Develop proactive approaches to safe systems and safe people
- Achieve reductions in mortality and avoidable harm
- Reduce the number and severity of patient adverse events.

Provide the best possible patient experience

- Ensure all indicators of patient experience improve year on year
- Ensure that local indicators compare well with national benchmarks
- Expand the range of indicators and increase their reliability.

Care and treatment is effective and compliant

- Ensure that best evidence-based practice is used for all patients
- Improve the reliability of care in key areas
- Use clinical audit effectively.

Build and sustain excellence as a care provider

- Identify key measures for improvement
- Secure effective clinical engagement
- Maintain robust quality, safety and governance structures
- Put quality at the heart of the organisational transformation plans and support the required cultural shift
- Establish and support quality education and development networks.

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

Key priorities were identified for delivering quality improvement

Objective	Actions	Outcome measure
Patient Experience		
1. Improve Friends and Family Test (FFT) scores to ≥ 95% for inpatients and Emergency Department and maintain response rates above the target level as described in the Quality Schedule.	Listen and respond to what patients tell us about their experience through feedback, complaints, compliments, FFT responses / free text, patient stories, online postings and observation E.g. 15 steps and Matrons' assurance visits.	FFT 'likelihood to recommend' rates will improve to ≥ 95%. FFT response rate will be maintained above the targets outlined in the Quality Schedule. Aspiration to achieve upper quartile for response rates and scores across all areas.
2. Improve patient and family experience in end of life (EoL) care.	Local actions led by EoL Steering Group and Palliative Care team. Provide increased opportunities for patients and relatives to give their views and feedback on end of life care. Implementation of patient and relative-driven improvements emerging from increased engagement.	Evaluation of initiatives resulting from complaints and other feedback from patients and relatives around EoL care. Increase percentage of Fast Track patients achieving preferred place of death.
Patient Safety		
1. Reduce healthcare associated infection related to Clostridium Difficile.	Through a comprehensive action plan deliver improved compliance and reduced variation across wards.	Reduce hospital acquired C Difficile rates against previous year. Internal reduction target of no more than 27 cases annually.
2. Improve management of patients with sepsis	Through acute pathway flow work, reduce time to investigation and treatment of emergency admissions. Improve antibiotic stewardship.	Achieve sepsis and antibiotic stewardship national CQUIN targets.
3. Reduce hospital acquired pressure ulcers.	Continue to build high reliability of high quality care across inpatient wards. Strengthen the Multi Disciplinary Team (MDT) approach to skin health. Strengthen partnership working across organisational boundaries.	Achieve a reduction in hospital acquired pressure ulcers based on last year. Aspiration to achieve a further 25% reduction on 2015/16.
4. Reduce inpatient falls	Through a focus on achieving high quality care for frail elderly patients, identify and minimise the risk of patient falls early in the patient pathway. Improve the approach to care of patients requiring enhanced care. Ensure timely availability of equipme nt to reduce patient falls. Strengthen the MDT approach to falls prevention.	Achieve and sustain a reduction in inpatient falls below 5 per 1000 bed days.

Effectiveness		
1. Improve pathway for urgent admissions	Improve flow through acute areas at weekends via the use of a GP in the emergency department (ED) to support minors flow and alleviate pressure on space within the department. Improve flow through assessment areas for frail patients via the introduction of the frailty pathway within ED and the Acute Frailty Unit in Terrington Short Stay (TSS). Strengthen admission avoidance capacity in the community via joint working with WNCCG / Norfolk Community Health & Care (NCH&C) (additional intermediate care bed (ICB) / virtual ward (VW) capacity). Enhance links with key Partners (IC24 / East of England Amublance Service via the QEH Catchment A&E Delivery Board to ensure delivery of the nationally mandated actions.	Decrease in 4-hour breaches and ambulance waits.
2. Ensure effective management of medicines	Commence Medicines Management 'Quality Inspection' to include an inspection of each ward every three months.	Maintain medicines reconciliation compliance. Reduce the incidence of omitted doses due to non-clinical reasons. Increase ward medicine trolley quality compliance. Eliminate out of date drug and fluid stocks on wards.
Build and sustain excellence		
1. Improve the experience for mothers and their families using maternity services	Implementation of maternity IT system. Introduce full choice for place of birth. Implementation of sustainable workforce model. Recruitment to leadership posts (medical and midwifery). Midwifery workforce review.	IT system in place September 2016. Establishment of Home Birth Service. Reduction in delivery suite closures. Reduction in Caesarean section rate. Increase in mothers choosing QEHKL as place for birth. FFT recommendation (upper quartile).
2. Improve staff Friends and Family Test scores	Recruit and retain the best staff. Improve vacancy rates, support staff through training, appraisal and improved working environment.	An increase in the response rate and in the proportion of staff recommending QEH as a place to work and to receive care.

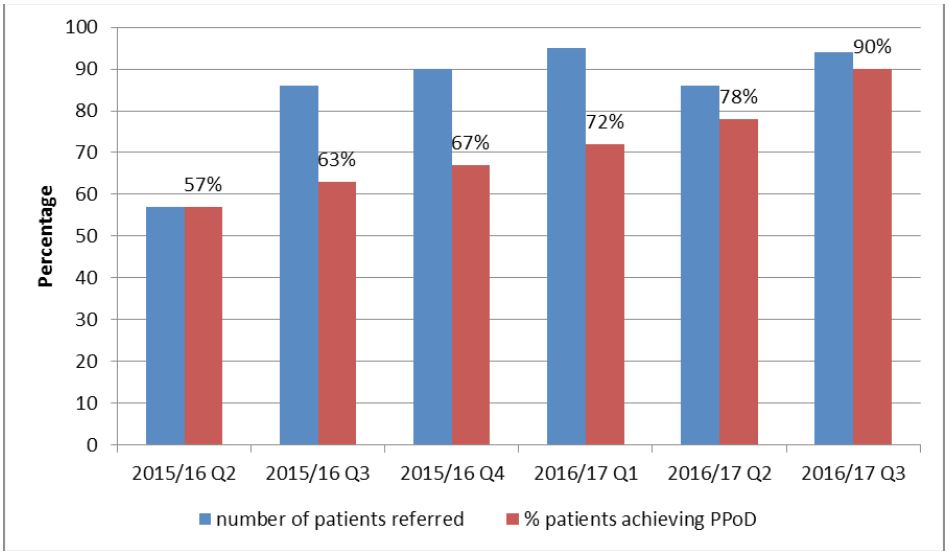
How we measured, monitored and reported our achievements in delivering our priorities

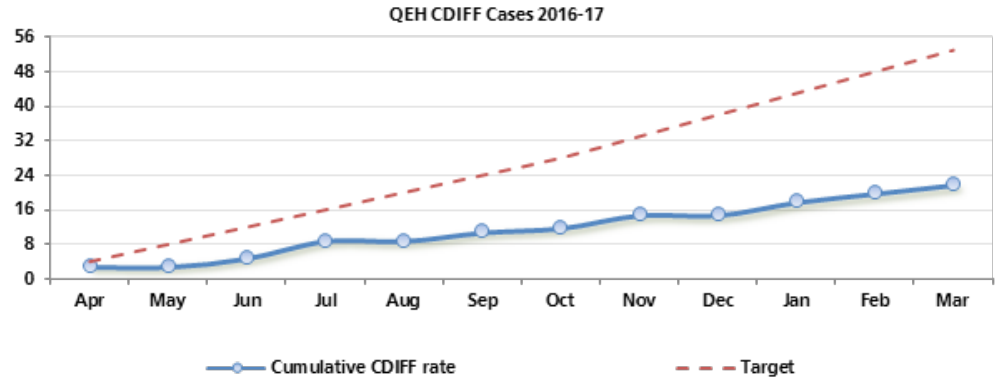
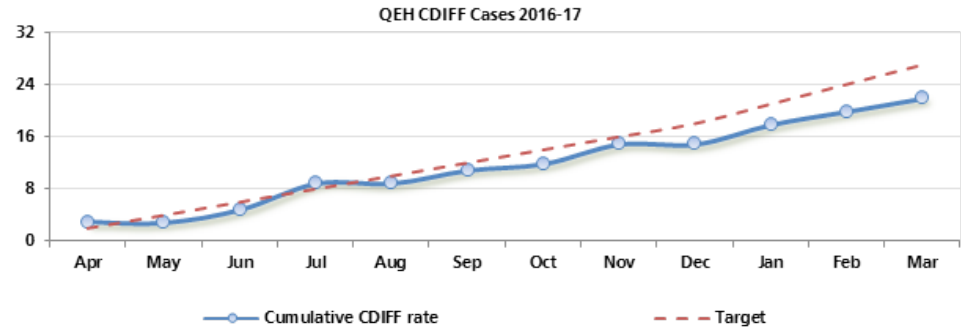
A Quality Improvement Implementation Programme was devised that clearly identified the key actions required to deliver our priorities and the performance metrics by which delivery would be measured. These were measured on a monthly basis and reported to the Board of Directors via the quality section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

The strategic objectives of the Quality Strategy were enshrined in the organisational transformation programme. The Trust's management and governance structure provided a framework for implementing change locally, monitoring progress and identifying any risks on delivery. Assurance on delivery and achievement was supported by the governance reporting systems and through Board review of the Board Assurance Framework.

How have we delivered on our priorities:

Objective	Achievement
Patient Experience	
1. Improve Friends and Family Test (FFT) scores and maintain response rates for inpatients and Emergency Department.	**FFT** The response rates across all categories have been above the recommended target rate with the following achievement across the year: A/E 25.74% (Target 20%) Inpatient & Daycase 35.00% (Target 30%) Maternity 19.47% (Target 15%) All areas consistently achieve their response rate target despite difficulties associated with the pressures in quarter 3. There has been a concerted effort across the hospital to maintain these levels of response to the Friends and Family Test, although engagement is less at remote locations in Ely and Wisbech. There has been a small but steady increase in recommendation rates. Maternity, inpatient and day case recommendation was maintained above the target rate of 95%, A&E have consistently improved their likelihood to recommend score every month since July (apart from a slight dip in December / February): A/E 90.72% (Target 95%) Inpt & Daycases 95.40% (Target 95%) Maternity 97.09% (Target 95%) It is difficult – in terms of benchmarking across the region – in relation to response rates the Trust is above halfway for each of the three main touch points – A&E, Inpatient and Day Cases, Maternity. In terms of likelihood to recommend both A&E and Maternity are above the halfway mark, although Inpatient and day cases have struggled to reach this all year. Work continues to promote the value of the FFT questionnaire with both patients and staff. Staff are introduced to the value of the FFT at induction and the value of patient experience is highlighted at many clinical training sessions. A weekly and monthly leader board is sent to senior clinical staff to promote 'healthy competition' in relation to response rates. A new provider 'Optimum' has been secured to provide the FFT service and, although some disruption to staff engagement has occurred during the latter part of the year as the service moved from one provider to another, efforts have been made by the Patient Experience team to limit these and hopefully this will result is a more effective service provision in the longer term.

2. Improve patient and family experience in end of life (EoL) care.	**End of Life** EoL related complaints numbers appear static at present year on year with four complaints in total for the year. Set out below is the Trust's performance in relation to the number of patients referred to the fast track service and the percentage of those patients who have achieved their preferred place of death (PPoD).  • Both the number of referrals and percentage of patients achieving PPoD are increasing. Quarter 3 shows this performance is now up to 90%. A 33% increase compared to Q2 in 2015/16. • Only two end of life care incidents were reported in November and December. These were both incidents recorded by the community. • Improvements have been made with the time to transfer decreased patients to the mortuary after death. No incidents were reported since the additional training and changes have taken place at the end of October 2016. • The End of Life Care Specialist Nurse has developed an EoLC survey which began at the end of November. The analysed results will be made available by the end of April 2017. At present, those surveys that have been returned are positive in nature and no issues have been identified as yet.

Patient Safety	
1. Reduce healthcare associated infection related to Clostridium Difficile.	**Clostridium Difficile** There has been a sustained improvement with the fight against Clostridium Difficile. This has been led by improved infection control measures being implemented at ward level with pro-active and prompt management of high-risk cases and early implementation of isolation/cohorting of identified patients. This, combined with regular but unscheduled spot checks by the Matrons, has sustained the focus on infection control. These measures have delivered a month by month below target number of incidents of Clostridium Difficile cases. The graphs below shows the cumulative C. Difficile cases against the trajectory for the quarter and for the year against the internal target trajectory:  
2. Improve management of patients with sepsis	**Sepsis** There has been an increase in Trust-wide education and audit presentations raising awareness of Sepsis 6. This has been delivered in key areas such as Emergency Department and Trust-wide via mandatory training from the Critical Care Outreach team. The Nurse Consultant for Critical Care has also undertaken teaching sessions presenting the audit results of patients admitted with sepsis into Critical Care to help raise awareness. The Outreach team have been involved in collecting data for the inpatient audits and can prescribe first line antibiotics, with a new patient group direction (PGD) acting as front line advocates for this group of patients. Posters have been produced on a quarterly basis by the Audit team to demonstrate the up to date results of the CQUIN and raise awareness for staff. Concise Sepsis care bundles are available via the electronic EDIS system in the Emergency Department and sticker format throughout the rest of the Trust. To date the Trust has achieved the sepsis, antibiotic stewardship and national CQUIN targets for both inpatient and the Emergency department consistently throughout the year.

3. Reduce hospital acquired pressure ulcers.	**Pressure Ulcers** The internal target for hospital acquired pressure ulcers was to achieve a 30% reduction based on 2015/16 rates. Data for the full year demonstrates a significant reduction in rates of pressure ulcers per 1000 bed days of 36%, which exceeds our internal target:

The figures below represent the total number of pressure ulcers (All grades) and the rate per 1000 bed days per quarter during financial year 2016/17 and the variance against the figures for 2015/16.

2016/17	Qtr	Pressure Ulcers - all grades	Rate per 1000 bed days	Variance to 15/16	Variance to 15/16 as a %
38487	Qtr 1	26	0.67	-0.73	-49%
37678	Qtr 2	27	0.71	-0.36	-34%
37840	Qtr 3	20	0.53	-0.17	-25%
38702	Qtr 4	21	0.54	-0.41	-41%

Work is ongoing to proactively drive the reduction in hospital acquired pressure ulcers (PU's). Although there has been a reduction in the number reported there has been some in month variation that needs to be managed to ensure a consistently improved performance in future.

4. Reduce inpatient falls.

Falls

In 2015 the Trust committed to setting a benchmark target for the number of inpatient falls for the organisation at <5 / 1000 bed days. The Trust inpatient falls monthly average per 1,000 bed days has maintained below 5/1000 bed days during the last three quarters of 2016/17.

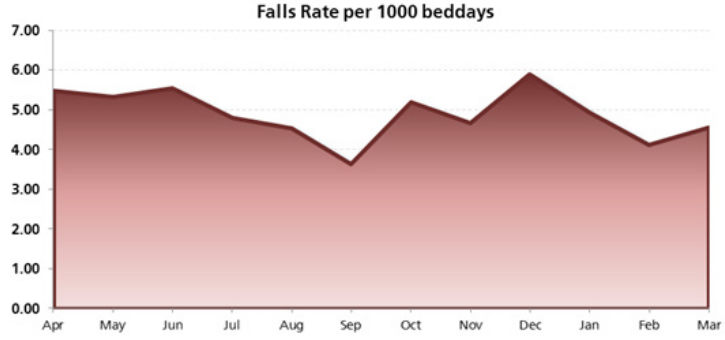
The figures below represent the total number of falls and the rate per 1000 bed days per quarter, during financial year 2016/17 and the variance against 2015/16.

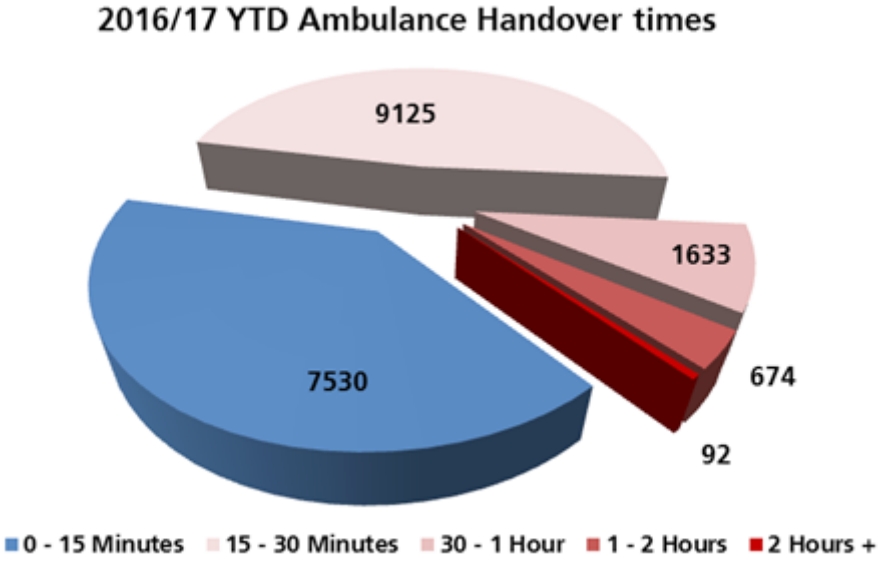
2016/17	Qtr	Falls- all grades	Rate per 1000 bed days	Variance to 15/16	Variance to 15/16 as a %
38487	Qtr 1	203	5.27	+0.47	+17.3%
37678	Qtr 2	152	4.03	-1.65	-24.3%
37840	Qtr 3	195	4.01	-1.59	-9.3%
38702	Qtr 4	171	4.41	-1.29	-22.6%

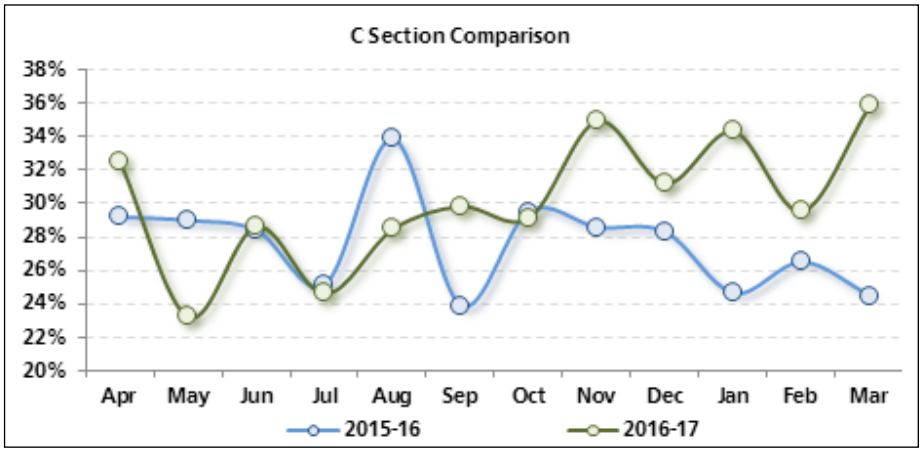
This success has been attributed to work streams that have been undertaking over the last 2 years in which there has been a robust review of a number of elements of care to ensure that all elements of fall's prevention and management are recognised and addressed. These have included:

- A full review of the nursing assessment document to ensure that it is in line with up to date NICE guidance and is multi-factorial. In addition, that all patients identified as at risk had a full plan of care in place
- The introduction of the Falls Coordinator position has been paramount in much of this year's achievements. A substantial element of this year's work has been in raising awareness and providing direct training on falls prevention and in ensuring that the steps to mitigating risk in the clinical areas are successfully implemented. The Falls Coordinator has also strengthened the incident reporting pathway thus ensuring that this platform captures all the significant information required to successfully investigate a fall. In turn this has ensured that data capture is robust and that it acts to prompt staff to implement further risk mitigating actions
- The use of assistive technology in the prevention and management of falls. This has been successfully used in a number of clinical settings and these individualised alarms have provided an additional level of support when identified for use with specific patients, maximising their safety and promoting harm-free care
- Alongside this work and in response to organisational learning & supporting literature a review of the Special Observation policy has taken place to make sure it not only encompasses those who are at risk to themselves or others but also those at risk of falling whilst in our care.

Overall, this work has afforded a strengthened assessment, care planning and documentation of falls risk and mitigation. In the next 12 months there will be a focus and review of the post-fall pathway of care, ensuring that patient care post-fall meets organisational, local and national standards and supports onward fall prevention.



Effectiveness	
1. Improve pathway for urgent admissions	**Urgent admissions**  There was a drop off in performance in quarter 3. This began to improve by December 2016 but was not sustained in quarter 4. The Trust did not reach the 95% target either for the quarter or the year as a whole. 

2. Ensure effective management of medicines.	**Medicines management** Medicines Reconciliation (MR) rates are reported monthly and the latest figure is 48% of inpatients with MR carried out within 24 hours of admission. This fails to meet the national target of 80% but is a reflection of the lack of pharmacists available over the weekend period to undertake the reconciliation. Medicines Management Inspections are carried out on all wards every three months and reported immediately to the Ward Manager. A summary report is presented to the Medicines Management Committee quarterly. The Medicines Management Inspection (MMI) reports on omitted doses, out-of-date medicines found in ward drug trolleys and on stocks of drugs on wards. Implementation of the MMI will allow monitoring of missed doses and ward medicines management key performance indicators (KPIs). These will be reported as trends in subsequent reports on Quality Priorities. There have been some improvements made: • Slight improvement in keeping cupboards for oral and injectable medicines locked • Significant increase in marking opened insulin vials with an opening or expiry date • All the fridges that were inspected were kept locked (100% of standard met) • All drug trolleys now secured to the wall when not in use (100% of standard met) • Significant increase in correct storage of patient specific items. i.e. insulin pens, inhalers, creams in use labelled and kept in patient's safety box, locker or fridge • Slight increase in the number of medicine reconciliations completed within 48 hours of admission.
Build and sustain excellence	
1. Improve the experience for mothers and their families using maternity services	**Experience of maternity services** 1. IT system implemented for March 2017. Training plan developed and delivered in February 2017 2. Formally launched low risk maternity pathway for women in February 2017 3. Task and finish group established to support this launch; expected outcomes include: a. Reduction in C section rate b. Improved experience for mothers and choice for place of birth d. Improved continuity of care for mothers 4. The graph below shows the C section rate for Q1,2 and 3 compared with last year 

2. Improve staff Friends and Family Test scores

Staff FFT

Response rate:

Quarter 2 of 2016/17 has shown an improvement in both the percentage of staff that recommended the Trust as a place to work and receive treatment compared to Q1 of 2016/17.

The number of responses received has decreased from 338 in Q1 2016/17 to 245 Q4 2016/17. There was no Staff Friends and Family Test results in Q3 2016/17 as the NHS Staff Survey is carried out in place of this for Quarter 3 each year.

Qtr	% recommend/ work	% not recommend/ work	% recommend/ care	% not recommend/ care	no. of responses
Q1 14/15	53	23	66	14	119
Q2 14/15	71	10	80	7	96
Q4 14/15	56	26	69	15	485
Q1 15/16	59	23	74	11	372
Q2 15/16	59	21	73	9	291
Q4 15/16	61	20	76	11	365
Q1 16/17	56	27	69	13	338
Q2 16/17	61	22	76	10	266
Q4 16/17	58	23	74	14	245

There has been no marked improvement in year in the percentage of staff recommending the organisation as a place to work but there has been an increase in the percentage recommending the Trust in terms of the care provided.

KEY PRIORITY PERFORMANCE

DELIVERING SAFE CARE

Reducing and eliminating healthcare associated infections

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

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

Management Structure for Infection Prevention & Control

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

Trajectory for MRSA and Clostridium Difficile
MRSA bloodstream infections (target = zero)

There have been no MRSA blood stream infections (to date 28 February 2017) associated with the Trust.

Initiatives that have been implemented have assisted with maintaining a zero tolerance of Blood Stream Infection and Blood Culture Contamination. These initiatives include blanket use of Octenisan Anti-microbial Body Wash for all inpatients (excluding admission areas) to reduce bacterial flora biomass on skin.

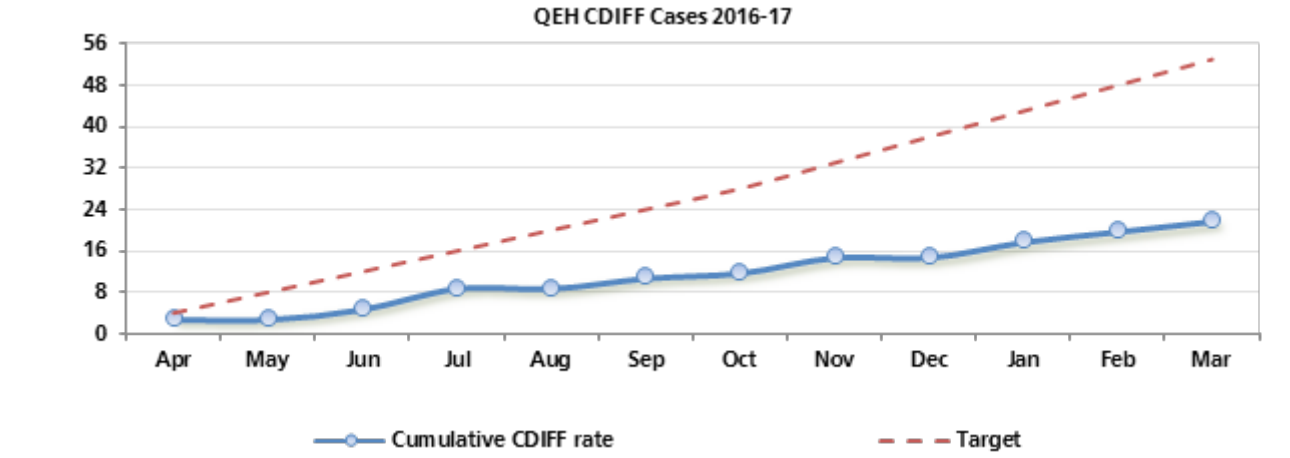
Screening rates for MRSA on admission and weekly are now maintained at 95% across the Trust. This has allowed quicker treatment of those patients who screen positive and early identification of any acquisition of MRSA colonisation with the Trust.

A programme providing competencies in Aseptic Non Touch Technique (ANTT) for clinical staff across the Trust is continuing and to date around 40% of staff have received training. A new cannulation pack is being introduced to the Trust and as this is implemented, staff will receive their ANTT training. In all areas (excluding A&E, Theatres and admission areas) a non-ported cannula will be in the pack, this is in line with current guidance to reduce any infection risk from a top port.

Clostridium difficile associated diarrhoea – CDAD (target = 53)

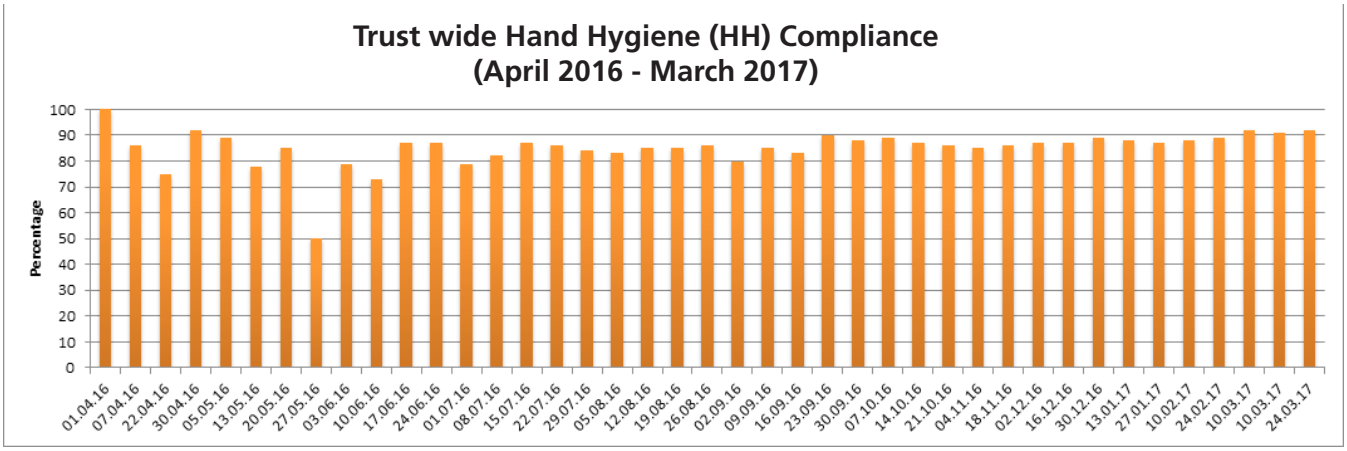
The Health Care Acquired failure target for 2016/17 was no more than 53 cases apportioned to the Hospital. The annual incidence of Clostridium difficile associated diarrhoea was 22 cases, this is a 50% improvement on last year when 39 cases were apportioned. Of the 20 this year one case has been successfully appealed and on another we are awaiting an outcome, these cases remain Hospital Associated cases but were unlikely to have been avoided and standard prevention protocols were not breached in practice.

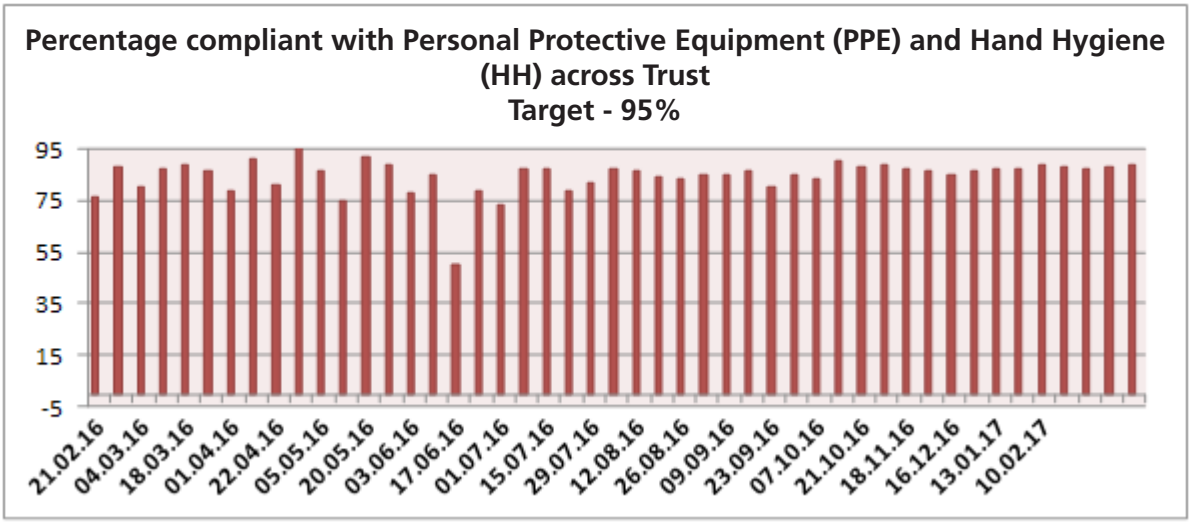
Key indicators in the prevention of Clostridium difficile transmission within the Hospital setting have also improved. Commodes and bed pan cleanliness is monitored across the Trust and reported on the weekly Quality Dashboard. Improvements in both this, Hand Hygiene and the correct use of Person Protective Equipment (PPE) (including gloves) have helped enormously in this reduction.



During the period of 1st April to 31st March the IP&C Team were responsible for undertaking a number of Audits:

Hand Hygiene - The team have undertaken weekly (now bi weekly) audits on all inpatient wards (excluding W&C – monitored via High Impact Interventions (HII) as with outpatient areas) this has been reported on the weekly Quality dashboard results below:





Commode/Toilet Raisers/Bed pan - The team have undertaken weekly (now bi weekly) audits on all inpatient wards (excluding W&C) this has been reported on the weekly Quality dashboard.

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

been placed on supportive measures:

Ward	Reason
W Raynham	MRSA PII
Oxborough now Necton	MRSA PII
Oxborough was Leverington	Norovirus outbreaks
W Newton	C Diff PII

Mattress Audit – In May 2016 an audit of all mattresses was undertaken with support from Invacare (suppliers of Trust mattresses). All mattresses were checked for staining and damage. Mattresses were replaced as required at the time; a further audit will be undertaken in 2017.

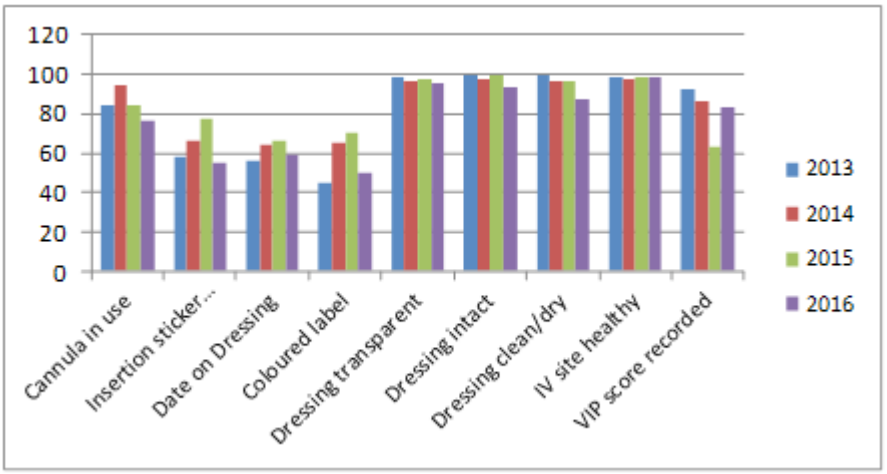
Octenisan Compliance – Since November 2016 when Octenisan body wash was introduced across the Trust the team have completed monthly audits in the use of this product. Education in the use of the product is continuing but audits are highlighting areas of poor compliance which will be targeted with education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

Completion Stool Charts – Since Jan 2017 the IP&C team have audited the compliance with documentation on stool charts. It is Trust standard that all inpatients have a stool chart and this is completed daily. A new chart was introduced last year providing clearer advice on actions. Audits have shown that the majority of patients have a stool chart but compliance with daily completion is less favourable. The Team have targeted this and are working with wards on improving compliance.

Isolation of Patients within Bed Space – As the Hospital has a limited number of single rooms a risk assessment is often required in order to prioritise which patient should be allocated the single room. Ideally all patients with any infection risk should be isolated in single rooms but due to a lack of these and an individual patient's needs, a single room is not always practical or safe. The IP&C team have provided guidance on how to isolate patients effectively within a bed space using 'isolation/ IP&C precautions' to prevent transmission of any micro-organisms. Since Jan 2017 the team have been auditing compliance with this guidance. Compliance has been seen to be good with just a few minor areas of improvement required around documentation of isolation. The IP&C team are working closely with wards to improve this.

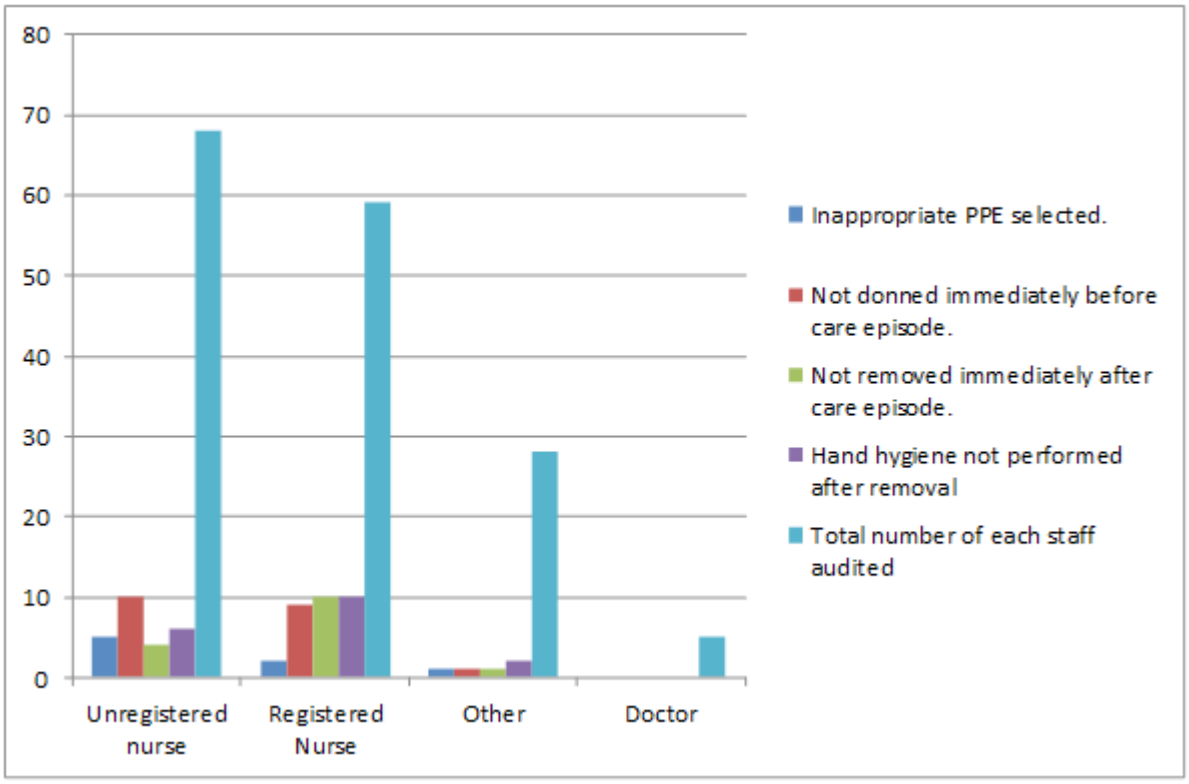
Annual Audits

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



The new cannula pack is to be introduced this year; it has a sticker on the outside of the pack, which can be peeled off and stuck into the patient's health record with all the details included. There will also be a new dressing with a space for date of insertion.

PPE Audit – A member of the IP&C team visited each adult inpatient ward to observe ten healthcare interventions by staff. The type of personal protective equipment used for each intervention was recorded and an assessment made as to whether it was appropriate for the intervention taking place. Where PPE was worn it was recorded if it was donned immediately before the care episode and removed immediately afterwards, followed by hand hygiene. The staff group of the person undertaking the intervention was also recorded. See graph below for compliance by staff group:



Management of patients with loose stools – The aim of this audit was to understand how wards manage inpatients with loose stools and to discover what documentation is used. The rationale was to identify if early detection takes place of patients suffering from diarrhoea so that isolation measures can be put in place as soon as possible to prevent cross contamination and the appropriate treatment can be given.

The data was collected by a member of the IP&C team who visited each ward and asked staff if there were any patients with loose stools. Once two patients were identified the medical and nursing notes were reviewed against the agreed data collection tool. A further five patients were then picked at random on each ward and the second data collection tool was used to review the documentation.

Findings – 53% of wards recorded daily bowel activity, but not for every patient; 19% did not have a stool chart; 10% of patients with loose stools did not have stool charts.

Antibiotic Audits – The Trust took part on Public Health England's (PHE) Point of Prevalence Survey 2016 looking at HCAIs, devices and antimicrobial use in acute hospitals. The data was collected in all hospitals between September and November 2016 and inputted into a national data base system for the results to be interpreted. IP&C Nurse and the antimicrobial pharmacist undertook the audit and data inputting. Full results and report are awaited.

Training and Education

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

ANTT

From October 2015 a programme of Aseptic non Touch Technique (ANTT) has been introduced, all clinical staff are expected to complete the training and be signed as competent. The ANTT has been covered by IP&C Nurses as part of the IV administration training run by Practice Development Nurses. A new cannula pack will be introduced in the next few months and with support from B Braun clinical education team IP&C nurses will visit all clinical areas to ensure staff are signed off as ANTT competent. ANTT is a practice framework for aseptic technique used widely in the NHS and internationally. It promotes safe and efficient practice providing standards and a framework to work and audit against.

Link Nurses

IP&C Link Nurses now form part of a larger group of link staff known as SAINTs. This group includes Tissue Viability, Nutrition, Dermatology and Continence link nurses and meets quarterly. In addition the IP&C Team have run a study day (supported by reps from various companies) off site and had attendance of roughly 70 staff. The day included internal and external speakers covering topics such Antimicrobial resistant organisms, sepsis, ANTT and many other subjects. Feedback from the day was good and another study day is planned.

Results and Surveillance

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

On average there are 15 imports a day to ICNET that require action from the IP&C Nurses. Norovirus and Influenza are also imported to ICNET. The IP&C team request Norovirus testing when required within the Trust as part of assessing patients with symptoms of D&V. The IP&C team monitor bays and wards and advise on patient flow and risk when these Viruses require bay or ward closures.

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

Reducing avoidable mortality

National research suggests that approximately 5% of in-hospital deaths could have been avoided if the quality of care had been better. Monitoring overall hospital mortality data is recommended as it can indicate where there are problems with the quality of care. Several indicators are used nationally, including the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital Mortality Indicator (SHMI).

HSMR: Hospital Standardised Mortality Ratio

The Dr Foster indicator and perhaps the best known:

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

SHMI: Summary Hospital Mortality Indicator

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

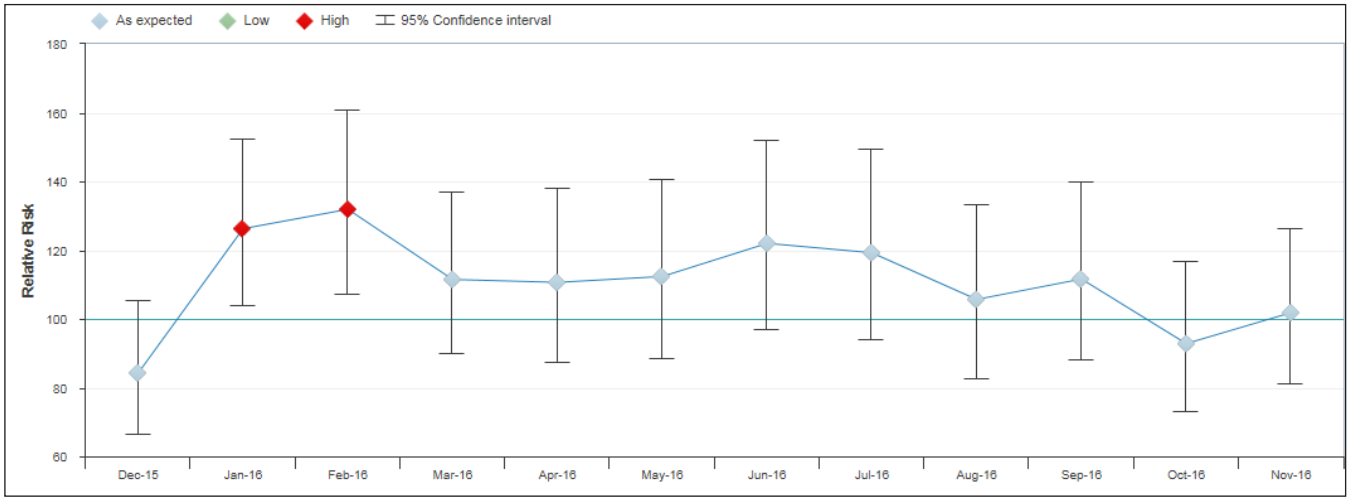
- Is available to the public on the NHS Choices website
- Risk of death based on diagnosis at first episode of care

- Includes deaths within 30 days of discharge
- Has a rolling 12 month average, updated quarterly and published six months in arrears.

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

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

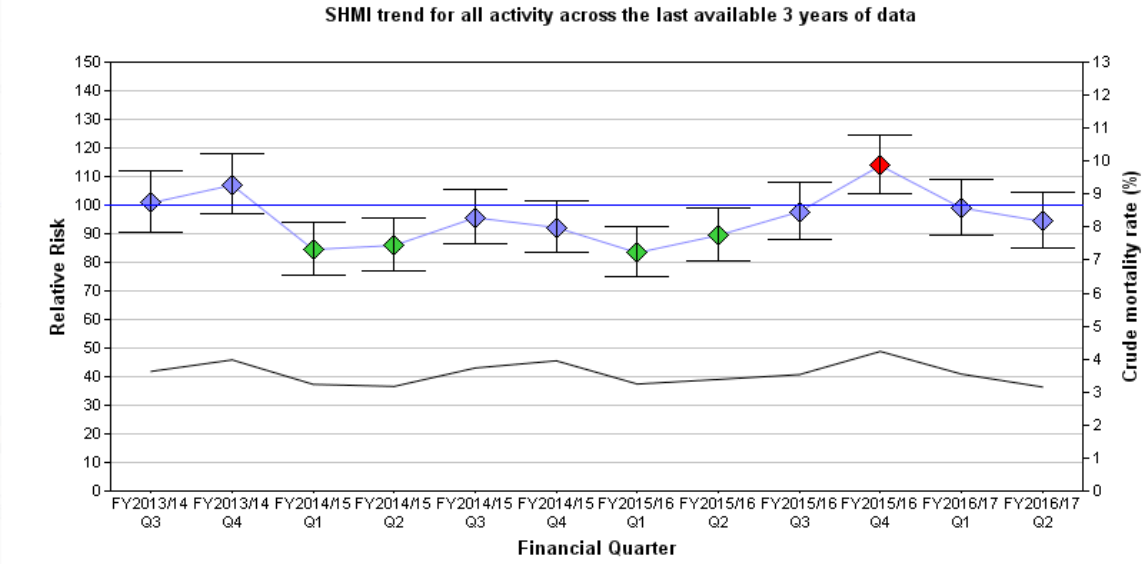
The graph below shows the HSMR trend from January to December 2016. The HSMR is above expected. Data is published three months in arrears and the last quarter is as yet unavailable.



The HSMR for the period from January 2016 – December 2016 was within the higher than expected range as follows:

Indicator	QEH (expected range)
Overall HSMR	110.2 (103.4 – 117.5)
Weekday	107.0 (99.3 – 115.3)
Weekend	120.1 (106.0 – 135.7)

In addition, the Board also monitors the SHMI. The data for the SHMI is published six months in arrears and for the period from July 2015 – June 2016 the SHMI was 100.24. This is within the as expected range:



Avoidable mortality

A paper published in the BMJ by Hogan et al in 2015 suggested HSMR and SHMI bore no reflection on quality and a better measurement is the avoidability rate which identifies where improvements can be made. There is a national move towards adopting this approach and to begin publishing our calculated avoidable deaths by October 2017. The Mortality Surveillance Group is in the process of developing a system. However, whether a death is avoidable or unavoidable the important issue is that lessons are learnt and that these are shared across the Trust and possibly across other healthcare organisations. The Mortality Surveillance Group will also oversee embedding of the 'lessons learnt' process.

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

Mortality Surveillance Group

Based on publications from NHS England on 'Learning from Mortality' and 'Avoidable Deaths' the existing Mortality Committee has reviewed its terms of reference and reformed as the Mortality Surveillance Group. It is chaired by the Clinical Director for Surgery. The group meets monthly and reviews data from a number of sources, including Dr Foster. It monitors the HSMR, SHMI and diagnostic groups falling outside the expected range. Along with this, the group also monitors high risk groups as outlined in the above publication.

As a result of concerns raised nationally into premature deaths of people with a learning disability, a review is now undertaken of all deaths involving a person with a known learning disability. This is done in conjunction with the Trust's Learning Disability Liaison Nurse. It is intended to adopt the structured review of case notes under the new Learning Disability Mortality Review (LeDer) programme.

The Group will also be monitoring deaths within national specialty databases. Any outlying areas will be further investigated with a case note audit. A new meeting agenda has been created to enable collection of this information.

This year our HSMR has been above the expected and this has been explained in part by a drop in our palliative care coding rate. Work is also being undertaken to review primary diagnosis recorded on admission. The Trust is reassured by our SHMI data - which does not include an adjustment for palliative care and has stayed within the expected range. Below is a summary of the completed audits:

CCS Group	Outcome
Intracranial injuries	No concerns, the majority of these cases were after falls.
Alcohol and Drug	Four cases were audited and no concerns were found.
Live-born	Very premature deaths: all cases externally reviewed with no concerns.

Secondary Malignancies	No concern, the secondary malignancy was the main reason for admission in patients with a progressive primary cancer diagnosis.
COPD	A more appropriate diagnosis code should have been recorded; most often this should have been Pneumonia.
Influenza	Three cases: all appropriately managed in ITU. No cases were considered avoidable.
UTI	A more appropriate diagnosis code should have been recorded; most often this should have been Sepsis.

End of Life

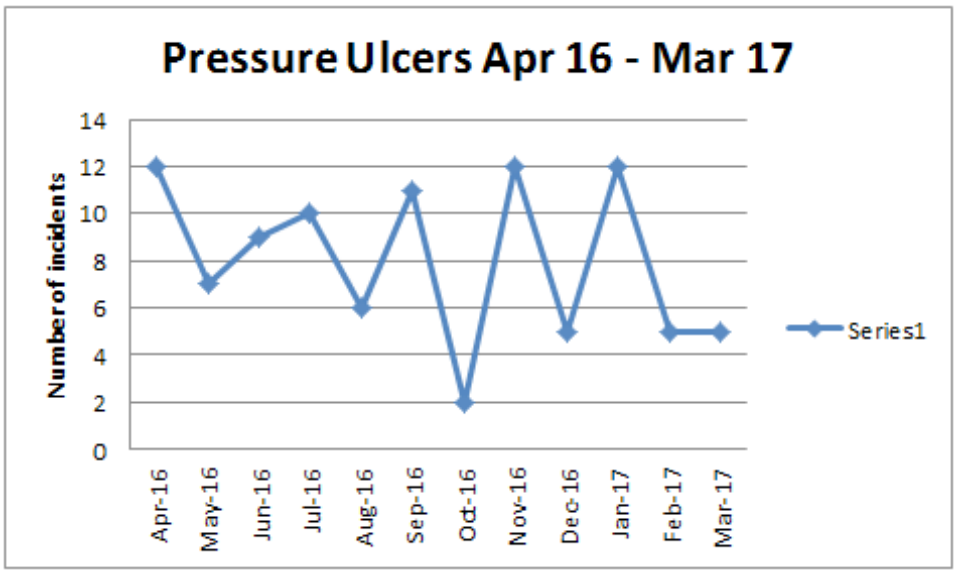
The Trust's End of Life committee has undertaken a number of initiatives to improve end of life care and treatment within the organisation. The committee has particularly focused this year on implementing strategies to ensure people are able to end their life in their preferred place of death. An audit of patients identified as a Fast Track discharge (prognosis < 6 weeks) demonstrates that 90% of the time patients have their preferred place of death. This is a 30% improvement on 2015/16. This work will remain a priority for the Trust in 2017/18.

In March 2017 the Trust was selected by NHS Improvement to join its End of Life Collaborative programme. Throughout 2017/18 the Trust will be working in partnership with Norfolk Community Health & Care NHS Trust to improve end of life care. Improvement priorities will include the roll out of the Amber Care Bundle in key clinical areas, implementing the 'Six ambitions for palliative and end of life care', introducing new individualised care plans and providing education and training to ward staff.

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

The standardised practice from the Ready to Roll Campaign continues to keep pressure ulcer prevention at the forefront of our minds and to maintain/improve current standards. Chart 1 shows the 2016/17 incidents. Audits are completed on every patient with a pressure ulcer seen by the Tissue Viability Nurses (TVNs) The audits are collated monthly by the audit team and delivered as Key Performance Indicators (KPIs). The results are sent to each ward manager and matron and this data helps to identify where specific training should be focused. This helps to identify any areas requiring improvement and allows focused education and training in those areas.

Chart 1 – Pressure ulcer incidents 2016/2017



Standardisation of practice

The following measures have taken place to improve standardisation of practice:

- Non-Invasive Ventilation mask changed to a full face mask to prevent pressure damage on the bridge of the nose
- Nasal cannula with built in foam over the ears as standard
- Introduction of Medical photography policy and pilot training commenced on the Medical Assessment Unit.

Education/training

The SaIINTS link group continues: this is a collaboration of five link groups, to allow a more holistic approach to patient care and reduce the number of staff being released to attend the meetings. In addition the following training has taken place:

- Mandatory training – 37 sessions per year. New format begins April 2017
- Induction – 12 sessions per year
- Overseas induction
- Preceptorship
- Healthcare assistant training - monthly
- Student nurses
- Ward-focused training
- Bespoke placements for students and Trust staff.

Training of late has been focused on documentation and the evidence it provides of the implementation of the ASKINS bundle and measuring 'avoidability' or 'preventability'. The goal is to achieve zero avoidable hospital acquired pressure ulcers on a continuous basis and in a consistent way across all areas of the Trust.

Expert Leadership

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

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

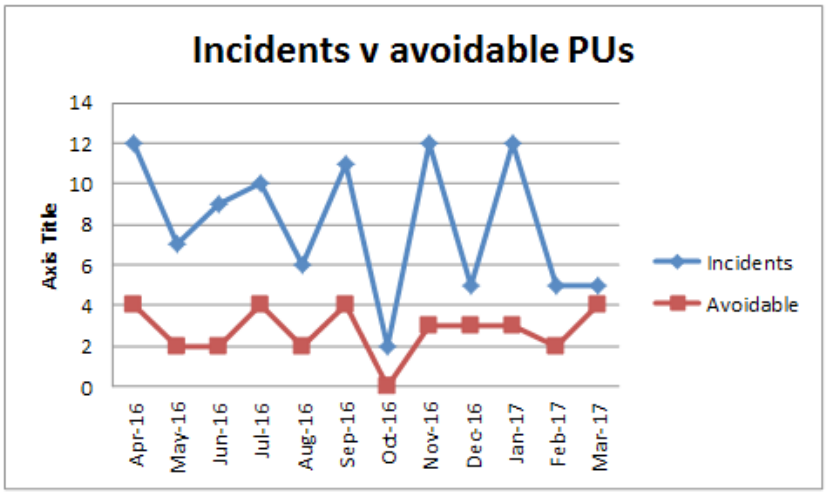
Avoidable v Unavoidable pressure ulcers

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

- All Grade 3 (or 4) Hospital Acquired Pressure Ulcers are reported and a template is in place as part of the investigation process
- The Tissue Viability Nurse (TVN) sees patient within 48 hours of a reported incident to assess and complete the review using the ASKINS criteria. The TVN undertakes the incident review and completes the report with a summary of findings. This has oversight via the Trust Risk and Governance framework. All reports are also submitted to the Director of Nursing (DoN) and a decision is made on whether the incident meets the serious incident reporting threshold. (The criteria for this threshold was devised and agreed in partnership with West Norfolk Clinical Commissioning Group)
- The TVN's also see patients within 48 hours following a reported incident of a hospital acquired Grade 2 pressure ulcer to assess and complete a 'mini' RCA using the ASKINS criteria, to ascertain avoidability. The findings are fed back to the ward manager/matron and this again helps the TVN's identify where

specific training should be focused.

Chart 2 – Avoidable hospital acquired pressure ulcers v incidents



Listening to patients

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

Patient and public involvement is integral to how the hospital plans and improves its services. In 2016/ 17 the Trust actively engaged with patients, their carers and members of the public - so that they could contribute to improving the quality of services that we provide.

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

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

Measuring and reporting patient experience

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

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

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

Friends and Family Test (FFT)

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

Hosting events

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

The Hospital also held an open day in October 2016 to welcome members of the public to learn about the way the hospital works and how it links with other public sector and third sector organisations.

Attending events hosted by other organisations

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

During this year representatives from the Patient Experience Committee requested a meeting with Integrated Care 24 (IC24), the provider organisation for 'out of hours' services, and were able to pass on comments fed back from patients and Patient Participation Groups and to question IC24 about its service provision. This supported an improved understanding of the patients' experience by both parties.

Patient Stories at Board Meetings

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

- Feedback from a patient on the experience of undergoing elective breast surgery
- The experience of a patient being admitted with problems associated with her Stage 4 cancer; the story was presented by her brother
- A patient's experience of the acute pathway of care on two separate occasions involving the Ambulatory Emergency Care ward, the Emergency Department and Terrington Short Stay ward
- Feedback from the mother of a patient with a learning disability on both her experience as a carer and on her daughter's experience as a patient.

National Patient Surveys

During April 2016 to March 2017 the Trust took part in the following National Patient Surveys:

- National Children and Young People's Survey Inpatient and Day case Survey 2017 - results to be

published later in 2017
- National Adult Inpatients Survey 2016 – results to be published later in 2017 (preliminary received from contractor January 2017)
- National Maternity Survey 2017 – results to be published later in 2017
- National Cancer Patients Experience Survey 2016 – results to be published later in 2017
- National Accident and Emergency Survey 2016 – results recently published.

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

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

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

- Patient placemats to be rolled out to all inpatient and day case wards to provide patients with information essential to their stay
- Red trays provided to each bed space to allow patients to safely store life aids (glasses, dentures and hearing aids) during their stay
- Earplugs and eye mask trial initiated to reduce noise at night; positive results have resulted in the Trust's identifying ways in which these could be economically made available to all patients requiring them
- Working in conjunction with local care homes and the Ambulance Trust to introduce a vanguard initiative from another region. Care home patients coming to hospital as emergency cases now bring a red bag containing specific documentation to aid communication and assessment, life aids and day of discharge clothes to improve the patient's experience and to facilitate discharge when the patient is ready to return home.

Communicating learning locally within wards and departments

- All room for improvement comments (accompanied by a positive comment) are returned to area leads for action
- A monthly report from our FFT Service Provider is made available electronically to senior staff across the Trust
- All NHS Choices / Patient Opinion comments and the response we have made are distributed to lead staff in the areas concerned
- Whole hospital improvements are promoted via a range of posters across the Trust.

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

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

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

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

In 2016/17 a wide range of changes were put in place after complaints. These included:

Key Issues	Lessons Identified	Action
Lack of information from doctor regarding medication. Poor communication from one nurse who was also 'rough' when moving the patient and failure to attend to the personal hygiene of the patient.	Information must be provided to patients in a way they can understand. Staff must improve their communication skills when dealing with individual patients and work with the patient when undertaking moving and handling duties. Explanations should be given to families if a patient refuses to be washed.	The doctor concerned accepted he should have explained the issues regarding medication in more detail. Feedback was provided to nursing team on the ward.
Failure by medical staff to identify the cause of the patient's numerous medical problems.	When the patient is under investigation at another hospital not to assume that the hospital will routinely share test results to this hospital.	Patients in this situation are now advised to emphasise to the other hospital involved in their care that they consent to sharing information with this hospital. Although the nurse involved with this patient has since left the Trust the Ward Manager shared these issues with staff at their next ward meeting.
A lumbar puncture was performed on the ward by a doctor despite the patient previously being advised that it would be completed in a theatre setting due to the patient's severe back pain.	The doctor who performed the lumbar puncture had appropriately requested advice from the anaesthetics department who advised that the procedure should be completed on the ward in the first instance. This decision was not effectively shared with the patient and he felt that he was not listened to and that the initial request was ignored.	Apologies were provided by the doctor's line manager. An explanation of the situation was provided and the patient understood and accepted the explanation. The Senior Clinician ensured that the doctor was made aware of the impact her poor communication had on the patient.
A discharge summary was sent to the patient's GP but not to her care home. Lack of information and poor communication with patient's family.	Ensure that in all such cases a copy of the Discharge Summary is sent with the patient. The need for good communication with patients and their families and between staff.	Matron reinforced these issues with staff at their next meeting. Matron raised this issue with all staff involved in patients' discharges.
Lack of communication regarding end of life care and treatment of a patient. Specifically it was not explained why the patient was placed on a Bipap machine and how blood gases were taken for monitoring purposes.	The discussions with the family at the time did not provide them with the assurances they needed to feel confident that the treatment being provided was appropriate.	The concerns were disseminated at ward level so that staff understood the impact of poor communication.

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

Sometimes patients and carers speak with the Patient Advice and Liaison Service (PALS) to raise suggestions rather than complaints. These suggestions vary and have included ways to improve the car park - to speed up the exit process and lower the charges, appropriate hand washing facilities that are fit for purpose in the main entrance and changes to appointment letters to be more informative.

PALS also helped with the placement of signs highlighting the baby changing facilities in the main entrance and no smoking signs on the main entrance canopy after feedback from patients and visitors.

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

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

Estates 2016/17

The Trust has committed to extensive Estate's works to improve the overall patient experience with the completion of the following projects:

- Refurbishment of West Raynham Stroke Ward and West Wing corridor
- Dedicated Peace and Hope Gardens for patients and their families in the Shouldham Ward/Breast Unit courtyard
- Refurbishment of the Training and Resource Centre as a dedicated training area and on completion renamed as The Inspire Centre, including also a Unison meeting room and a Human Resources recruitment office area
- New treatment rooms in the Brancaster Unit
- Third Echo Room for the Cardiorespiratory department
- Refurbishment of the Specialist Doctors' mess
- New ENT treatment room
- Creation of 50 office spaces in the empty first floor path labs, where all teams involved in Discharge and community support are located together
- Refurbishment of Roxburgh Children's Centre – new floors, new treatment rooms
- Sustainable solution to medical gases infrastructure
- Implementation of new portering task software
- Implementation of Zonal Cleaning for great supervision and response resources
- Development of The Hub Restaurant – new opening times and a focus on healthy menus.

In the new financial year of 2017/18 we are looking at undertaking the following improvement initiatives:

1. Installation of the second of two new CT scanners
2. Installation of a Pharmacy robot
3. Programme of upgrading and improving fire detection and retardation
4. Start of a five-year rolling programme to replace and upgrade the roof.

Supporting our staff

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

The Trust has developed and successfully introduced a number of apprenticeships including the Aspiring Nurse Health Care Apprenticeship programme and has also invested in new roles such as Physician's Associate to support the medical workforce. The Trust supports staff to develop as appropriate from unregistered to registered roles; this is likely to lead to a greater commitment and loyalty to the organisation.

The Trust has also recruited internationally and supported nurses from overseas to orientate them to the organisation and area. In addition the Trust has provided specific training to help them to successfully pass the Nursing and Midwifery Council practical tests to enable them to become registered nurses.

Supporting Managers to Support their Staff

This one day workshop, first introduced in 2015, continued to be offered regularly throughout 2016 enabling 70 managers the opportunity to improve their understanding and application of Trust policies. The scenario and group learning approach facilitated by HR Business Partners continues to receive very positive ratings with managers commenting on a sense of improved confidence in maintaining a positive work environment. Further regular sessions are planned throughout 2017 to help embed and maintain the support created to date.

Leadership Development

Accelerating challenges in healthcare have made it imperative that front line clinicians, particularly nurses and midwives, have the leadership capability to drive radical service redesign and improvement. The ability to influence and lead change at the front line is now central to delivering this agenda at all levels within the hospital.

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

The second phase of a nursing and leadership development programme was completed during 2016 with a prime purpose of increasing understanding of the context for change with enhanced cohesive and productive teamwork. The evaluation results demonstrate significant improvement in awareness and confidence relating to change and teamwork from the ward managers and an improved awareness and confidence from the matrons. The overriding theme in the final evaluation process from all participants was the importance of being together to learn, share and develop. It is proposed that five action learning sets will be facilitated during 2017 to enable a self-sustaining model for learning and development for nurse leaders within the hospital.

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

Lifelong Learning

Lifelong Learning is a partnership programme between the Trust and our recognised trade unions. It aims to give staff learning opportunities to help with confidence and encourage access to personal development. The opportunities do not necessarily relate to work, with classes including wellbeing activities such as Pilates, yoga, dancing and sewing as well as continuing support for dementia awareness sessions. The approach to partnership working in setting up Lifelong Learning and the development of a dedicated centre (The Inspire Centre) onsite at the hospital has been recognised nationally and the Trust has been shortlisted for the HPMA (Healthcare People Management Association) Excellence Award. The final announcement and presentation will be held in June 2017.

Trust Values

The Trust has continued to embed and ensure continued focus on its values starting from values based recruitment, induction and appraisal processes. In addition, we have also continued with monthly values-in-action awards where staff can be nominated for a particular value, providing details of how the staff member has put the Trust values into action within their role. These values in action awards are presented by the Trust

Chief Executive, and details of the award winners are communicated throughout the Trust.

Values in Action Awards

Between April 2016 and March 2017, 176 members of staff have between them received values awards. The breakdown of the values awards is as follows:

24 - Compassion
8 - Courage
18 - Curiosity
90 - Pride
36 - Responsibility

Long Service Awards

The Trust recognises staff long service and the following numbers of staff received an award presented by the Chief Executive and Trust Chair for reaching 40, 30, 20 or 10 years' long service from 1 January 2016 to 31 December 2016:

40 years : 1 member of staff
30 years : 12 members of staff
20 years : 30 members of staff
10 years : 66 members of staff

Staff Engagement

The aim is to ensure an excellent quality experience for staff working at the Trust in order to support staff retention and the delivery of high quality patient care. By developing an engaged, enabled and empowered workforce, well-led and supported, the Trust can ensure its staff are getting the best possible experience, and

in turn patients are getting the best care. Motivated and involved staff are at the forefront of enabling the Trust to know what is working well and how we can better improve our services for the benefit of patients and the public.

The Trust encourages open and honest communication throughout the organisation. It is acknowledged that research consistently shows that high levels of staff engagement in the NHS have a positive impact on quality, cost and, most importantly, on the patient experience. The Trust plans to review staff engagement mechanisms and use the appointment of the Trust Freedom to Speak Up Guardian to further improve staff engagement.

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

Staff Survey 2016

The Trust Staff Survey 2016 was provided to 3073 staff to complete, 1376 surveys were completed providing a response rate of 45%. The Staff Survey 2015 was provided to a random sample of 800 staff, 416 staff at the Trust took part in the Staff Survey 2015 therefore a response rate of 53%. There was not a significant change between the Trust Staff Survey Results for 2015 and 2016.

In terms of staff engagement the Trust scored slightly lower (worse) in the Staff Survey 2016 compared to 2015. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The Trust's score of 3.78 was below (worse than) average when compared with trusts of a similar type where the national average for acute Trust was 3.81 and lower than the score of 3.80 in the 2015 staff survey.

The table below shows how The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2015 survey:

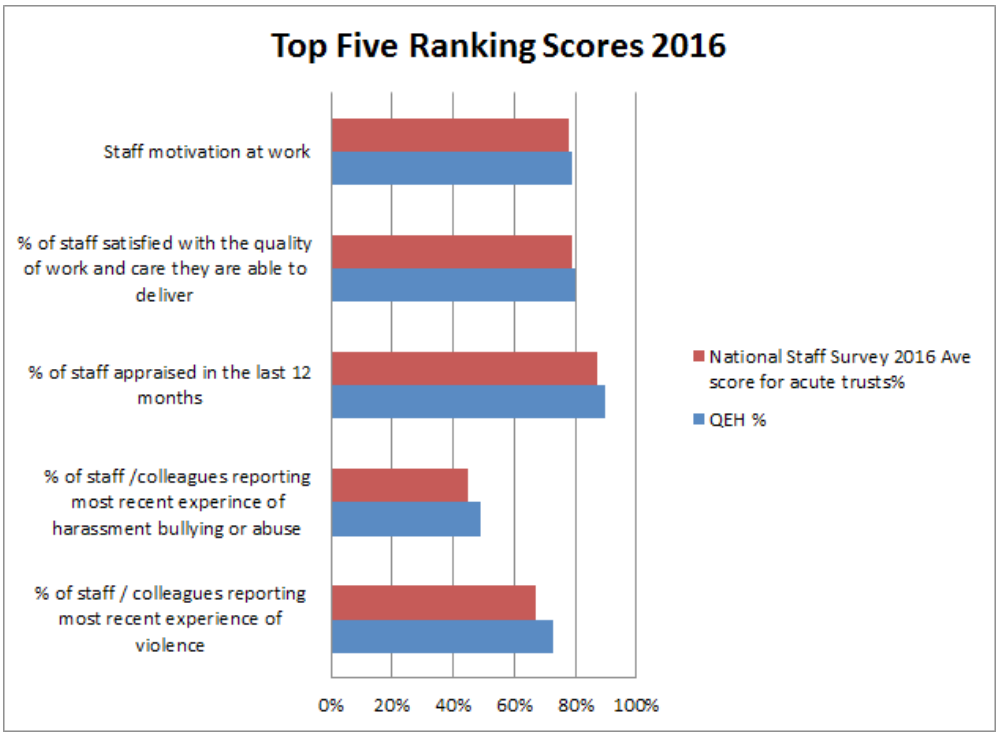
	Change since 2015 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	No change	Below (worse than) average
KF1. Staff recommendation of the Trust as a place to work or receive treatment	Decrease	Below (worse than) average
KF4. Staff motivation at work	No change	Above (better than) average
KF7. Staff ability to contribute towards improvements at work	No change	Average

In addition the Trust has identified that improvements are required in relation to how staff responded both in terms of Equality and Diversity and in relation to Violence, Harassment and Bullying:

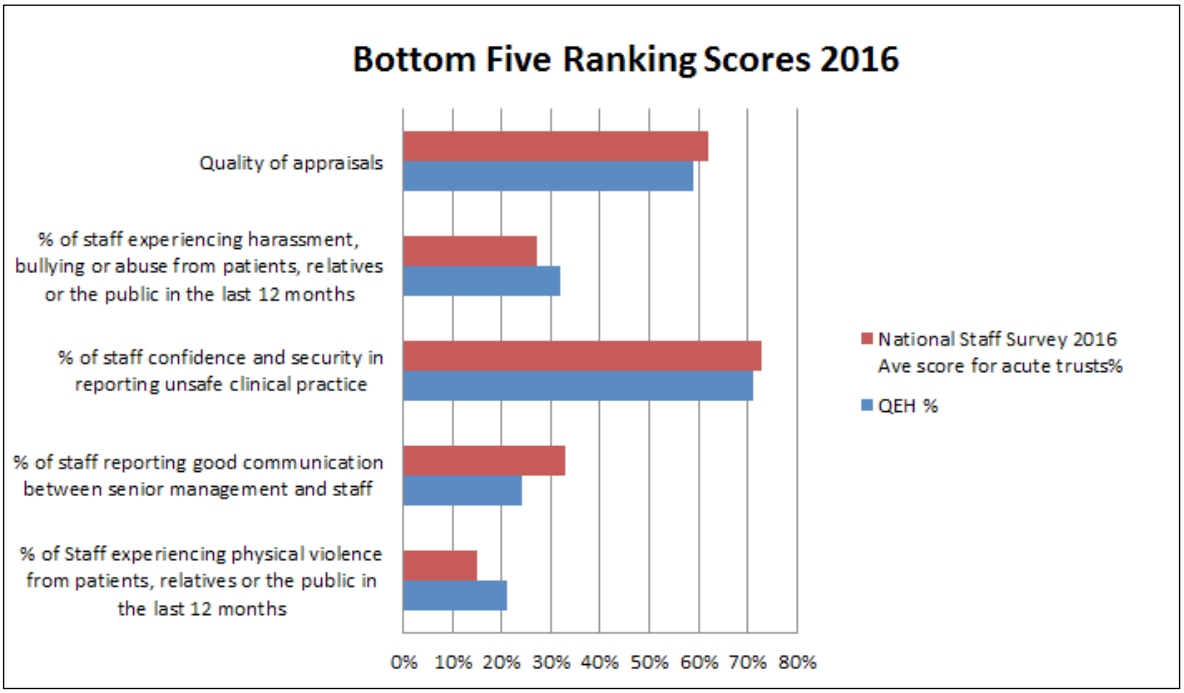
	Change since 2015 survey	Ranking, compared with all acute trusts
EQUALITY & DIVERSITY		
KF21. Staff believing that the Trust provides equal opportunities for career progression or promotion	Decrease	Below (worse than) average
VIOLENCE, HARRASSMENT & BULLYING		
KF26. Staff experiencing harassment, bullying or abuse from staff	No change	Below (worse than) average

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

The Trust Top Five Ranking Scores 2016



The Trust Bottom Five Ranking Scores 2016



Development of Staff Survey Action Plans

It is recognised that the Staff Survey 2016 results showed that improvement is needed in a number of areas. The results of the Trust NHS Staff Survey 2016 are being communicated within the organisation in different ways. Action plans for areas requiring improvement will be developed with progress being monitored and reported on with the involvement of the Freedom to Speak Up Guardian and staff.

In addition, there is a need to consider and to take forward best practice with regard to workforce initiatives, to explore what initiatives have worked well in other Trusts with above average Staff Survey scores compared to other acute Trusts and to implement any changes required to make a positive impact on staff experience at the Trust. Progress reports will be shared with the Workforce Committee, the Board and with staff through formal reports, staff briefings and 'Leading the Way' sessions.

The Trust has also seen some improvements in staff experience highlighted in the staff survey including:

- Percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves
- Percentage of staff appraised in last 12 months

It is intended to build on these and continuously improve, however, it is also recognised that there was not a significant change between the Trust Staff Survey Results for 2015 and 2016. The results were also disappointing when compared with some local trusts and national performance.

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

- Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months
- Percentage of staff reporting good communication between senior management and staff
- Staff confidence and security in reporting unsafe clinical practice
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
- Quality of appraisals

In relation to the response on the quality of appraisals, the Trust has a process to gain feedback from staff on the quality of their appraisal. Its two key questions are: 'How well structured did you think the appraisal was?' and 'Overall how would you rate the value, quality and usefulness of the appraisal discussion?' This feedback is monitored on a monthly basis and any issues highlighted addressed, but overall over 90% of staff that completed the survey provided positive feedback on the quality of their appraisal.

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

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

The Trust takes any incident of harassment, bullying and abuse very seriously, whether it arises from a patient, a member of the public or another member of staff. Advice for staff is available in person by contacting their Human Resources Business Partner or on the Human Resources intranet site, where there are links to leaflets and policies to aid staff to report such incidents. The percentage of staff experiencing discrimination at work in the last 12 months has seen a reduction from 17% in 2015 to 14% in 2016 according to the staff survey results.

Staff Friends and Family Test (SFFT)

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

The Staff Friends and Family Test was introduced during 2014/15 and requires NHS Providers to ask their

workforce two simple questions:

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

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

Quarter	1	2	3	4
No. of responses received 2014/15	119	96	undertaken as part of the annual staff survey	485
No. of responses received 2015/16	372	291	undertaken as part of the annual staff survey	365
No. of responses received 2016/17	338	266	undertaken as part of the annual staff survey	245

The Trust will focus in 2017/18 on improving participation in the Staff Friends and Family Test and will be trying new approaches to inform staff about the difference completing the test has made; it will show changes made after feedback was received.

2.1 QUALITY PRIORITIES FOR IMPROVEMENT 2017/18

2017/18 marks the end of the previous Quality Strategy and the appropriate moment to pause and review the Trust's current position in relation to improvements in the quality of its services. The arrival of a new Executive team provides an opportunity for the Trust to embed current improvements and then to embrace new ideas and approaches which can build on the work that has already been successfully implemented and can prepare the organisation for the challenges ahead during the next three years.

The Quality Priorities for the coming year will therefore look to progress national priorities, build on achievements to date and ensure that improvements are sustained and strengthened. In addition, the Trust has chosen to focus on the experience of children as one of its priorities as much of the improvement work to date has focused on improving services for the majority patient group, namely the frail, older patient:

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

How and where will progress be reported?	Regular reports and updates to: Mortality Review Panel Quality Committe Board of Directors
Clinical Effectiveness priority	**Improvement in the care of our patients when their condition deteriorates on our wards**
Why is this a priority?	Patients who are admitted to hospital believe that they are entering a place of safety, and they and their families and carers, have a right to believe that they will receive the best possible care. They must feel confident that should their condition deteriorate, they are in the best place for prompt and effective treatment. It is important that any deterioration is consistently recognised and acted on promptly.
Lead Director	**Chief Nurse**
What is our target?	We will improve compliance with Early Warning Safety System (EWSS) and Paediatric Early Warning System (PEWS) to 95% and reduce the number of incidents of failure to detect and escalate.
What will we do to improve our performance?	EWSS training and use of 'observations made easy' training for all new staff or anyone unfamiliar with the ward so that all staff are confident and competent in undertaking clinical observations and acting on their findings. Introduction of the Nightingale Project - where team members identify and discuss patients who they are worried about and decide on the actions to take. Use of Situation, background, assessment, response (SBAR) as a communication tool to support escalation of concerns, to aid decision making, handover and documentation of action.
How will we measure and monitor our performance?	% Staff trained % of patients with accurate EWSS/ PEWS score % of incidents of failure to detect and escalate Number of unexpected cardiac arrests Audit use of SBAR proforma Reduction in number of incidents relating to failure to escalate
How and where will progress be reported?	Reports and updates to: Quality Committee Board of Directors
Patient Experience priority	**Improve the experience of children attending the Trust**
Why is this a priority?	Patient experience is a key element of quality alongside providing clinical excellence and safer care. Being in hospital can be a frightening for children and it is important that the Trust delivers services that are informed by the voice of children and young people. Care and treatment must be 'child centred' and focused on the needs of the child rather than on the needs of the service and must be provided in an appropriate environment.
Lead Director	**Chief Nurse**

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

What will we do to improve our performance?	• Adoption of the SAFER Patient Flow bundle • Expected date of discharge used as a part of routine clinical practice • Implementation of early discharge for appropriate patients • Patients (and /or their next of kin) will be involved in developing their plan of care and made aware of their progress and the plan for discharge • Improve partnership working to ensure services are provided to patients in the most appropriate setting for the patient • Frequent attenders meetings will aim to identify the most appropriate interventions to support such attenders to manage their health & social needs outside the hospital setting • Delayed transfer of care meetings will work collaboratively to ensure that patients that are medically stable and fit to transfer out of hospital will be facilitated to transfer to a more appropriate care setting as soon as possible
How will we measure and monitor our performance?	Metrics used that demonstrate: • % of patients receiving senior review before 11am • % of patients discharged before both 10am and midday • % of patients with a length of stay over 7 days reviewed by system peers on a weekly basis • % of patients or their next of kin that can answer the 4 standard questions relating to their condition, treatment, progress and arrangements for discharge.
How and where will progress be reported?	Regular reports and updates to: Quality Committee Board of Directors

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

2.3 STATEMENTS OF ASSURANCE FROM THE BOARD

Review of services

During 2016/17 the Trust provided and/or sub-contracted 45 NHS services. The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100% of these NHS services.

The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust for 2016/17.

2.4 PARTICIPATION IN CLINICAL RESEARCH AND CLINICAL AUDIT

Participation in Clinical Research

The number of patients in 2016/17 receiving relevant health services provided or sub-contracted by The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust that were recruited between 1 April 2016 and 4 April 2017 to participate in research approved by a research ethics committee was 644.

This included 600 patients recruited to National Institute for Health Research (NIHR) portfolio studies and 44 patients recruited to non-portfolio studies. In 2016/17 the Trust was involved in conducting 50 NIHR portfolio and 10 non-portfolio clinical research studies.

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

Participation in Clinical Audits and National Confidential Enquiries

During the reporting period 2016/17, the Trust engaged in 35 National Clinical Audits and 6 National Confidential Enquiries covering the relevant health services that The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust provides. During that period The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust participated in 95% of the National Clinical Audits and Patient Outcomes Programme (NCAPOP) and 100% of the National Confidential Enquiries which it was eligible to participate in. In addition the Trust participated in a further 5 National Audits (Non-NCAPOP) recommended by Healthcare Quality Improvement Partnership (HQIP).

The National Clinical Audits and National Confidential Enquiries that we as a Trust were eligible to participate in and for which data collection was completed during 2016-17 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits 2016/17

The national clinical audits and national confidential enquiries that The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust was eligible to participate in and for which data collection was completed during 2016/17 are listed as follow, alongside the percentage of cases submitted as a percentage of the number of

registered cases required by the terms of that audit or enquiry:

Audit Title	Participation	% of cases submitted
Acute		
Case Mix Programme - Adult Critical Care (ICNARC) (CMP)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	80%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Trauma Audit Research Network (TARN)	Yes	85%
Consultant Sign Off (RCEM)	Yes	100%
Severe Sepsis and Septic Shock (RCEM)	Yes	100%
Asthma Care in Emergency Departments (RCEM)	Yes	100%
Cancer		
National Bowel Cancer audit (NBOCAP)	Yes	100%
National Lung Cancer Audit (NCLA)	Yes	100%
National Oesophago-gastric Cancer audit(NOGCA)	Yes	100%
Prostate Cancer(Urology)	Yes	100%
Head and Neck Cancer Audit	Service is carried out in tertiary care settings	
Cardiology		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	92%
Cardiac Arrest Audit (NCAA)	Yes	99%
Heart Failure	Yes	95%
Diabetes		
National Diabetes Audit	No	Trust software not compatible
National Diabetes Foot Audit	Yes	100%
National Diabetes in Pregnancy (NPID)	Yes	100%
National Diabetes Inpatient Audit (NADIA)	Yes	100%
Surgery		
Elective surgery (National PROMs Programme)	Yes	100%
National Hip Fracture Database (FFFAP) (NHFD)	Yes	96.4%
National Joint Registration (NJR)	Yes	100%
National Obstetric Anaesthesia Database(NOAD)	Yes	100%
Nephrectomy Audit (BAUS)	Yes	100%
Surgical Site Infection (SSI)	Yes	99%
UK Registry of Endocrine and Thyroid Surgery (UKRETS)	Yes	80%
Vascular surgery (VSGBI Vascular Surgery Database)	Service is carried out in tertiary care settings	
Other		
Psoriasis (IBAD)	Yes	100%
Audit of Patient Blood Management in Adults undergoing elective, scheduled surgery	Yes	100%
National Audit for Rheumatoid and Early Inflammatory Arthritis	Audit not collecting data 2016/17	
National Audit of Dementia	Yes	100%
Inflammatory Bowel Disease	Yes	100%
National Comparative Audit of Blood Transfusion	Yes	100%
National COPD Audit Programme (BTS): Emergency use of Oxygen	Yes	Data collection on-going
Adult Asthma (BTS)	Yes	100%
Role of Inflammatory Markers in Patients Presenting with Acute Ureteric Colic	Yes	100%
Renal Replacement Therapy	Service is carried out in tertiary care settings	
LeDeR Programme (HQIP)	Unavailable to Trust for 2016/17	

Audit Title	Participation	% of cases submitted
Women and Children		
Asthma Audit (Paediatrics) (BTS)	Audit not collecting data 2016/17	
British Society of UroGynaecologist (BSUG) audit	Yes	70%
Community Acquired Pneumonia Audit (Paediatric) (BTS)	Yes	100%
Each Baby Counts (five- year project)	Yes	Five year project
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
National Neonatal Intensive & Special Care Audit Programme(NNAP)	Yes	100%
National Paediatric Diabetes Audit	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%

National Confidential Enquiries 2016/17

Audit Title	Participation	Eligible Number	Actual Submissions
Acute Pancreatitis	Yes	4	3 (75%)
Acute Non-Invasive Ventilation (NIV)	Yes	3	0 (0%) **
Mental Health	Yes	4	2 (50%)
Chronic Neurodisability	Yes	2	2 (100%)
Young Persons' Mental Health	Yes	5	3 (60%)-in progress
Cancer in Children, Teens and Young Adults	No	Currently in progress	

** 3 Clinical questionnaires were returned for the Acute NIV study, however all were excluded due to receiving CPAP, as the study was focusing on patients receiving BiPAP.

National Audits – Actions and Outcomes

The reports of 21 national clinical audits were reviewed by the Trust between 1 April 2016 and 31 March 2017 and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Hip Fracture Database (NHFD) – Comparative audit highlighting best practice nationally. The results of the audit show the following positive outcomes:

- Perioperative medical assessment is up from 71% to 93%
- Increased attainment of Best Practice Tariff from 54.5% to 80.5%.

Changes made to improve patient care include:

- Increased provision of Orthogeriatrician cover
- A trial of qualified therapy staff to cover weekends, offering mobility on the first day post-surgery seven days a week
- Incorporating hip fracture activity/performance into monthly clinical governance meetings
- Establishment of four 'trauma' beds on Gayton to allow the 'fast-tracking' of hip fracture patients from the Emergency Department
- A Standard Operating Procedure (SOP) for hip fractures
- Pre-operative nurse-led fascia iliac blocks.

National Diabetes Inpatient Audit (NADIA) – The audit took place in September 2016 and collected data on the care received by those diabetic inpatients in hospital at the time of the audit. Key findings from the audit include:

- 49.3% of patients included in the audit were visited by a member of the diabetes team against a national average of 34.1%

- 18.6% of patients with diabetes at The QEH experienced one or more medication error against a national average of 37.8%
- 3.4% of patients with diabetes at the QEH experienced at least one medication management error, against a national average of 24.1%
- 96.9% of patients with diabetes at the QEH reported that all or most of the staff caring for them were aware they had diabetes
- 91.5% of patients at the QEH reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital.

Sentinel Stroke National Audit Programme (SSNAP) – The latest report has shown fantastic improvements over the past 14 months with the unit rating increasing from an E to an A rated unit.

National Neonatal Audit Programme (NNAP) – Comparative audit highlighting best practice nationally. The results of the audit show the following positive outcomes:

- Documented consultation with parents by a senior member of the neonatal team within 24 hours of admission is up from 99% to 100%
- Breast milk feeding at discharge is up from 75% to 80%
- Two-year data outcome entry is up from 40% to 100%

Local Clinical Audit

The reports of 89 local clinical audits were reviewed by the provider in 2016/17. A selection of these audits is outlined below and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

Infection Prevention & Control (IP&C) – Cannulation Audit 2016 – Compliance audit undertaken in relation to guidelines on the care of peripheral cannulae – this demonstrated that there were areas of practice where compliance was less than 100%, this included recording the date and time of insertion, removal of cannula if not in use and monitoring score recorded on observation chart.

Follow up action:

- Infection, Prevention & Control Team, Matrons and Ward Managers to work with wards and departments to increase compliance
- To introduce B Braun Cannulation Pack
- Reinforcement of best practice to be given at mandatory training
- To discuss documentation after insertion of cannula prior to admission with the East of England Ambulance Service.

Respiratory – Chest Drains Audit – Audit undertaken to evaluate if the Trust is meeting requirements set out by the British Thoracic Society (BTS) for 'Chest Drain insertion' and 'Thoracentesis'. Results have highlighted that only two of the 13 standards were met when audited.

Follow up action:

- Create a Concise Care Bundle to be used when performing pleural procedures
- To develop:
  - Pleural effusion referral pathway
  - Pleural safety campaign/ workshop
  - Pleural safety publicities (A4 laminated posters in acute areas)
  - Pleural Nurse champions (one each for Necton Ward, Terrington Short Stay and MAU)
  - Pleural Lead for Acute Areas
  - Continue chest drain safety course
  - Pleural Whatsapp group for trainees.

Acute Medicine– Management of Hyponatraemia – An audit was undertaken to assess if patients admitted with Hyponatraemia received appropriate investigations in accordance with the Trust's Concise Care Bundle. A six- month sample of patients admitted between December 2015 and June 2016 was analysed and the

results demonstrated that only 17% of patients with serum sodium (Na) <135mmol/L were investigated in accordance with the Concise Care Bundle.

Follow up local action:

- To revise the Trust Concise Care Bundle in accordance with European Society Guidance
- To provide teaching to doctors at the Wednesday Acute Medical Session.

Obstetrics & Gynaecology – Post-Partum Haemorrhage (PPH) Audit – An audit took place to determine if there could be any learning from reviewing the patient notes of women who had a post-partum haemorrhage over 1500mls between the months of July-September 2016. The results showed that none of the standards set out in the local guidelines were met.

Follow up action:

- To document PPH Risk on the ward whiteboard in purple pen to highlight to midwives and doctors to be vigilant and ensure a robust plan is in place
- Memo to go out to all co-ordinators asking them to ensure the PPH proforma is completed for all PPHs that occur during their shifts
- To make PPH as 'Hot Topic' on staff room board to highlight risks, appropriate drugs and case reviews.

Dermatology – An audit to determine if pre-screening checks for patients receiving Methotrexate are completed as set against the standards – this demonstrated that the main problematic area was the completion of the urine dipstick.

Follow up action:

- Patients to be informed in the doctor's clinic that a urine specimen will be required when attending the nurse led clinic for initiation of Methotrexate.

Care of the Elderly – Trust-wide Falls Audit – The audit was undertaken to prioritise and support improvements inpatient care throughout the Trust with regard to falls. It demonstrated that the Trust did not meet any of the standards set out by the Falls and Fragility Fracture Audit Programme (FFFAP) for the National Inpatient Falls Audit.

Follow up action:

- The care bundles for Delirium and Continence to be revised
- Lying and standing blood pressure to be included in the Comprehensive Geriatric Assessment and included in mandatory training
- New Comprehensive Geriatric Assessment Paperwork to be introduced – Education of staff to be provided at Friday Grand Round.

Paediatric - Audit on the referral to Paediatrics for Safeguarding Assessment for non-mobile infants presenting to the Emergency Department with bruising. The audit revealed that just 15.8% of infants applicable to the audit were referred to Paediatrics for Safeguarding Assessment.

Follow up action:

- A flow chart on how to manage injuries/bruising in non-mobile infants has been developed.

Patient Experience/Satisfaction

In addition to the Friends and Family Test feedback cards, specialties have participated in the following nine patient experience or patient satisfaction (service evaluation) studies in 2016/17:

- Breast Care – Awareness of Breast Soreness in Women

- Dermatology – Skin Cancer Regional Satisfaction
- Diabetes – Insulin Pump Service
- General Surgery - Stoma Care Clinic
- Endoscopy – Endoscopy Clinic
- Obstetrics and Gynaecology – Colposcopy Clinic
- Pain Management – Pain Service Satisfaction
- Pharmacy – Dispensary Service
- Radiology – Nuclear Medicine Patient Satisfaction.

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

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

A proportion of the income received by The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between The Queen Elizabeth Hospital, Kings Lynn, and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. The monetary total for income in 2016/17 conditional on achieving these quality improvement and innovation goals and the monetary total for the associated payment in 2015/16 are as follows:

Acute		Specialist	
2015/16	£3,042,243.00 *£2,923,56.79 achieved*	2015/16	£87,984.00
2016/17	£3,453,807.00 *Full achievement*	2016/17	£158,774.00

Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at www.qehkl.nhs.uk and included within this document.

CARE QUALITY COMMISSION & MONITOR

The CQC

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

The Trust was formally rated:

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

As a result of the improvements identified by the CQC between 2014 and 2015 inspections, the Trust was removed from 'Special Measures' in August 2015. The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has no conditions on its registration and the Care Quality Commission has not taken enforcement action against The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust during the reporting period from 1 April 2016 to 31 March 2017.

The Trust has introduced a Quality Improvement Group to oversee and evidence the delivery of the 'Must' and 'Should' recommendations of the CQC's inspection report and to focus the Trust on delivering services in accordance with the CQC's Fundamental Standards. A Quality Summit was held in 2016/17 to review progress and further summit work is planned.

In 2016/17, an Internal Audit was undertaken of the Trust's methodology for providing assurance to the Board in respect of CQC compliance. The Internal Audit provided 'reasonable assurance' (amber/green). The Trust has assimilated the recommendations of the audit and in 2017, will be reviewing and strengthening its processes for driving quality improvements and evidencing CQC compliance. This work will include improved visibility for the Board.

The CQC inspection identified additional improvement work to be undertaken in particular respect of:

- Obstetrics and Gynaecology
- Outpatients
- End of Life Care.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has made the following significant progress by the 31 March 2017 in securing and embedding further improvements in these areas and this work has been overseen by the Trust's Transformation Committee. Improvements include:

Obstetrics and Gynaecology:

- Recruitment to vacant midwifery posts
- Focus on reducing the caesarean rate
- Improving mother's choices in relation to birth with the provision of the Midwifery-led Birthing Unit (MLBU) and the reinstatement of the home birth service in February 2017
- Launch of new midwifery-led pathway in February 2017
- Implementation of Badgernet electronic record to improve communication and handover between healthcare professionals and improve the quality of record-keeping
- Introduction of a new maternity dashboard to ensure greater oversight of quality measures.

Outpatients:

- Appointment of additional consultant posts to support activity
- Work has continued to address Did Not Attend and Appointment Slot Issue rates
- Focus on improved communication to improve patient satisfaction, likelihood to recommend >95%.

End of Life Care:

- 90% of patients now achieving their preferred place of death
- Review of all complaints or incidents by the End of Life Group
- Trust to participate in the national NHSI End of Life Care Collaborative project.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period 2016/17.

SECONDARY USER SERVICES (SUS)

The Trust submitted records throughout 2016/17 to the Secondary User Services for inclusion in the Hospital Episodes Statistics, which are included in the latest published data. As of January 2017, SUS data which included the patient's valid NHS number was:

• Inpatient	GP practices 100%	NHS number 100%
• Outpatient	GP practices 100%	NHS number 100%
• Emergency Dept	GP practices 100%	NHS number 100%.

INFORMATION GOVERNANCE ASSESSMENT REPORT

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (RCX) Information Governance Assessment Report overall score for 2016/17 was 80% and was graded Green (Satisfactory).

CLINICAL CODING ERROR RATE

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust was not subject to a Payment by Results (PbR) clinical coding inpatient quality audit during the reporting period by our regulators because audits are now being targeted on trusts with a higher error rate. The Trust completed internal coding audit reviews for evidence for the Information Governance Toolkit. These audits did not reveal any particular areas of concern. However, the results are based on 200 notes for each audit out of 80,000 notes coded each year so the results should not be extrapolated further than the actual sample.

Accuracy	Percentage achieved
Primary diagnoses	94.50%
Secondary diagnoses	91.50%
Primary procedures	97.00%
Secondary procedures	95.00%

Data Quality

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust will be taking the following actions to improve data quality:

- Continue monitoring data quality via SUS submission dashboards
- Continue the data quality forum to investigate and correct data quality issues
- Carry out regular audits on the recording of data across the Trust.

2.5 REPORTING AGAINST CORE INDICATORS

Indicator	**Summary Hospital-Level Mortality Indicator (SHMI)** SHMI is a hospital-level indicator that measures whether mortality associated with a stay in hospital was in line with expectations. SHMI is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by the Trust. SHMI is not an absolute measure of quality but it is a useful indicator to help Trusts understand mortality rates across every service provided during the reporting period. A Lower score indicates better performance					
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL Score**	**National average**	**Highest score**	**Lowest Score**	**Banding**
	Oct 11 - Sept 12	0.9993	1	1.1235	0.8901	2
	Jan 12 - Dec 12	0.9899	1	1.1919	0.7031	2
	April 12 – March 13	1.0154	1	1.1697	0.6523	2
	July 12 – June 13	1.0067	1	1.1563	0.6259	2
	July 13 – June 14	0.94	1	1.12	0.9	2
	July 14 – June 15	0.883	1	1.209	0.661	3
	Oct 15 – Dec 16	1.0138	1	1.1638	0.6897	2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period (the palliative care indicator is a contextual indicator)	**June 11 - June 12**	14.5	18.6			
	Oct 11 - Sept 12	18.8	19.2			
	2013/14	15.2	NA			
	2014/15	14.3	26.1			
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons: • The Trust is banded as a '2' which is 'as expected' mortality. This correlates with information gained from local clinical quality meetings.						
The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services by: • Recruitment of nursing staff to vacant and new posts to ensure that minimum ratios were achieved across the Trust • Continued monitoring and investigations of mortality through the mortality committee • Improved pathways for emergency admissions including the ambulatory emergency care unit • Further use of the 'care bundles' approach to standardise early treatment of emergency conditions • Continued emphasis on routine harm prevention including sustained rates of risk assessment for venous thromboembolism, falls and nutritional status.						

Footnote: NA = Not Available

Indicator	Patient Reported Outcome Measures (PROMs) scores PROMs measure a patient's health-related quality of life from the patient's perspective using a questionnaire completed by patients before and after four particular surgical procedures. These questionnaires are important as they capture the extent of the patient's improvement after surgery.				
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL Score**	**National average**	**Highest score**	**Lowest Score**
The Trust's patient reported outcome measures scores for groin hernia surgery	**2011/12**	0.081	0.087	0.143	-0.002
	2012/13	0.126	0.085	0.277	-0.1
	2013/14	0.132	0.086	0.2	-0.033
	2014/15	0.087	0.081	0.273	-0.17
	2015/16	0.008	0.088	0.61	-0.14
	2016/17	Due Sept 17	Due Sept 17	Due Sept 17	Due Sept 17
The Trust's patient reported outcome measures scores for varicose vein surgery	**2011/12**	0.240	0.095	0.240	0.047
	2012/13	0.081	0.093	0.239	-0.155
	2013/14	0.171	0.102	0.23	-0.043
	2014/15	NA	0.1	0.264	-0.051
	2015/16	NA	0.1035	0.532	-0.14
	2016/17	Due Sept 17	Due Sept 17	Due Sept 17	Due Sept 17
The Trust's patient reported outcome measures scores for hip replacement surgery	**2011/12**	0.450	0.416	0.532	0.306
	2012/13	0.492	0.438	0.621	0.247
	2013/14	0.628	0.447	0.724	0.177
	2014/15	0.489	0.442	0.765	0.187
	2015/16	0.377	0.453	1.0095	0
	2016/17	Due Sept 17	Due Sept 17	Due Sept 17	Due Sept 17
The Trust's patient reported outcome measures scores for knee replacement surgery	**2011/12**	0.285	0.302	0.385	0.18
	2012/13	0.403	0.319	0.557	0.115
	2013/14	0.466	0.339	0.683	0.073
	2014/15	0.458	0.328	0.745	0.055
	2015/16	0.48	0.334	0.912	-0.175
	2016/17				

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- Results are monitored and reviewed as part of the quality schedule agreed with local commissioners
- NA indicates where numbers are so low statistically analysis cannot be performed.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Extending the monitoring of PROMs; this is undertaken by the Patient Experience Steering Group as well as the Divisional Boards.

Indicator	**Re admission rates** The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.				
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL Score**	**National average**	**Highest score**	**Lowest Score**
Percentage of patients aged— (i) 0 to 15;	**2013/14**	11.10%	NA	14.20%	7.80%
	2014/15	10.48%	8.4%	NA	NA
	2015/16	11.7%	NA	NA	NA
	2016/17	11.14%	NA	NA	NA
And (ii) 16 or Over	**2013/14**	7.51%	7.0%	NA	NA
	2014/15	8.02%	8.0%	NA	NA
	2015/16	7.9%	NA	NA	NA
	2016/17	8.80%	NA	NA	NA

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- Readmission rates are monitored at divisional and Board level monthly
- Data is provided from both NHS England and Dr Foster.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Maintaining high quality outcomes for its patients to reduce the readmissions required
- Working within the health system to ensure discharges are safe and appropriate.

Indicator	**The Trust's score with regard to its responsiveness to the personal needs of its patients during the reporting period.** **This indicator, which is based on data from the National Inpatient Survey, forms part of the NHS Outcome Framework**		
The data made available to the Trust by the Information Centre with regard to: The overall patient survey score	**Reporting period**	**QEHKL Score**	**England**
	2013/14	73.7	76.9
	2014/15	76.4	76.9
	2015/16	77.7	77.3

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has worked with the inpatient survey provider (Quality Health) to ensure that a random and fair sample of its patients have been questioned.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services by:

- Continuing to focus on recruitment of nursing staff to vacant and new posts to ensure that minimum staffing ratios are achieved across the Trust
- Monitoring staffing levels on a daily basis and support areas under pressure so that patients receive the care that meets their needs
- Focusing on improving the urgent care pathway
- Introducing new initiatives to support better communication and improved care for older, vulnerable patients – red trays for personal aids, placemats providing information on the ward area and the 'red bag project' to support better communication with Care Homes
- Making improvements to the patient environment to support a better patient experience;
- Ensuring a daily presence of the Matron for the area on the wards to monitor the provision of care and to be available for patients and relatives to speak to and raise issues as they arise
- Providing a process of weekly feedback to clinical areas from FFT process including all written comments and highlighting those areas achieving the highest response rates
- Responding to and following up all comments on NHS Choices and Patient Opinion.

Indicator	Staff friends and family test				
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL Score**	**National average**	**Highest score**	**Lowest score**
The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends	**2012/13**	58	65	94	24
	2013/14	49	67	93	39
	2014/15	52	67	89	38
	2015/16	76	79	96	58
	2016/17 (Q2)	76	80	100	44

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- Responses to the NHS Staff survey are independently reviewed.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Providing regular 'Leading the Way' open discussion sessions with the Chief Executive to provide an opportunity for staff to feed back their thoughts and comments and to ask questions
- Developing and 'growing our own' staff to fill registered and unregistered nursing roles and continuing with successful international nurse recruitment; further cohorts are planned
- Developing and implementing a new Health and Wellbeing portal 'Just for You' and other health and wellbeing initiatives such as Yoga and Pilates classes and Staff Gym, delivering on the NHS Constitution Staff pledges and improving communication and engagement
- Communication via the 'Friday Round-Up' trust wide staff communication email and the 'Knowledge' weekly magazine to improve communication and ensure that staff are well informed of key issues in the organisation
- Maintaining the Values Awards that recognise staff who are exemplars of the Trust's agreed Values and Behaviours.W

Indicator	Patient Friends and Family Test Accident and Emergency				
The data made available to the Trust by NHS England FFT Data Pages	**Reporting Period** (annual information not available hence March of each year used as snapshot)	**QEHKL Score**	**National average**	**Highest score**	**Lowest score**
The percentage of patients during the reporting period who would recommend the Trust to Friends and Family	March 2014	86	86	99	53
	March 2015	92	87	99	58
	March 2016	90	84	99	49
	March 2017	91	87	100	46

The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust follows FFT Guidance
- The Trust has worked with 2 external FFT providers to manage the administration of the service and validate data prior to upload to NHS England.

The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of it services by:

- Ensuring feedback is available monthly to all senior staff to cascade to colleagues across the Trust
- Sharing feedback with patients and the public through ward noticeboards and additionally to staff through regular Trust wide internal communications methods – The Knowledge and Friday Round Up
- Reviewing negative feedback, sharing with colleagues and providing an action plan to resolve issues highlighted by patients if appropriate
- Monitoring feedback following changes to ensure that impact has been positive by reviewing both positive and negative feedback
- Sharing actions between areas
- Triangulating FFT feedback with Complaints, PALS, NHS Choices, Twitter, Google Review, national surveys and other forms of feedback and reporting internally and externally to the organisation (to Commissioners) monthly
- Incorporating aspects of the FFT at all patient experience training for staff from induction through to doctors' mandatory training sessions.

Indicator	**Patient Friends and Family Test Inpatients**				
The data made available to the Trust by NHS England FFT Data Pages	**Reporting Period** (annual information not available hence March of each year used as snapshot)	**QEHKL Score**	**National average**	**Highest score**	**Lowest score**
The percentage of patients during the reporting period who would recommend the Trust to Friends and Family	March 2014	86	94	100	75
	March 2015	91	95	100	78
	March 2016	95	96	100	72
	March 2017	96	96	100	82

The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust follows FFT Guidance
- The Trust has worked with 2 external FFT providers to manage the administration of the service and validate data prior to upload to NHS England.

The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of it services by:

- Ensuring feedback is available monthly to all senior staff to cascade to colleagues across the Trust
- Sharing feedback with patients and the public through ward noticeboards and additionally to staff through regular Trust wide internal communications methods – The Knowledge and Friday Round Up
- Reviewing negative feedback, sharing with colleagues and providing an action plan to resolve issues highlighted by patients if appropriate
- Monitoring feedback following changes to ensure positive impact has been by reviewing both positive and negative feedback
- Sharing actions between areas
- Triangulating FFT feedback with Complaints, PALS, NHS Choices, Twitter, Google Review, national surveys and other forms of feedback and reporting internally and externally to the organisation (to Commissioners) monthly
- Incorporating aspects of the FFT at all patient experience training for staff from induction through to doctors mandatory training sessions.

Indicator	Patient safety incidents and the percentage that resulted in severe harm or death.				
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL Score**	**National average for small acute Trusts**	**Highest score**	**Lowest score**
The number and rate of patient safety incidents reported within the Trust during the reporting period	**Based on 1000 bed days**				
	April 2014 - Sept 2014	53.36	35.1	74.9	5.8
	Oct 2014 - Mar 2015	48.48	35.35	82.21	3.57
	April 2015 - Sept 2015	47.93	38.25	74.67	18.07
	Oct 2015 - Mar 2016	41.76	39.31	75.91	14.77
	April 2016 - Sept 2016	37.9	34.74	71.81	21.15
The % of such patient safety incidents that resulted in severe harm or death during the reporting period	**Based on 1000 bed days**				
	April 2014 - Sept 2014	0.4	0.4	8.6	0.1
	Oct 2014 - Mar 2015	0	0.1	1.1	0
	April 2015 - Sept 2015	0	0.1	0.7	0
	Oct 2015 - Mar 2016	0.3	0.4	1.4	0
	April 2016 - Sept 2016	0.7	0.6	0.9	0

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has actively promoted an open culture and encouraged the reporting of incidents to ensure lessons are learnt; this has also positively influenced the reporting rate.

Examples of the safety improvements and risk reduction strategies put in place this year include:

- Confidential waste bins sited at key exit points and a move towards a paperless handover system
- Posters located on the walls and doors at all Trust exits; these remind staff to 'STOP – CHECK (their pockets) – BIN (Handover sheets in the confidential waste bins)'
- Introduction of more robust systems for checking computer hardware prior to disposal
- Improve staff training in post-fall management. All registered nurses to have additional training with a focus on neurological observations and a competency assessment in performing the observations
- Review of induction and orientation for both substantive and Agency staff
- Encouragement of staff to escalate concerns through shift leader
- Improved education and training in relation to patient assessment targeting Early Warning Scores
- Access to senior clinical staff extended to NOK who can refer directly to CCOT if they are concerned about the care being provided on a ward
- Documentation of retained packs has been improved to identify those patients with intentionally retained packs and instructions on timing for removal
- Improved communication with patients discharged home after surgery
- Contact cards provided for patients at time of discharge, with details of telephone numbers for advice post- operatively
- Improved staff education in relation to when VTE must be assessed and re-assessed
- Training of staff in pre-op assessment to identify patients at risk
- VTE assessment incorporated into the WHO safe surgical check list.

Indicator	Patients admitted to hospital who were risk assessed for venous thromboembolism				
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL Score**	**National average**	**Highest score**	**Lowest score**
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	**2012/13**	97.12%	93.87%	100%	80.9%
	2013/14	97.58%	95.77%	100%	79%
	2014/15	97.51%	96%	100%	79%
	2015/16	97.49%	Not available	Not available	Not available
	2016/17	97.78% Current year to date	Full year data not yet available	Full year data not yet available	Full year data not yet available

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The coding team check that all admitted patients have been risk assessed
- The data is shared monthly with clinical teams and reviewed and monitored through the specialty governance meetings.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Venous Thromboembolism Exemplar Status has been revalidated by consistent good practice demonstrated by the monthly report on all VTE risk assessments carried out by Trusts. Government initiative – at least 97.24% of hospitalised patients have to be risk assessed for VTE on admission to hospital. Target was achieved in 2016 with a final figure of 98.05% of all patients having had a VTE risk assessment carried out

- In accordance with NICE 2010 Quality standards Root Cause Analysis of all patients diagnosed with VTE after hospital admission in previous three months continues to be carried out to identify Hospital Associated Thrombosis (HAT). Of the 74 cases identified as requiring RCA, six (8.1%) were not risk assessed. Some 25 cases (33.8%) were potentially preventable and required completion of section 4 of RCA. Of these, 22 were not given thromboprophylaxis in accordance with the Trust guidelines (A07.0). All cases were fully investigated and action plans monitored. Teaching was carried out when required

- Use of compression hosiery – The company continues to train all relevant staff and will continue to do this on a regular basis. This fulfils NICE guidelines: patients eligible for compression hosiery must be measured by a trained person

- FFT has consistently been 100% that our service would be recommended to family and friends

- The Trust Specialist Nurse has produced VTE exemplar site network newsletter, which is available on their website.

Indicator	Clostridium difficile infection rate				
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL Score**	**National average**	**Highest score**	**Lowest score**
The number of reported cases per 100,000 bed days amongst patients aged 2 or over during the period	2010/11	23.5	29.7	71.2	0
	2011/12	25.1	22.2	58.2	0
	2012/13	12.5	17.3	30.8	0
	2013/14	28.0	13.36	144	0
	2014/15	28.2	14.16	121	0
	2015/16	26.3	NA	NA	NA
	2016/17	22.0	NA	NA	NA

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The accuracy of data is thoroughly checked by the infection prevention and control team and crossed checked with the laboratory (external assurance) prior to submission.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Weekly and then bi-weekly monitoring of commode and bed pan cleanliness, hand hygiene and correct compliance with the use of personal protective equipment;
- Pro-active and prompt management of high risk cases and early implementation of isolation/ cohorting of identified patients;
- Regular but unscheduled spot checks by the Matrons sustaining the focus on infection control;
- Increased support to specific areas in periods of increased incidence;
- Continuing the joint Link Nurse programme, the SaIINTS, to share best practice.

Part 3 OTHER INFORMATION

NATIONAL, LOCAL AND SYSTEM-WIDE CQUINS

Priority 1

HEALTH & WELL-BEING

Why do we need to improve?

In 2015 Public Health England estimated the cost of sickness absence to the NHS at £2.4bn. Work in the NHS can often be physically, emotionally and psychologically demanding, providing NHS services 24 hours a day, 365 days per year. There is an opportunity for the NHS as an employer to impact positively on staff overall health, well-being and happiness.

Staff retention rates are shown to improve when staff feel their employer cares about their health and wellbeing, which in turn leads to improved team cohesion and better working environments.

The NHS health and well-being review led by Dr Steven Boorman and NICE guidance have outlined the link between staff health and wellbeing and patient care, including improvements in safety, efficiency and patient experience.

Aim and goal

To improve in three specific areas:

1a Improving support across musculoskeletal, mental health and physical activities
1b Healthy food for NHS staff, visitors and patients
1c Improving uptake of flu vaccinations by frontline healthcare workers.

1a Improving support across musculoskeletal, mental health and physical activities

What did we do to improve our performance?

At the start of the project the Trust was already providing a number of health and well-being initiatives for staff including counselling services, staff physiotherapy, staff gym, smoking cessation support, cycle to work scheme and classes including yoga, dance and pilates as part of the Lifelong Learning programme. However, services were provided by different departments and teams and it was difficult for staff to explore the full range because they were not centrally communicated. Promoting the various initiatives was piecemeal.

A team was drawn together to include representation from Occupational Health, Human Resources, Lifelong Learning, Rehabilitation Services, the Communication Team, Car Parking and Information Services. New initiatives were introduced - such as outside seating for staff and a Rapid Access to Healthcare policy (short-notice or cancellation appointments for staff off work or not fully working) and improved measures in some work areas to support staff in avoiding musculo-skeletal strain.

An intranet portal 'Just For You' was produced as a central resource point for information on staff health and well-being initiatives. This was broadened to include all benefits available to Trust staff. It became apparent to the team that although electronic communication works for many people, others either have no computer access at work or are too busy to access information. To resolve this, a 'poster-trail' was mapped across the Trust site to provide information to all staff in their work places; this is regularly refreshed to promote health and well-being activities with mental health and musculo-skeletal health in particular being targeted.

How we monitored and reported progress

The team met regularly throughout the year to discuss and map progress and had the support of the Project Management Team to help collate data. Data collected included the number of staff participating in each of the initiatives together with staff feedback. A staff survey was undertaken after the launch of the 'Just for You' portal and 'Poster-trail', incentivised by a prize draw. This was attached to staff payslips to ensure all staff were included.

Outcome

Data collection on staff participation in each of the activities is currently being collated and finalised to submit for the CQUIN.

Some 183 members of staff responded to the survey, and 23% of respondents said that they had taken part in physical health and well-being activities (such as pilates, yoga, gym, dance or walking). Some 55% said that they had accessed support such as counselling, physiotherapy, or Lifelong Learning and other training activities, with 64% of respondents feeling that health and well-being activities were clearly communicated to them.

Working on this CQUIN resulted in a Trust-wide collaboration, which has been beneficial in both improving and promoting health and well-being initiatives for staff. The team will continue to meet to build on this progress and to improve the use of data to inform and review staff health and well-being initiatives.

1b - Healthy food for NHS staff, visitors and patients

Why did we need to improve?

The national drive to reduce obesity and the comorbidities associated with obesity such as diabetes, has focused this element of the CQUIN on improving the diet of members of staff, patients and visitors alike by encouraging healthy eating. The goals laid out in the CQUIN were to:

- Ban the promotion of high fat/ high sugar products
- Ban the sale of high fat/ high sugar products at the checkout
- Ban the advertising of high fat/ high sugar products at checkouts
- Offer more healthy food and drink options.

What did we do to improve our performance and what was the outcome?

A series of meetings took place with Costa to discuss how these changes could be implemented within their operation. Internally there was a re-think on how The Hub operated and laid out food and drinks for sale. A number of approaches were introduced to improve our performance. This included:

- Banning all price promotions and offers on sugary drinks and foods high in fat in all facilities
- Removing all unhealthy snacks/ crisps etc. from the till locations
- Placing healthy options bars / salad/ crudités and vegetable pots near the tills
- Reducing the price of the salad bar, with the option of a meal deal being added
- Adding healthier options to the salad meal deal i.e. yoghurts, vegetables and fruit pots
- Placing a fruit stand at the till point (The Hub and Main shop)
- Increasing the price of chocolate products and reducing the number of lines available
- Reducing the size of scones and cakes made on site
- Increasing the lines available on low calorie fizzy drinks and reducing the availability of drinks high in fat
- Providing a snack trolley with healthier options to buy.

There have also been changes to the vending machines and these have included:

- Introducing fresh fruit pieces and pots at eye level and reducing the lines of high fat options
- Ensuring that the public vending machines now hold additional 30% more healthy options
- Introducing a vending machine offering healthy meals and snacks that can be heated in the microwave. This machine is kept stocked 24/7. The supplier was invited to carry out a demonstration. This was attended by some members of staff and they had the opportunity to taste these new products – the talk was well received
- Purchasing two chillers/ fridges to increase the healthier lines currently on offer
- Increasing the number of lines of gluten free and vegetarian products.

In The Hub changes were made to ensure that portion size was better regulated and standardised and now all meals are served in individual dishes to ensure the correct quantity is provided.

Work has been undertaken with Costa and the Amigo shop, who are part of Medirest, to ensure that all unhealthy point of sales items have been removed from the till area and that sandwiches are offered for sale that are under 500 calories. These areas have also removed all full fat drinks and provide low calorie options. They do not promote any two for one sale items. Costa offers semi-skimmed milk for their drinks and uses syrups that are sugar-free.

1c – Improving uptake of flu vaccinations by frontline healthcare workers

What did we do to improve our performance?

There has been a Trust-wide collaboration to increase frontline healthcare worker uptake of the flu vaccine. The Occupational Health Department provided vaccine clinics during weekdays, weekends, evenings and early mornings in the Occupational Health Department. Departmental staff spent many hours walking around the hospital site providing vaccines to staff on wards and in departments in order to reach staff in their workplaces, including staff working night duty and at weekends.

The Trust's Communications team supported the campaign with regular updates about vaccine clinics and walk-about schedules.

The campaign started in September 2016 but towards the end of October the rate of uptake was not high. The Chief Executive and Director of Infection Prevention and Control became involved and a more Trust-wide approach was adopted, including involvement of senior managers and increased involvement of the Communications team and the Programme Management Team working with the Occupational Health Department. Two Flu Songs were produced by Trust staff, one of which was played on local radio, and circulated on Trust social media. Staff produced a Mannequin Challenge video, which was distributed on social media. A Poster Campaign targeted staff in their workplaces. As the campaign was nearing its end a final push was accomplished with a Prize Draw as an incentive (all staff who had received the vaccine would be entered if the target of 75% was reached by December 2016).

How we monitored and reported progress

The Occupational Health Department monitored staff uptake on a weekly basis and were supported by Information Services and the Project Management Team. Two sets of statistics were monitored and reported:

ImmForm, is the system used by the Department of Health, the NHS and Public Health England to record data in relation to uptake against immunisation programmes and incidence of flu-like illness. Statistics are uploaded onto the system monthly throughout the campaign by Occupational Health, as in previous years.

CQUIN data. This was new for this year, and our local indicator excluded bank staff and staff unavailable to be vaccinated because of either being inactive and not working, or long-term absence.

Outcome

Year	2014/15 ImmForm	2015/16 ImmForm	2016/17 ImmForm	2016/17 CQUIN
Percentage of front-line healthcare workers vaccinated for influenza	49.1%	49%	68.76%	81%

Priority 2

SEPSIS SCREENING

Why do we need to improve?

Sepsis is a common and potentially life-threatening condition in which the body's immune system goes into overdrive in response to an infection, setting off a series of reactions that can lead to widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean the blood supply to vital organs such as the brain, heart and kidneys is reduced – potentially leading to death or long-term disability. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 32,000 deaths in England attributed to Sepsis annually. It is estimated that out of this overall figure some 11,000 deaths could be prevented.

Aim and Goal

The aim is to incentivise providers to screen for sepsis in all those patients for whom this is appropriate and rapidly initiate intravenous antibiotics within one hour of presentation for patients who have suspected severe sepsis, Red Flag Sepsis or septic shock. This CQUIN covered both Emergency Department and Inpatient settings.

What did we do to improve performance?

Posters have been produced on a quarterly basis to demonstrate the up to date results of the CQUIN analysis and to remind providers of the importance of the 'sepsis six'. These have been displayed in all emergency areas in the hospital.

The sepsis Concise Care Bundle (CCB) has been made available electronically as a care plan on EDIS for use in the Emergency Department.

How we monitored and reported progress

The CQUIN for sepsis was reviewed and reported in two parts:

Part 2a: Timely identification and treatment for Sepsis in the Emergency Departments

Screening – (An audit of a random sample of 50 sets of patient records coded for sepsis per month)

The audit sought to determine the total number of patients presenting to the Emergency department and other units that directly admit emergencies who met the criteria of the local protocol and were screened for sepsis.

The Emergency Department screening element of the CQUIN requires an established local protocol that defines which emergency patients require sepsis screening.

Initiation of treatment and day three review – (An audit of a random sample of 30 sets of patient records coded for sepsis per month)

The number of patients sampled for case note review who:

- present to ED and other wards/units that directly admit emergencies with Red Flag Sepsis or Septic Shock for whom a decision to treat with intravenous antibiotics is made, and these are administered, both within one hour of presenting and
- an empiric antibiotics review is carried out by a competent decision maker by day three of their being prescribed

Part 2b: Timely identification and treatment for Sepsis in acute inpatient settings

Screening – (An audit of a random sample of up to 50 sets of patient records coded for sepsis per month)

Total number of patients sampled for case note review who were admitted to the provider's acute inpatient services that met the criteria of the local protocol and were screened for sepsis.

The inpatient screening element of the CQUIN requires an established local protocol that defines which inpatients require sepsis screening.

Initiation of treatment and day three review - (An audit of a random sample of up to 30 sets of patient records per month)

The total number of patients sampled for case note review:

a) Where a patient is newly admitted, for whom in the course of their admission a decision to treat with intravenous antibiotics is made by a competent decision-maker, and these are administered, both within 60 minutes of the possibility that the patient has Red Flag Sepsis or Septic Shock was identified.

b) Where a patient is an existing inpatient, for whom a decision to treat with intravenous antibiotics, or to change the type of antibiotics previously prescribed, is made by a competent decision-maker, and these are administered, both within 90 minutes of the possibility that the patient has Red Flag Sepsis or Septic Shock was identified.

AND (for both of the above categories):

- an empiric antibiotics review is carried out by a competent decision maker by day three of their being prescribed.

The quarterly data totals were then submitted to the commissioners via UNIFY.

Outcome

2a. Throughout 2016/17, 50 patient records were reviewed on a monthly basis for 2a (i) and 30 patient records were reviewed on a monthly basis for 2a (ii). The results are as follows:

a.i)

Quarter	% of patients who met the local criteria and were screened for sepsis	
	Target	Actual
1	90%	97%
2	90%	97%
3	90%	94%
4	90%	99%

a.ii)

Quarter	% of patients where antibiotics clearly recorded as GIVEN within 60 minutes of arrival and empiric antibiotics review within three days	
	Target	Actual
1	67% (baseline)	67%
2	70%	74%
3	80%	81%
4	90%	91%

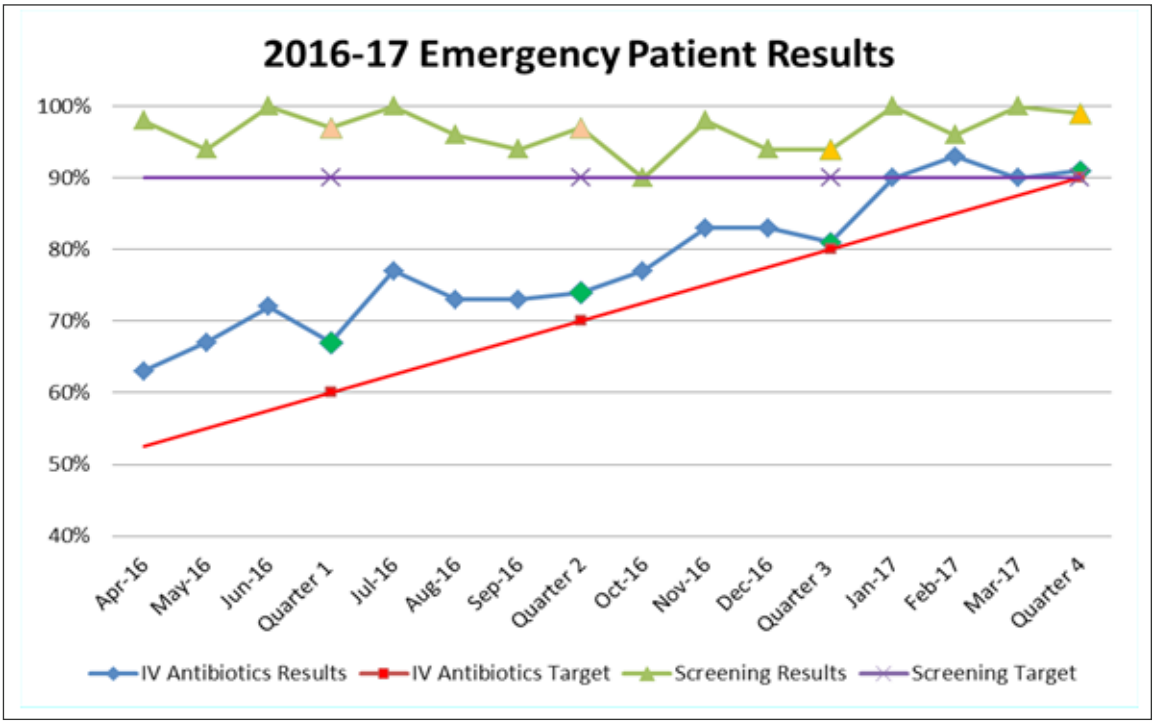
2b. Throughout 2016/17, up to 50 patient records were reviewed on a monthly basis for 2b (i) and up to 30 patient records were reviewed on a monthly basis for 2b (ii). The results are as follows:

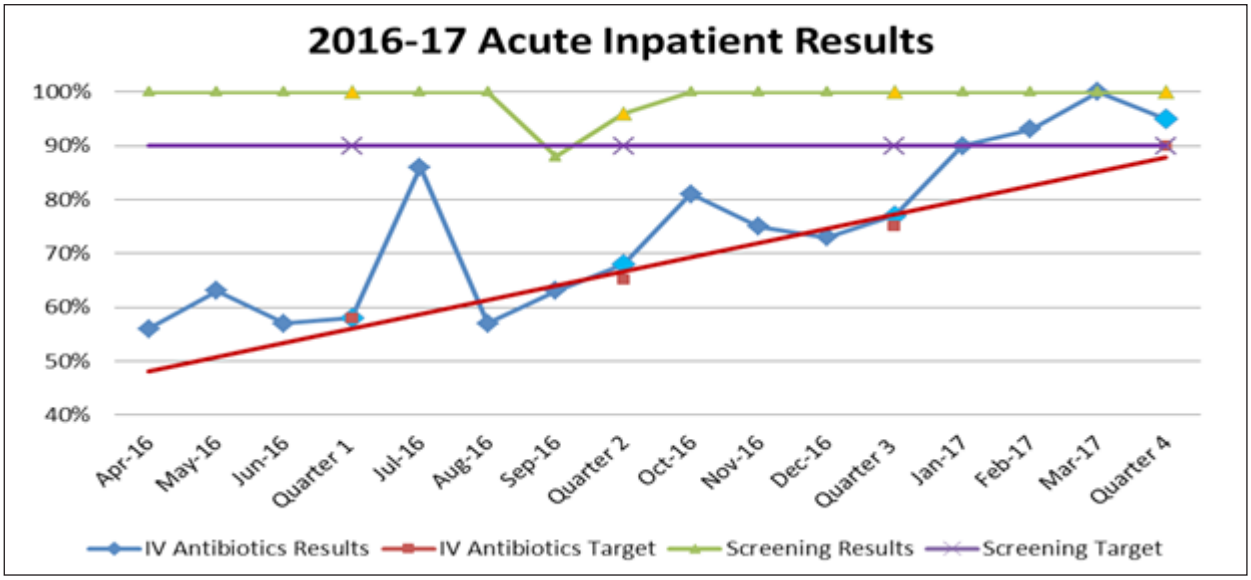
b.i)

Quarter	% of patients who met the local criteria and were screened for sepsis	
	Target	Actual
1	90%	100%
2	90%	96%
3	90%	100%
4	90%	100%

b.ii)

Quarter	% of patients where antibiotics clearly recorded as GIVEN within 90 minutes of arrival and empiric antibiotics review within three days	
	Target	Actual
1	58% (baseline)	58%
2	65%	68%
3	75%	77%
4	90%	95%





There has been an increase in Trust-wide education and audit presentations raising awareness of Sepsis 6. This has been delivered in key areas such as Emergency Department and Trust-wide via mandatory training from the Critical Care Outreach team. The Nurse Consultant for Critical Care has also undertaken teaching sessions presenting the audit results of patients admitted with sepsis into Critical Care to help raise awareness.

The Outreach team have been involved in collecting data for the inpatient audits and can prescribe first line antibiotics with a new patient group direction (PGD) acting as front line advocates for this group of patients.

Posters have been produced on a quarterly basis by the Audit team to demonstrate the up to date results of the CQUIN and raise awareness for staff.

Concise Sepsis care bundles are available via the electronic EDIS system in the Emergency Department and sticker format throughout the rest of the Trust. To date the Trust has achieved the sepsis, antibiotic stewardship and national CQUIN targets for both inpatient and the Emergency department consistently throughout the year.

Priority 3

ANTIMICROBIAL RESISTANCE & ANTIMICROBIAL STEWARDSHIP

Why do we need to improve?

Antimicrobial resistance (AMR) has risen alarmingly over the last 40 years and inappropriate and overuse of antimicrobials is a key driver. The number of new classes of antimicrobials coming to the market has reduced in recent years and between 2010 and 2013, total antibiotic prescribing in England increased by 6%. This leaves the prospect of reduced treatment options when antimicrobials are life-saving, and standard surgical procedures could become riskier with widespread antimicrobial resistance.

An AMR CQUIN aims to reduce total antibiotic consumption measured as defined daily doses (DDDs) per 1000 admissions as well as to obtain evidence of antibiotic review within 72 hours of commencing an antibiotic. The CQUIN has two parts, the first aimed at reducing total antibiotic consumption and certain broad-spectrum antibiotics and the second focused on antimicrobial stewardship and ensuring antibiotic review within 72 hours.

Aim and goal

Reduction of 1% or more against the baseline 2013/14 of:

- total systemic antibiotic consumption
- carbapenem consumption
- piperacillin-tazobactam consumption

Where consumption is measured as defined daily dose per 1000 admissions.
Number of antibiotic prescriptions reviewed within 72 hours to be 90% or greater by Q4 of 2016/17.

What did we do to improve our performance?

The key aspects of good antimicrobial prescribing were promoted through presentations to prescribers and reporting of progress with the CQUIN and, where improvement was required, to the clinical governance groups.

To comply with the reduction in consumption of antimicrobials, a review of the antimicrobial guidelines was undertaken to replace where possible, carbapenems and piperacillin-tazobactam with alternatives. This may compound the reduction in total antibiotic consumption as often multiple antibiotics would be required to cover the same antibacterial spectrum. The antibiotics were promoted to prescribers and encouragement was given to challenge unclear or inappropriate antimicrobial prescribing with support from the consultant microbiologists.

How we monitored and reported progress

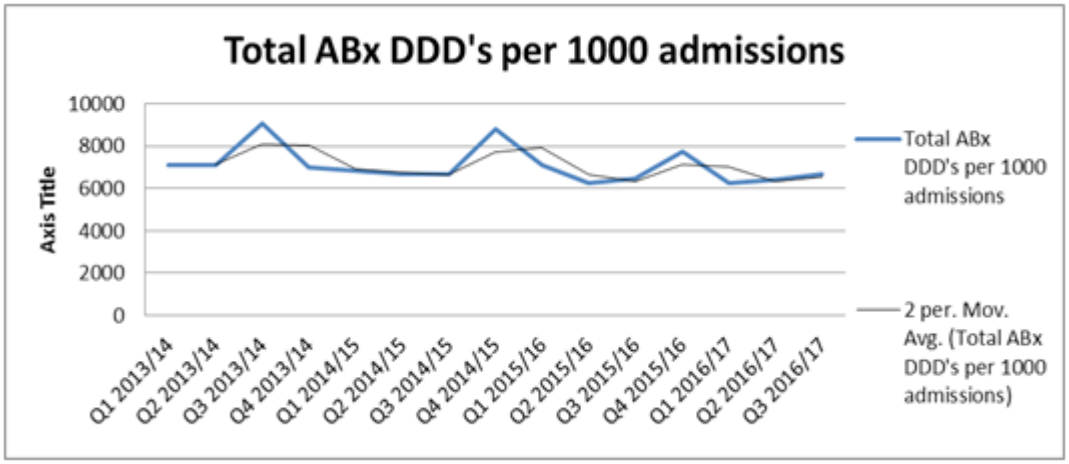
In terms of antimicrobial stewardship, a minimum of 50 antibiotic prescriptions were taken each month from a representative sample across all inpatient wards in the hospital and were analysed and the findings recorded. Patients had to have been on an antibacterial for 72 hours or more to be included in the study. The study was not point prevalence therefore patients may not have been receiving antibiotics at the time but would have received 72 hours or more of antibiotics during the sample month. The findings were recorded and then reported quarterly.

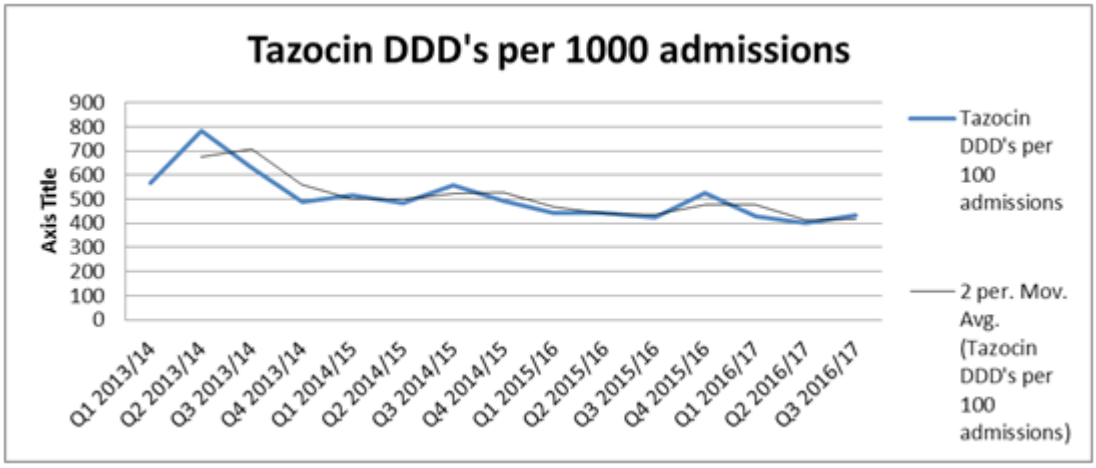
In terms of antimicrobial resistance issues, the use of all systemic antibacterial drugs from the Pharmacy were obtained quarterly and converted into the number of defined daily doses (DDD) for each agent (as per the WHO index). In accordance with the ESPAUR report of 2014, consumption was determined to be the

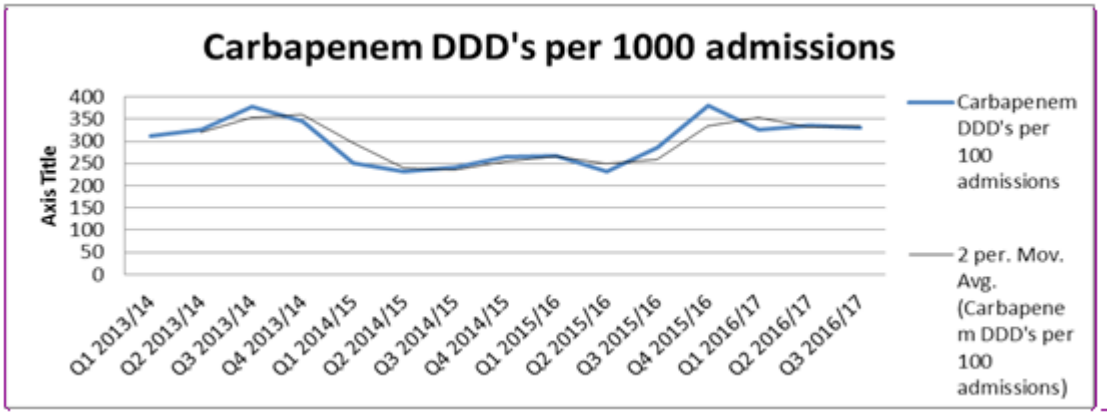
number of DDDs per 1000 admissions as it was felt this better represented hospital activity.

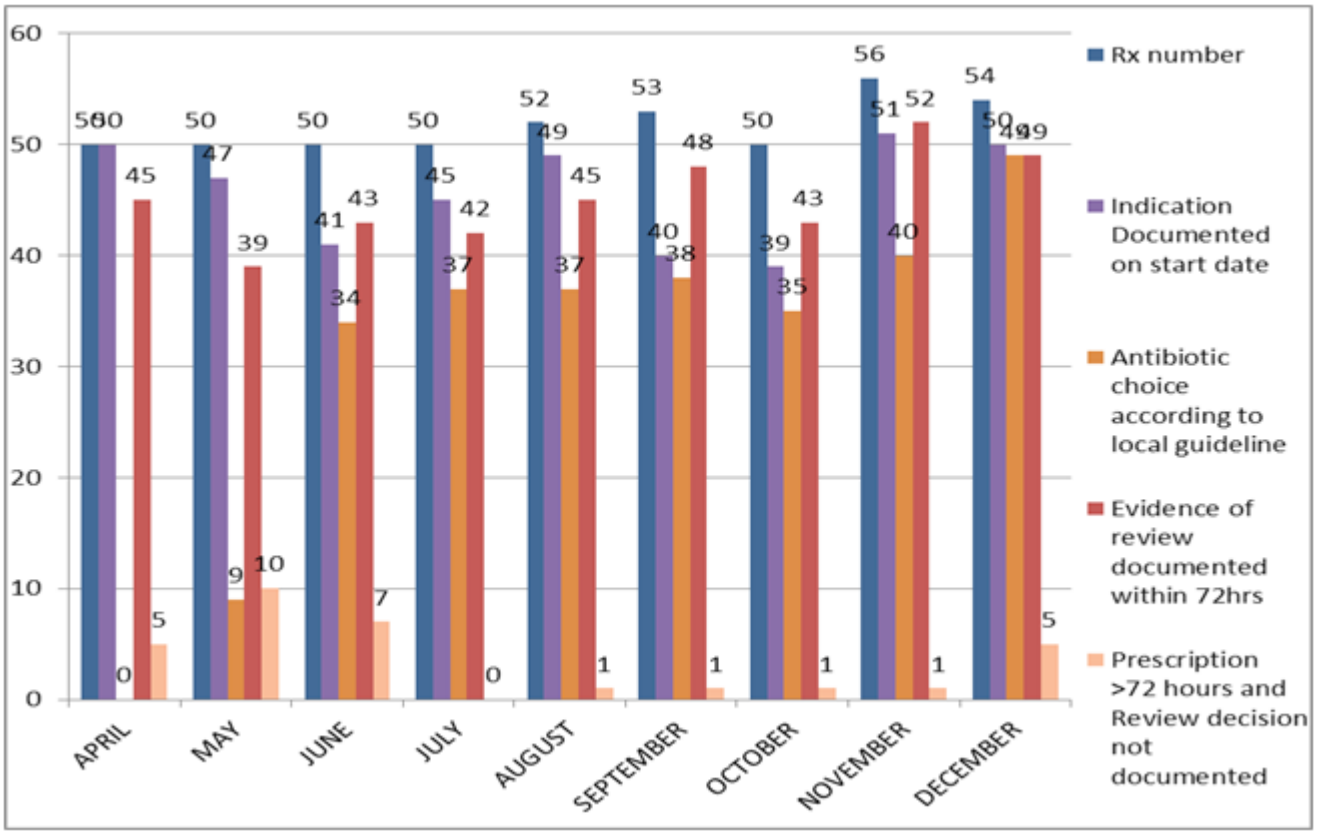
Outcome

To date:





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50
40
30
20
10
0
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
Rx number
Indication Documented on start date
Antibiotic choice according to local guideline
Evidence of review documented within 72hrs
Prescription >72 hours and Review decision not documented

Priority 4

FRAILTY

Why do we need to improve?

The Government, in its response to the Francis Report and publication of 'Hard Truths',[1] agrees that the link between culture and compassionate care for older patients is fundamental across all health and care settings. It also supports the development of a new frailty pathway and the implementation of a frailty assessment tool has the potential to reduce harm and improve the experience of older people.

Implementation of this pathway also underpins all five domains of the NHS Outcomes Framework. It is designed to engage and capture the energies and commitment of medical, nursing and allied health professional leaders who have responsibility for meeting the domain requirements.

The implementation of an assessment strategy is vital to understand the complex needs of frail and elderly patients. It will enable healthcare professionals to ensure a consistent approach to the assessment of frail and elderly patients so that their care is delivered in an effective way.

To meet these identified needs the Trust has committed to a three year CQUIN programme which supports and underpins elements of care that ensure the successful development and delivery of a frailty pathway.

Key Outcomes for the Frail and Elderly

We recognise that Frailty is a complex and fluctuating syndrome and that patients will enter the pathway at different levels. This may require identification in Primary Care in order to access appropriate services along the pathway. However, identification of frail people and the level of frailty can be a challenge. While many experienced clinicians can instinctively recognise a frail person, there is a need to support identification using case-finding tools and techniques[2].

The essential elements of an end-to-end pathway of care for frail older people are described below:

- Healthy active ageing and supporting independence
- Living well with simple or stable long-term conditions
- Living well with complex comorbidities, dementia and frailty
- Rapid support close to home in crisis
- Good acute hospital care when (and only when) needed
- Good discharge planning and post-discharge support
- Good rehabilitation and re-ablement after acute illness or injury
- High-quality nursing and residential care for those who truly need it
- Choice, control and support towards the end of life[3]

1 Hard Truths: the journey to putting patients first
https://www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response
2 Safe, compassionate care for frail older people
https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf
3 Making our health systems fit for an ageing population
https://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population

As frail people engage at different stages of the pathway we understand that this will require a range of interventions that are clinically effective and appropriate for their level of frailty. These interventions may well involve voluntary and community sector groups, in addition to clinical assessment and support, particularly at the early stages of frailty when the focus should be on maintaining independence and optimising function and health.

Achieved Aims & Goals (Year 1) 2014/15 and (Year 2) 2015/16

The first two years of this programme focused on putting in place the framework for providing a clear pathway for frail older patients following admission and in particular successfully included:

- The development of a suitable Frail Elderly Patient Assessment tool
- The provision of training to a wide cohort of staff in identified clinical areas on understanding frailty and the use of the assessment tool
- Evaluation of patient experience in following the pathway through the use of a patient feedback survey
- Monitoring data on the identification, assessment and management of identified frail, older patients and monitoring key performance indicators such as patient's length of stay and re-admission within 30 days.

This was supported through the development of a ward area specifically focused on frail, older patients which was appropriately designed and staffed to facilitate the delivery of the frailty pathway and to optimise care delivery.

Agreed Aims & Goals (Year 3) 2016/17

Following on from the work undertaken in years 1 & 2 of the Frailty CQUIN, year 3 focused on the implementation of the Comprehensive Geriatric Assessment (CGA) and in the development and embedding of a number of additional concise care bundles. The Comprehensive Geriatric Assessment and concise care bundles were designed to address the specific needs of the frail patient ensuring an individualised person-centred approach to the provision of care and improve patient experience. Care bundles were designed to work seamlessly alongside the CGA; ultimately enhancing the pathways of assessment, planning, implementation and evaluation of care within the acute care environment.

Aims

1. Development of a programme of training for existing acute medicine consultants & middle grade staff covering MAU;
2. Agree the comprehensive geriatric assessment (CGA) proforma and arrange printing and distribution;
3. Agree care bundles for the specific frailty syndromes (continence and nutrition/hydration) as identified with the relevant consultant and nurse leads;
4. Submit the draft care bundles to the commissioners for information and feedback;
5. Deliver training on the use the of the Comprehensive Geriatric Assessment proforma and use of the defined care bundles (continence and nutrition/hydration) to all new junior doctors and middle grade doctors commencing in August 2016;
6. 90% of MAU registered nursing staff to be trained in the use of the defined care bundles (Continence and Nutrition/hydration) *excluding those staff groups unavailable for training (for example: maternity leave);
7. 90% of eligible* patients to be assessed using the Comprehensive Geriatric Assessment during November 2016 *(unplanned medical admissions to MAU, for patients aged 75 or older on day of admission);
8. Undertake a baseline audit of 70 patient notes in November 2016 to determine:
   - The number of appropriate care bundle/s identified, of the number of care bundle/s identified, how many were implemented;
9. Meet with key stakeholders in December 2016 to:
   - Review the outcomes of the audit
   - Present and agree recommendations as a result of the audit
   - Discuss the progress of the implementation of the care bundles;
10. Report on the implementation of the comprehensive geriatric assessment and associated care bundles, indicating the percentage of patients > 75yrs of age in receipt of the pathway of care, any issues identified and recommended changes/additions to care bundles to improve patient outcomes.

What did we do to improve performance and what were the outcomes?

An essential part of the framework for the frailty pathway to date has been the consistent provision of training in frailty syndromes and ensuring the skill set required exists or is developed within the workforce. Where required, the skill set uplift has supported the Trust to provide an appropriate initial and comprehensive assessment of frailty within the registered nursing and medical workforce in key areas, building upon the equally relevant workforce development in years 1 & 2 with the introduction of the acute frailty pathway and unit and the skill infrastructure that was required for this to be successful.

Some of our initial work streams explored the use of the Edmonton assessment tool and understanding frailty. This year, in response to the change of focus to a comprehensive assessment document rather than a stand-alone frailty assessment an indication for the requirement for further knowledge and skills uplift within both the medical and nursing workforce within key clinical areas of patient assessment was identified.

To achieve the objectives in year 3 additional training was undertaken in the second quarter of the year with the first part of workforce development being undertaken with two dedicated documentation sessions being delivered specifically for medical staff. These sessions provided attendees with a full overview of the documentation used across the organisation. Following on from this a process of further CGA and care bundle awareness was provided as a number of revisions have been made to the original CGA proforma since its initial conception during quarter 1.

This has included the interface of the medical and nursing proforma to make one concise CGA document. This change had been positively welcomed and embraced by both staff groups. To ensure that all staff are fully aware of the changes, further face to face overviews of the document have been undertaken with staff and within the identified medical staffing groups.

As agreed during the planning phase of the project, the nursing workforce on the Medical Assessment Unit (MAU) have been exploring with the Lead Nurse for Older People the benefits of using a CGA and the concise care bundles, developing their knowledge and skill set accordingly. The trajectory set for this was 90% of the registered nursing workforce on the Medical Assessment Unit and this has been achieved.

We recognised during the development and initial planning stages that there was still a requirement for an initial trigger assessment to be present within the documentation and that this could seamlessly be built into a much wider comprehensive document that provided a holistic individualised assessment of the frail older patient. This had already been implemented in year 2 so the workforce were already suitably skilled to interpret it and no further training need was identified.

As in previous years, a training package was developed by the Lead Nurse for Older People and delivered by the Lead Nurse and the Consultant Geriatrician. It consisted of a short presentation to be given at ward level together with hand-outs constructed of supporting documents regarding the use of the comprehensive geriatric assessment and a concise care bundle booklet. Staff had the opportunity to explore the practical application of the supporting concise care bundles and recognition of their use through the CGA document and to understand the positive patient outcomes that could potentially be achieved with this patient group.

The Trust had already undertaken in the two previous years a substantive amount of research into the validated screening tools that exist to help healthcare professionals identify frailty. This included guidance from the Department of Health [2]. In year 3 with a multidisciplinary approach, a decision was made to not continue to use the previously implemented Edmonton Frailty Tool but to launch the CGA and continue to use an initial trigger to identify frailty as part of the Trust-wide patient admission clerking process before undertaking a full frailty assessment.

Comprehensive Geriatric Assessment

The 'comprehensive geriatric assessment' should be seen in the context of an integrated approach to the assessment of older people, according to the type and extent of their needs (British Geriatrics Society 2010)[4]

Many frail older people, once identified, will require comprehensive geriatric assessment (CGA) (British Geriatrics Society, 2010)[4]. This is defined as a 'multi-dimensional interdisciplinary diagnostic process focused on determining a frail older person's medical, psychological and functional capability in order to develop a coordinated and integrated plan for treatment and long-term follow-up'. The CGA has a very strong evidence base for effectiveness and has been shown to increase patients' likelihood of being alive and in their own homes after an emergency admission to hospital.[5]

4 Comprehensive Assessment of the Frail, Older Patient
http://www.bgs.org.uk/good-practice-guides/resources/goodpractice/gpgcgassessment
5 Comprehensive geriatric assessment for older adults admitted to hospital
http://www.bmj.com/content/343/bmj.d6553

What are the benefits of comprehensive assessment?

It is generally frail older people who benefit most. People with a range of severe and disabling illnesses will require detailed assessment in order to maximise their recovery, function or quality of life, and the comprehensive assessment will be adapted to meet their particular needs. A standardised comprehensive assessment linked to a coordinated and integrated plan or treatment and follow up can make a significant difference. (British Geriatrics Society 2010)[4].

There is good evidence for improved functional outcomes as a result of this approach in a variety of conditions. These include stroke, hip fracture, people having elective surgery, heart failure, older medical inpatients with complications such as delirium. There are other circumstances where a coordinated and comprehensive assessment can identify the potential for avoiding significant changes in life such as admission to a care home. (British Geriatrics Society 2010).

The CGA aims to ensure:

That the older person is central to the process:-

- Their capacity to participate voluntarily must be assessed, and if lacking, then there needs be a system to address their needs in an ethical fashion.
- Links between social and health care should be good enough for older people who need comprehensive assessment to receive it in a timely and efficient manner, and proportionate to their degree of need.
- Assessments should be standardised and carried out to a reliable standard (British Geriatrics Society 2010)[4]

Concise Care Bundles

To strengthen this assessment pathway, we recognised that key to supporting patients to move into the frailty pathway and with effective management plans to continue on and/or be successfully discharged from the frailty pathway was to develop joint integrated pathways to attend to the complex medical, functional, social and psychosocial aspects of frailty.

We used the following definition form NHS Midlands & East to support the development and construction of each care bundle:

'A care bundle is a collection of interventions that may be applied to the management of a particular condition, or as preventative measures to reduce the risk of complications. By implementing a care bundle we should improve consistency of care delivered, ability to examine and measure the process of care in a systematic way (audit)'.[6]

We have specifically given consideration as to how the bundles will be integrated in pathways of care and run seamlessly alongside the Comprehensive Geriatric Assessment. We augmented both the CGA and the bundles to ensure this is always undertaken by building prompts and triggers within the CGA and nursing admission documentation, promoting the development of individualised care planning. We will promote the

care bundles in assessment areas initially with a measured approach to Trust-wide use.

6 NHS Midlands & East 2012
https://www.england.nhs.uk/mids-east/

The frailty specific care bundles were designed and in some cases revised, from existing packages to ensure that they were suitably developed to assess the needs of the frail elderly. The care bundles designed to support management of the frailty syndromes incorporate a stepped pathway approach as follows:

- Clinical Assessment
- Initial Management
- Further management

In the development of the concise care bundles we also recognised the concept of 'frailty syndromes'. Anyone interacting with the older person should consider that the individual concerned may have frailty. The 'frailty syndromes' can be represented in broad terms as:

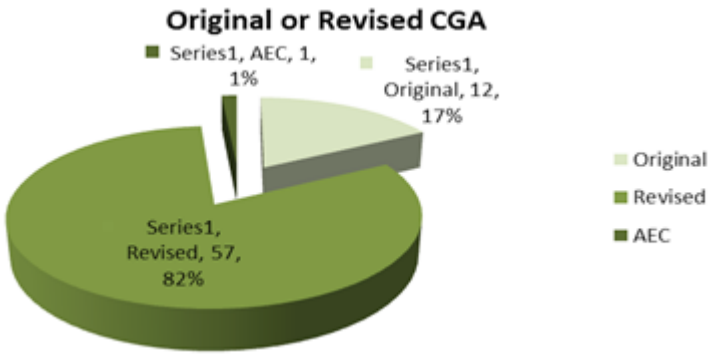
- Falls
- Immobility
- Delirium
- Continence
- Susceptibility to the side effects of medications

All relevant specialty teams were consulted on the construction of the concise care bundles; recognising their expert contribution to ensuring the development of safe and effective care bundles.

How the Trust Monitored the Implementation and Outcome

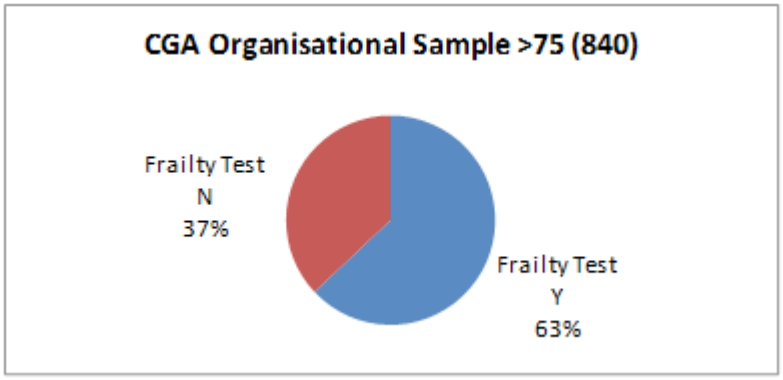
We deployed a number of strategies throughout year 3 to ensure that the agreed aims and goals remained on track for delivery and achieved the desired outcomes for improving patient care for the frail elderly.

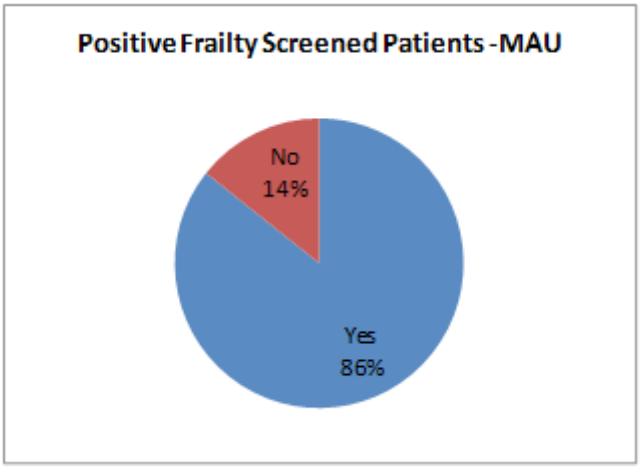
To ensure that the project was on track for delivery, during the latter part of this year we undertook an audit reviewing 70 sets of Health Records. This explored the efficacy of implementation of the new CGA document. We initially identified at the beginning of the audit period there were a number of the original CGA clerking booklets in circulation that had been utilised during the pilot phase. There was a small difference in layout and formatting between the two versions so the audit therefore included a question as to whether the patient had been clerked using the original or revised CGA:

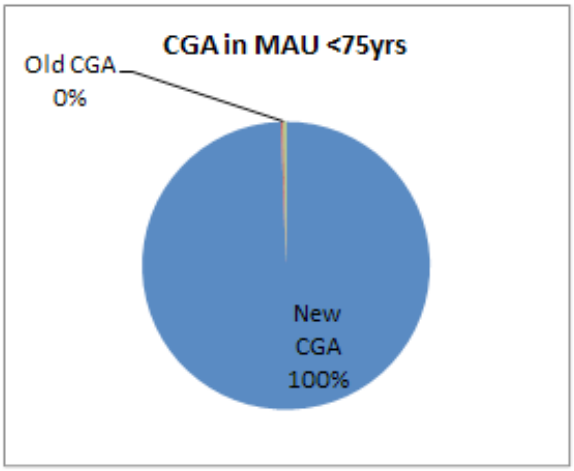


During the audit we were also keen to understand the impact of the implementation of the concise care bundles and explore the number of care bundles identified and used to support care pathways. To undertake the audit we included a review of each patient's health records to identify whether specific care and treatment guidance from each part of the pathway was evident in the patient's health records. The patient's health records were reviewed in their entirety for the admission period and evidence of application of appropriate care bundles was determined from examination of the entire record and not just the CGA. For the audit period there were in total 840 patients over the age of the 75 years admitted within the organisation across a number of clinical areas and specialties.

The work streams and subsequent audit have been primarily focused on those patients who are aged 75 years or older and whose admissions were unplanned, medical focused and to our Medical Assessment Unit. From our data collection from the agreed period there were a total of 529 patients assessed as being frail across the entire organisation with 405 eligible patients admitted via the Medical Assessment Unit, of which 347 patients scored positively on frailty screening and 58 who were not assessed as being frail:







Paramount to this process was to undertake a post audit pathway review. This included discussions with key Trust stakeholders regarding the findings of our audit and sought to agree on the implementation of further elements of the frailty work streams and operational strands. We ascertained that there are a number of variables that potentially with any future audits should be taken into account. We recognised that an extended lead time was needed due to significant issues in obtaining case notes embedded within existing post discharge Trust pathways. This did not support us to be able to approach selecting the audit sample as planned but this is not thought to have affected the audit findings as a result.

We recognised that a number of patients had re-presented for a second admission subsequent to the audit period and that we would explore re-admissions for this period looking to ascertain any learning that may be identified.

It was apparent from our findings that the strength in the care bundles application currently sits within the initial assessment stage and that additional work to further support the entire pathway of care would be required going forward to ensure a consistent application of the complete care bundle for this to have the greatest impact on patient care.

Going forward we will continue to consolidate the work streams and strands considered and implemented in all three years of the project. We must also consider how the patient's holistic assessment will be shared as part of essential elements of onward care pathways and how this could potentially be incorporated into a number of existing e-discharge systems or through SystmOne. We are currently exploring work undertaken nationally that has successfully integrated this document within the SystmOne software platform.

It is intended that a further review of documentation will take place to ensure the optimal design of the clerking and health record to optimise the use of a comprehensive geriatric assessment and management plan.

There are still a number of strands of work that will require embedding in the next 12 months and to continue to implement this process successfully we must continue with an education programme that continues to address the workforce learning needs in key areas as well as considering the future specialties and workforce that may require this additional knowledge and skill set.

The outcome of this work has been monitored internally through the Frail Elderly and Dementia Steering Group and shared externally with the Clinical Commissioning Group and the West Norfolk Frailty forum.

There are still a number of strands of work that will require embedding in the next 12 months and to continue to implement this process successfully we must continue with an education programme that addresses the workforce learning needs in key areas. We must also consider the future specialties and workforce that may require this additional knowledge and skill set.

Priority 5

IMPROVING THE OUTCOME AND EXPERIENCE OF BARIATRIC PATIENTS ADMITTED FOR AN ELECTIVE EPISODE OF CARE OR TREATMENT

Why do we need to improve?

Over the last five years the Trust has increasingly been required to provide access to health care services for patients that fall into the category of obese and morbidly obese. This is in line with the national picture in which the prevalence of obesity in England is one of the highest in the European Union, with a quarter of adults (26% of both men and women aged 16 or over) classified as obese in 2010, with a Body Mass Index (BMI) of 30kg/m2 or over, (Health Survey for England, 2014).

The increase in BMI has been associated with an increase in the number of obesity-related co-morbidities. The number of patients with ≥ 3 comorbidities has been shown to increase from 40% for a BMI of < 40 to more than 50% for BMI 40-49.9, to almost 70% for BMI 50-59.9 and ultimately to 89% for BMI > 59-9.

Aim and goals

The aim is to improve the clinical outcomes and experience for bariatric patients as defined as >25 stone / 160kgs, when they are referred for an elective episode of care and treatment.

Responsibility for overseeing the delivery of this CQUIN lies with the Bariatric Steering Group (BSG). This is pre-existing multidisciplinary group which has already reviewed and identified gaps in service provision.

What did we do to improve our performance?

The existing elective care pathway for bariatric patients was reviewed by the BSG in discussion with key clinical stakeholders including ward managers, discharge planners, occupational therapists, surgical pre-assessment team and matrons.

The key focus for service improvement has been at the pre-assessment stage in order to identify high-risk patients. This is to ensure rapid referral into the rehabilitation team to pre-empt potential complications, poor outcomes and delays to discharge.

In support of the provision of safe working practice in all clinical areas, a generic risk assessment has been developed, which can be adapted for local use. This is located in the Health & Safety folder in each department – an established location for risk assessments. The Bariatric Operational Policy and Guidelines have been reviewed and ratified and will continue to be updated to reflect changes in practice resulting from this work stream.

The existing bariatric patient training programme was reviewed and a workbook was developed for key clinical staff to complete. This workbook constitutes the teaching theory and this is then supported by practical training sessions for clinical staff held throughout the year. The combination of the workbook and practical sessions enabled The Trust to reach the required target of 90% of staff having completed the Management of Bariatric Patients training programme in key areas.

A new patient booklet has been developed. It mirrors the elective pathway and travels with the patient from their initial referral and visit to the pre-assessment department through to the ward and their discharge. This is a dynamic document, reviewed regularly and changed accordingly. Eight structured questions have been developed by the Lead for Patient Experience. These are used to gain feedback from this patient group about their experience with us, and are also for the Trust to use to improve practice where required.

This work has been supported by parallel projects in the Main Operating Department, Outpatients and Pre-assessment. These aim at ensuring that the Trust has timely access to the correct equipment required for this group of patients.

How we monitored and reported progress

The BSG monitored the progress with the quarterly CQUIN targets, via a monthly meeting. Quarterly reports were submitted to the Clinical Commissioning Group, and provided the evidence required for each of the criteria. Training figures were collated and reported to the BSG and a total of 212 key staff completed the bariatric training workbook. A total of 18 clinical staff attended the practical training sessions, with more training sessions planned for 2017.

Developing the pathway has been a challenge for the Trust and there have been difficulties getting clinical staff released from their duties to attend training but, where possible, other clinical members of staff have been nominated in order to achieve the training requirements.

Outcome

The elective pathway that has been developed will be taken forward into 2017/18 and adapted as required. Improvements have already been made to the pathway as a result of comments made via patient feedback forms.

This work will form the foundation for the development of a more complex emergency pathway that will present additional challenges. Staff training will continue via the workbook and practical sessions, with the aim of delivering four practical sessions in 2017 for key clinical staff. The Trust is committed to providing safe and dignified care for this patient group, who often have complex medical needs. The BSG will continue its work to support best practice.

Priority 6

ACUTE KIDNEY INJURY

Why do we need to improve?

Acute Kidney Injury (AKI) is an emerging global healthcare issue. As health care increases in complexity, the interaction between long term medical conditions, medication and inter-current illness are too often complicated by acute kidney injury. It is estimated that one in five emergency admissions into hospital are associated with acute kidney injury (Wang et al, 2012), that up to 100,000 deaths in secondary care are associated with acute kidney injury and that 25-33% have the potential to be prevented (National Confidential Enquiry into Patient Outcome and Death Adding Insult to Injury 2009).

Aim and Goal

To improve outcomes from AKI requires a systematic approach. This has been led by the 'Think Kidneys' programme and requires work to improve risk assessment for AKI, provide timely recognition of AKI, to ensure reliable treatment and to enhance recovery. This Local CQUIN is designed to improve the recovery of individuals with AKI and to ensure appropriate follow-up to minimise short and long term consequences.

The format of the CQUIN was designed to ensure that secondary care teams communicate information about AKI to primary care and that both mutually determine a follow up plan to evaluate kidney function and re-establish medication for other long term conditions. It is intended that the coding of episodes of AKI in GP records will improve risk assessment in the community and the more reliable follow-up of individuals after AKI, will lead to reduced readmission rates and allow for better management of Chronic Kidney Disease (CKD). It is increasingly recognised that CKD and AKI are interlinked conditions, resulting in harm through end stage renal failure, premature cardiovascular death and increased risk of death if AKI complicates illness.

What did we do to improve performance?

Specific prompts were further developed in the electronic discharge proforma to remind doctors to include details for follow-up of patients with AKI. Audited results of completion rates were fed back monthly to clinical staff, and low performing areas were targeted for more focused training.

How we monitored and reported progress

A count was undertaken of completed key items found within the discharge summaries of patients with AKI that had been detected through the pathology laboratory information management system (LIMS), and who had survived to discharge. Each monthly sample was based on the calendar month of discharge.

Requirements in the discharge summary are:

- Stage of AKI (a key aspect of AKI diagnosis)
- Evidence of medicines review having been undertaken (a key aspect of AKI treatment)
- Type of blood tests required on discharge for monitoring (a key aspect of post discharge care)
- Frequency of blood tests required on discharge for monitoring (a key aspect of post discharge care)

Each item counts separately towards the total i.e. review of four items in each of 25 discharge summaries creates a monthly numerator total of up to 100.

Denominator

The total number of discharge items is calculated by multiplying the number of patients in the sample by 4. For a sample size of 25 patients the denominator will total 100.

Successful compliance with the CQUIN required the Trust to achieve:

- Q1 – 75%
- Q2 – 80%
- Q3 – 85%
- Q4 – 90%

Quarterly results were submitted by the CQUIN Co-ordinator to the West Norfolk Clinical Commissioning Group.

Outcome

Some 25 sets of patients' notes were reviewed each month using the criteria and results presented as quarterly averages. The results were as follows:

Quarter	% of Criteria met
Quarter 1	75.67%
Quarter 2	82.67%
Quarter 3	85.33%
Quarter 4	92.70%

CQUINS - SPECIALIST

Priority 7

PRE-TERM HYPOTHERMIA

Why do we need to improve?

Across the country 6.7% of 11,500 pre-term babies (770 babies) received inadequate measurement of temperature control in 2014. Hypothermia can lead to harmful effects such as hypoglycaemia, respiratory distress, hypoxia, metabolic acidosis, coagulation, acute renal failure, necrotising enterocolitis, failure to increase weight, weight loss and increased mortality – especially in babies <28 weeks.

The aim of this CQUIN is the prevention of hypothermia in pre-term babies by routine monitoring of temperature within one hour of admission to a Neonatal Intensive Care Unit (NICU) and to limit variation in different units so that all units achieve 95% or more of babies ≥36˚C within one year.

What did we do to improve performance?

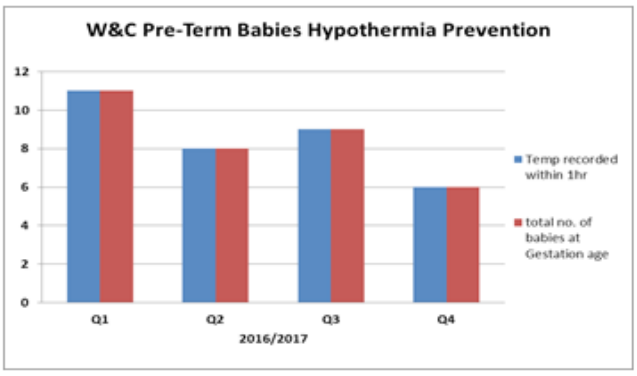
Standards were applied and written into documentation that all babies admitted to NICU have their temperature recorded on admission, and mitigating actions were put in place to ensure normothermia within that first hour. The temperature readings were recorded on Badgernet and within the babies' individual clinical records.

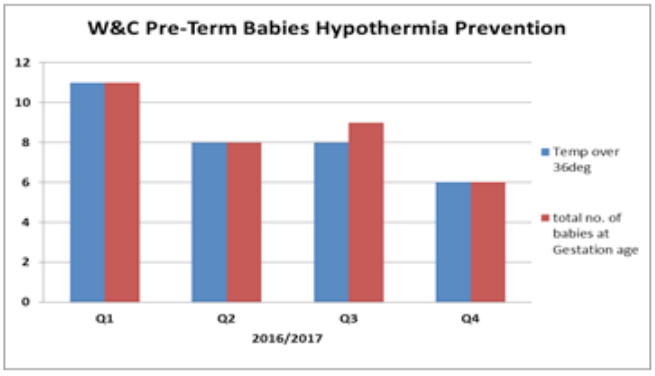
How did we monitor our progress?

Progress was monitored continuously and discussed at the Unit's sister's meeting with information being fed back to staff via the Unit's newsletter.

Outcome

All babies had their temperature taken in accordance with the agreed protocol and the standards were met in each quarter although one baby in Quarter 3 was recorded as being just below the standard at 35.9˚C but this was considered within the margin of error:





Priority 8

Dose Banding of Adult Intravenous Systemic Anticancer Therapy (SACT)

Why do we need to improve?

Dose banding and dose standardisation will support the National Medicines Optimisation agenda. Standardisation of doses of SACT has the potential to improve patient safety and to ensure that patients are in receipt of doses that meet nationally approved parameters.

In addition dose banded SACT may release some cost savings as costs of preparation may be reduced through preparation of fewer 'patient-specific' dosages. Wastage of SACT would also be reduced as the potential for re-use of unused dosages would increase.

In due course national standardisation should further enable greater efficiency in procurement.

Aim and goal

>90% of doses (from a prescribed list of chemotherapy agents) will match the dose banding tables Q4 for 2016/17.

What did we do to improve our performance?

The Trust adopted the national tables for the agents identified and included agents that might at a later date be included in a future CQUIN.

How we monitored and reported progress

Data was submitted each quarter for the total number of doses dispensed and the number of doses matching the dose banding tables.

Outcome

Time period	Q1	Q2	Q3	Q4
Target	Baseline	40%	60%	90%
Achieved	12%	96%	97%	TBC

CQUINS – PUBLIC HEALTH

Priority 9

DENTAL DASHBOARD

Why do we need to improve?

A Dental Quality Dashboard has been developed nationally in order to capture information to facilitate planning for the new dental pathways. Submission of the dashboard will lead to increased intelligence about activity at a local, regional and national level to support pathway development in line with NHS England's published Commissioning Guides for Commissioning Dental Services.

What did we do to improve performance?

All required information was identified and the data recorded on a monthly basis for the dental specialties provided within the Trust.

How we monitored and reported on progress

All the information on activity specified was captured on a Quality Dashboard and submitted on a quarterly basis to the CCG.

Outcome

The Trust was fully compliant with populating the Dental Quality Dashboard for 2016/17.

Priority 10

BREAST SCREENING

Why do we need to improve?

This local CQUIN was developed to ensure the sustainability of the breast cancer screening programme across Norfolk through the development of a clinical network between the three acute trusts (The Queen Elizabeth Hospital, James Paget University Hospital and the Norfolk and Norwich University Hospital) and to aid business continuity and service development.

Aims and Goals

- Enable cross organisational clinical supervision
- Provide operational support where possible and appropriate
- Provide shared quality clinical education and training
- Generate service improvements across pathways and organisations
- Work together on workforce planning
- Act as a clinical reference group to the STP process in relation to new models / ways of working
- Enable consistent achievement of KPI's and quality, performance standards in breast screening.

What did we do to improve performance?

- QEH lead identified by September 2016
- Agreed plans from the three trusts were submitted for the development of a clinical network and this included the new terms of reference
- First meeting of the three trusts was held on 20 January 2017
- Three trusts agreed network objectives and action plan submitted
- Training plan developed and submitted.

How we monitored and reported progress?

All three trusts have met up on a regular basis to agree aims and objectives and to determine progress.

Outcome

The Trust has participated fully in the development of the network and has met all the requirements of the CQUIN.

Priority 11

ARMED FORCES

Why do we need to improve?

The Armed Forces Covenant is now included within the NHS Constitution. The Trust Board Armed Forces Champion plays a pivotal role in ensuring the Armed Forces Covenant is applied in clinical practice and across all access pathways. The principle of no disadvantage is understood and upheld in terms of clinical need.

Extract of The Armed Forces Covenant, 'Today and Tomorrow':

The Armed Forces Community should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area in which they live. They should retain their relative position on any NHS waiting list if moved around the UK as a result of being posted.

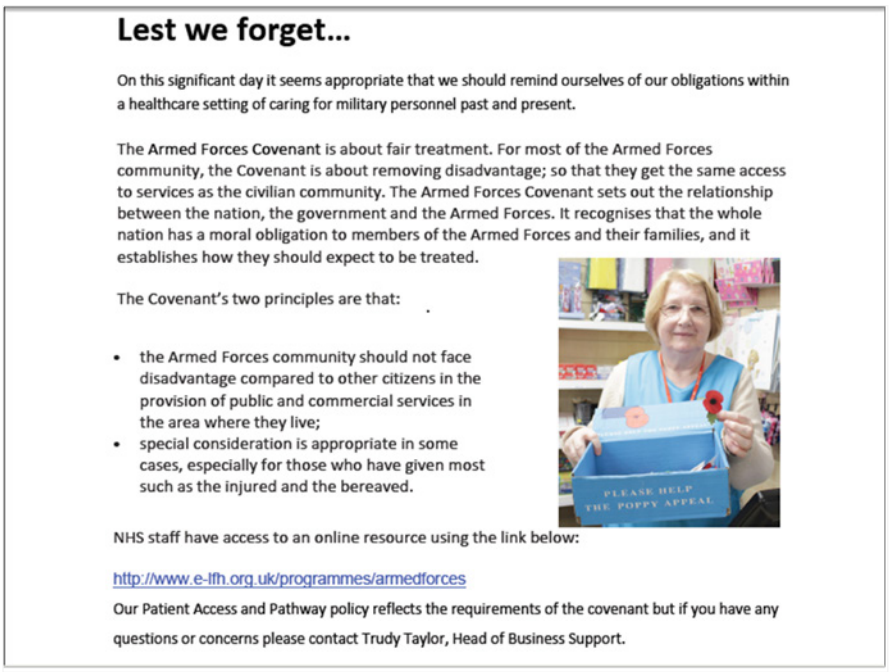
Veterans receive their healthcare from the NHS, and should receive priority treatment where it relates to a condition that results from their service in the Armed Forces, subject to clinical need. Those injured in the Service, whether physically or mentally, should be cared for in a way that reflects the Nation's moral obligation to them, while respecting the individual's wishes. For those with concerns about their mental health, where symptoms may not present for some time after leaving Service, they should be able to access services with health professionals who have an understanding of the Armed Forces culture.

What did we do to improve performance?

Our Trust is supporting the Armed forces covenant by updating our Access policy to ensure that armed forces personnel are not disadvantaged when moving between areas as part of their military commitment.

A Trust awareness communication was sent out on Remembrance Day to remind all our staff of our obligations within a healthcare setting of caring for military personnel past and present.

Outcome



Lest we forget...

On this significant day it seems appropriate that we should remind ourselves of our obligations within a healthcare setting of caring for military personnel past and present.

The **Armed Forces Covenant** is about fair treatment. For most of the Armed Forces community, the Covenant is about removing disadvantage; so that they get the same access to services as the civilian community. The Armed Forces Covenant sets out the relationship between the nation, the government and the Armed Forces. It recognises that the whole nation has a moral obligation to members of the Armed Forces and their families, and it establishes how they should expect to be treated.

The Covenant's two principles are that:

- the Armed Forces community should not face disadvantage compared to other citizens in the provision of public and commercial services in the area where they live;
- special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.

NHS staff have access to an online resource using the link below:

http://www.e-lfh.org.uk/programmes/armedforces

Our Patient Access and Pathway policy reflects the requirements of the covenant but if you have any questions or concerns please contact Trudy Taylor, Head of Business Support.

Further training and communications are planned to ensure that we keep our obligations to military personnel at the forefront of our care commitments.

2017/18 COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

National & Regional CQUINs 2017/19 (ACUTE CONTRACT)

Goal No.	Description of Goal	Indicator Name	National or Regional Indicator	Indicator Weighting of contract Total Value 2.5
1a	Improvement of Health and Wellbeing of NHS Staff	**Improving staff health & wellbeing**	National	0.25
1b	Healthy Food for NHS Staff, Visitors and Patients			
1c	Improving the Uptake of Flu Vaccinations for Front Line Staff within Providers			
2a	Timely Identification of Sepsis in Emergency Departments and Acute Inpatient settings	**Reducing the impact of Serious Infections (Antimicrobial Resistance & Sepsis)**	National	0.25
2b	Timely Treatment for Sepsis in Emergency Departments and Acute Inpatient settings			
2c	Antibiotic Review			
2d	Reduction in Antibiotic Consumption per 1,000 Admissions			
4	• Reduce by 20% the number of attendances at A&E for those within a selected cohort of frequent attenders who could benefit from mental health and psychosocial interventions • Sustain reduction in year 1 • Reduce total number of attendances to A&E by 10% for all people with primary mental health needs	**Improving services for people with Mental Health needs who present in A&E**	National	0.25
6	Offering Advice & Guidance (75% of GP referrals are made to elective outpatient specialties which provide access to A&G services by Q4 18/19)	**Advice & Guidance**	National	0.25
7	GP referrals to consultant-led first o/p services only. All providers to publish ALL such services and make ALL their First O/P apt slots available on NHS e-Referral Service by 31 March 2018	**YEAR 1 ONLY** **NHS e-Referrals**	National	0.25
8	Overall aim is to increase the proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within seven days of admission for patients aged 65+	**Supporting proactive & Safe Discharge**	National	0.25
9	Reinforcing the critical role Providers have in developing and implementing local STPs	**Sustainability & Transformation Plans**	National	0.5
10	If a provider delivers its agreed organisational control total in 2016/17, the CQUIN will be paid at the beginning of 2017/18 to the provider, who will be required to hold it as a reserve until release for investment is authorised (see below). If the provider's agreed 2016/17 control total is not achieved, the 0.5% risk reserve will be held by its commissioners until release is authorised.	**Risk Reserve**	National	0.5
				2.5

NOTE: The following CQUIN will replace Indicator No. 7 above for Year 2

- Preventing ill health & risky behaviours – Alcohol and Tobacco.

National & Regional CQUINs 2017/19 (SPECIALIST CONTRACT – including Public Health and Armed Forces)

Goal No.	Description of Goal	Indicator Name	National or Regional Indicator	Indicator Weighting of contract Total Value
1	The expectation is that the targets and metrics will unify hospital pharmacy transformation programme (HPTP) plans and commissioning intentions to determine national best practice and effective remedial interventions	**Hospital Pharmacy Transformation and Medicines Optimisation**	Regional	2.0
				2%
1	Submission of fully populated Dental Quality Dashboard Quarterly	**Dental quality Dashboard**	Regional	0.77
2a	Improving the uptake of breast screening for first attendees (prevalent screen)	**Breast Screening**	Regional	0.11
2b	A shared picture archiving and communication system (PACS) between the three Norfolk Breast screening units (TBC)		Regional	0.12
				2.5%
1	Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community	**Armed Forces Health**	Regional	
				2.5%

TRUST PERFORMANCE AGAINST THE 2016/17 RISK ASSESSMENT FRAMEWORK

Description	Target	Performance	Achieved Y / N
18 weeks (admitted / non-admitted)			
Admitted	90.0%	83.62%	No longer national target
Non-admitted	95.0%	93.00%	No longer national target
Incomplete pathways	92.0%	92.64%	Y
Cancer			
2ww	93.0%	97.27%	Y
Breast symptoms 2ww	93.0%	97.98%	Y
31 day – Diagnosis to first treatment	96.0%	98.93%	Y
Subsequent treatments (31 day) – Drug treatments	98.0%	99.41%	Y
Subsequent treatments (31 day) - Surgery	94.0%	98.89%	Y
62 day – Waits for first treatment (urgent GP referral)	85.0%	82.87%	N
62 day – Waits for first treatment (NHS Cancer Screening referral)	90.0%	82.66%	N
A&E			
Patients seen in < four hours	95%	90.64%	N
Clostridium Difficile			
Total number of cases YTD	53	22	Y
Risk of or actual failure to deliver commissioner requested service – Homebirth service is now re-instated			

Annex 1 – Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

The Queen Elizabeth Hospital Governors' Council

The Trust's Governors have been invited to review the draft Quality Report for 2016/17.

Governors' observations and comments have, where appropriate, been assimilated into the final drafting of the Quality Report. Such observations included:

- The need to clarify the meaning of some acronyms / abbreviations
- The need to add explanatory notes to explain some clinical / technical terminology and datasets

Governors have identified through their review of the Quality Report 2016/17 and through their regular reviews of performance information throughout the period, several areas where Trust focus is required in order to secure sustained Quality improvement in 2017/18:

- Incidence of falls and pressure ulcers
- Staff sickness absence
- Staff engagement
- Communication with patients
- Learning from complaints and incidents
- Improvements in the discharge process

The Governors feel broadly that the Quality Report 2016/17 is comprehensive, balanced and provides evidence of a successful year in 2016/17.

Governors highlighted several Quality improvements secured and evidenced in 2016/17:

- Governors welcomed developments in Maternity Services, giving mothers more choice about where to have their babies, through the 'Midwifery-led Pathway'
- Governors applauded the Trust's 'A' Rating for Stroke Services. During 2016/17, the Governors led a Trust 'Stroke' Healthcare event for the public. The event was very well-received and contributed significantly to public information and education
- Governors celebrated significant environmental improvements, improving both the patient and staff experience, such as ward refurbishments, A&E environment improvements and theatre upgrades
- Governors recognised significant success in Research and Development

The Governors have found the Trust's 2016/17 ambition of 'Aiming for Excellence' compelling. The Governors hope and expect that the Trust's plans for the 2017/18 and beyond will build on this work and indeed the Governors endorse the Trust's Quality Priorities for 2017/18.

The Trust has used a 'journey' metaphor throughout 2016/17 and the Governors see in the Quality Report, clear evidence of significant progress in many areas and also the continuing quality improvement 'journey' into 2017/18. The Governors have identified several areas where good progress has been made in 2016/17 and where further improvements are expected:

- Care for our frail, elderly patients – including the Trust's work with healthcare partners
- Medicines Management
- Emergency pathway – especially effective and timely discharge for patients
- The patient experience of children and young people

The Governors have welcomed the opportunity to comment on the Quality Report for 2016/17 and look forward to working with the Board in the year ahead, for the benefit of the Trust, the patients and community served by it and the people working for it.

Healthwatch Norfolk

Healthwatch Norfolk appreciates the opportunity to make comments on the Quality Account for 2016/2017. In terms of the format and readability the document at 135+ pages compared to 94 in 2015/2016 is quite challenging for the lay reader. However the layout is logical and clear. In the main each topic is discussed in plain language at the start of each section before more technical details are introduced. Whilst the report is written for a range of audiences the needs of the public are properly catered for.

There is no glossary but generally acronyms and technical terms are explained when first introduced.

It is not specified whether the draft document is available in different formats e.g. electronic, hard copy, Braille, other languages.

The priorities for the past year are very clearly identified.

With two exceptions the Trust has achieved the objectives set out in the 2015/16 Quality Account. Substantial improvements have been made in Friends and Family Test scores, End of Life experience, reduction in Clostridium Difficile levels, management of Sepsis, hospital acquired pressure ulcers, inpatient falls, experience of maternity services and staff FFT scores. Effective management of medicines failed to meet the national target of 80% for Medicines Reconciliation rates. However the report details a number of initiatives aimed at improving the situation. The other area where priorities were not achieved is as mentioned earlier the pathway for urgent admissions where A&E performance in 10 out of the 12 months in 2016/2017 was below the 4 hour performance target. This is information is given but is not discussed in more detail elsewhere in the report – nor is it included in the priorities for 2017/2018. This is surprising given the national attention being paid to this topic and also in the light of the actions the Trust has taken and is taking to address this issue. More detail about these steps would help to reassure the general public that something is being done to try and improve matters.

There is a CEO statement which provides a comprehensive overview of the more detailed information contained in the body of the report. Comments about a "strong performance against the 4 hour Emergency Department target " and "further focus on achieving improvements" are somewhat at odds with the body of the report where there is a simple statement that targets have not been met and no information at all about steps being taken to secure improvements.

The priorities for the forthcoming year are clearly identified and are set out in detail. The report includes topics of patient safety, clinical quality and effectiveness, patient experience including the family & friends test, and complaints.

During this year the Trust participated in 39 National Clinical Audits.

It is noted that neither the Patient-Led Assessments of the Care Environment (PLACE) assessment nor the 18 week target results are included in the report.

The IG Toolkit compliance score for 2016/2017 was 80% and was graded green (satisfactory).

The last CQC inspection was in June 2015 which resulted in the Trust being removed from special measures in August 2015. Three areas were rated as "Good" with "Are Services Safe at this Trust?" and "Are services at this Trust responsive?" being rated a requiring improvement. In addition particular improvement work was required in respect of: Obstetrics and Gynaecology, Outpatients and End of Life Care. The Trust has introduced a Quality Improvement Group to oversee and evidence delivery of these requirements.

HWN was pleased to see information about new services introduced such as the

- Midwifery led maternity pathway and reintroduction of the home birthing service.
- range of health and wellbeing initiatives for staff including fitness classes and facilities, and
- "Red Bag" project to improve sharing of vital information with care homes when their residents are admitted to and discharged from hospital.

HWN remain committed to continue to work with the Trust to ensure that the views of patients, their families and carers are taken into account and to make recommendation for change where appropriate.

Alex Stewart
Chief Executive
May 2017

West Norfolk Clinical Commissioning Group

West Norfolk Clinical Commissioning Group (WNCCG) as the lead Commissioner for the QEH supports the Trust in its publication of the 2016/17 Quality Account. WNCCG has reviewed the mandatory detail of the report and can confirm that the Trust has incorporated all of the mandated elements required within the Quality Account.

The CCG recognises the challenges which the Trust has experienced during 2016/17 and their continued ambition of "Aiming for Excellence" which can be demonstrated in the improvement and progress which has been made against the quality objectives and priorities for 2016/17. Notably, the Trust has made significant improvement in the following key quality objectives:

- **Reduction in healthcare associated infection related to Clostridium Difficile** (year-end total of 22 cases against a ceiling target of 53 cases). This is a very positive improvement which has been achieved through focussed areas of work which has resulted in changes in the organisational culture and approach to managing all aspects of Infection Prevention and Control.
- **Reduction in hospital acquired Pressure Ulcers.** The Trust has implemented and established a range of initiatives and changes in practice to achieve a substantial improvement in this important area of patient care.
- **Improvement in the experience for mothers and their families using Maternity services.** The Trust has re-instated the Home Birth Service as part of the recently launched Midwifery Led Pathway which is a very positive improvement in the patient experience.
- **Reduction in the number of inpatient falls.** Whilst the Trust has made significant progress on the overall reduction in the number of inpatient falls there is a need to continue to make improvements around the number of inpatient falls where there has been patient harm. The CCG is pleased to note that the Trust has confirmed its commitment to focus on this key quality indicator during 2017/18.
- **Improvement in the frail, elderly patients clinical pathways.** The Trust has implemented a Comprehensive Geriatric Assessment and deconditioning initiatives to promote improved care and management for frail, elderly patients. The CCG can confirm that the Trust has fully participated with partner organisations and the CCG to improve the frailty, elderly patients clinical pathways during 2016/17 and that this work will continue in 2017/18.
- **Improve pathway for urgent admissions.** Clearly the Trust has experienced significant challenges in terms of patient flow during 2016/17 which has also been reflected across the whole health and social care system. The Trust has been a proactive member of the A/E Delivery Board and has participated in all of the initiatives around the non-elective clinical pathways. Whilst the Trust has endeavoured to improve patient flow (and in particular around discharge planning) it is recognised by both the Trust and the CCG that there is still more work to do to positively improve the patient experience. The CCG has noted that the Trust has confirmed its commitment to a further focus on improving patient flow during 2017/18.

The CCG has worked closely with the Trust around the Cancer clinical pathways during 2016/17 and the establishment of the Cancer Delivery Board with CCG attendance has been seen as a positive initiative. Whilst Cancer has not been specifically highlighted by the Trust as a key focus for 2017/18 the CCG would confirm its commitment to supporting the Trust in maintaining a focus on this key area of patient experience during 2017/18.

The Trust has made improvements around all aspects of engagement with patients and families during 2016/17 and in particular around the Friends and Family response and recommendation rates. However, the CCG is pleased to note that this focus will continue to be maintained during 2017/18.

The CCG supports the Trust's specific areas of quality improvements for 2017/18 and looks forward to continuing to work in a proactive, positive and collaborative manner with the organisation to ensure patient safety, patient experience and clinical effectiveness remain a high priority in the continued improvement of patient care.

Maggie Carter
Director of Quality Assurance

Norfolk Health Overview and Scrutiny Committee

The Norfolk Health Overview and Scrutiny Committee has decided not to comment on any of the Norfolk provider Trusts' Quality Accounts for 2016-17 and would like to stress that this should in no way be taken as a negative comment. The Committee has taken the view that it is appropriate for Healthwatch Norfolk to consider the Quality Accounts and comment accordingly.

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Annex 2 – Statement of Directors' responsibilities for the quality report

The quality report must include a statement of directors' responsibilities, in the following form of words:

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;
- 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 11/05/2017
  - feedback from governors dated 11/05/2017
  - feedback from local Healthwatch organisations dated 13/05/2017
  - feedback from Norfolk Health Overview and Scrutiny Commitee dated 22/05/2017
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 01/06/2016
  - national patient survey (due to be published soon)
  - national staff survey (published on 07/03/2017)
  - the Head of internal audit's annual opinion of the Trust's control environment dated 18/05/2017
  - CQC quality and risk profiles dated 9-11 June 2015
- the quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with NHSi's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board

Edward Libbey - Trust Chair
Date: 23/5/2017

Jon Green – Chief Executive
Date: 23/5/2017

Annex 3 - Auditor's Statement

INDEPENDENT AUDITOR'S REPORT TO THE GOVERNORS' COUNCIL OF QUEEN ELIZABETH HOSPITAL KINGS LYNN NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Governors' Council of Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust to perform an independent assurance engagement in respect of Queen Elizabeth Hospital Kings Lynn 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;
- 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 latest national patient survey;
- the latest national staff survey;
- Care Quality Commission Inspection, dated 9 – 11 June 2015
- 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 Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust as a body, to assist the Governors' Council 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 Governors' Council 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 Governors' Council as a body and Queen Elizabeth Hospital Kings Lynn 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 Queen Elizabeth Hospital Kings Lynn 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
Chartered Accountants Dragonfly House
2 Guilders Way Norwich Norfolk,
NR3 1UB

23 May 2017

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Financial Report

2016/17

Contents

Foreword to the Accounts

These accounts for the year ended 31 March 2017, have been prepared by the Board of Directors of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 to the National Health Service Act 2006.

Jon Green – Chief Executive
Date: 23/5/2017

Independent auditor's report

to the Governors Council of Queen Elizabeth Hospital Kings Lynn 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 Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust for the year ended 31 March 2017 set out on pages 186 to 227. In our opinion:

- the financial statements give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2017 and of the Group and 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.

2. Emphasis of matter

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of disclosures made in Note 1 ("Going concern") of the financial statements concerning the ability of the Trust to continue as a going concern.

The Trust has incurred a significant deficit of £23.4 million (including a £5 million charge for asset impairments) for the year ended 31 March 2017. In addition, the Trust has submitted a 2017/18 revised financial plan to NHS Improvement with a planned deficit of £16.6 million. The plan includes a cost improvement programme of £8.2 million (4% of costs); and £5 million is income generation through increased clinical income. The Trust will also need a significant injection of loan support of £21.6 million (£4.8 million capital and £16.8 million revenue) over the course of 2017/18 in order to meet its liabilities and continue to provide healthcare services. The extent and nature of the financial support from the Department of Health, including whether the support will be forthcoming and sufficient, is currently uncertain, as are any terms and conditions associated with the funding.

These conditions together with other matters explained in Note 1 ("Going concern") of the financial statements, indicate the existence of a material uncertainty which may cast significant doubt over the Trust's ability to continue as a going concern. The financial statements do not include any adjustments that would result if the Trust was unable to continue as a going concern.

Overview	
Materiality: Group financial statements taken as a whole	£1.8m (2015/16: £1.7m) 1% (2015/16: 1%) of income from operations

Risks of material misstatement		vs 2015/16
Recurring risks	Going Concern	◀▶
	Valuation of Land and Buildings	◀▶
	Recognition of NHS and non-NHS income and provision for doubtful debt	◀▶

3. 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:

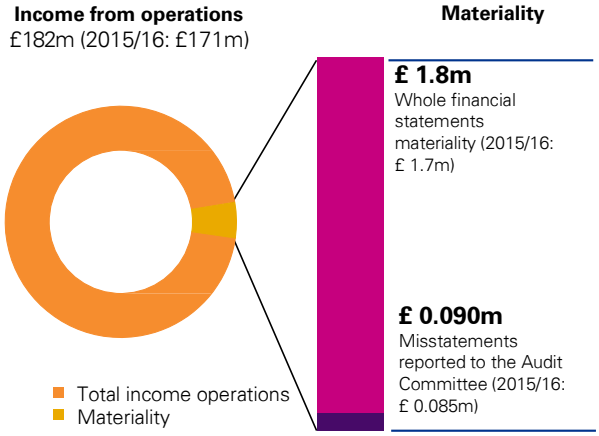
	The risk	Our response
Going Concern *Refer to page 192 (accounting policy)*	**Going concern and financial resilience** The Trust is reliant on ongoing support from the Department of Health to sustain its financial position and continue to be able to provide health care provision. Under guidance from the Department of Health the Financial accounts should continue to be prepared on a Going Concern basis as long as the Trust has a licence to provide services and does not expect this to be withdrawn or intend to apply to revoke that licence	Our procedures included: — **Financial plans:** We obtained the Trust's financial plans submitted to NHSi for 2017/18 and 2018/19 and we reviewed correspondence with NHSi in relation to the financial plans. — **Future income and support:** We obtained copies of signed contracts from the Trusts largest commissioners for 2017-19 and agreed these to the financial plans. We considered recent correspondence with NHSi to understand the agreed process for approval of future funding and borrowing requirements. — **Presentation:** we reviewed the disclosures in the financial statements to ensure they were appropriate
Property, plant and equipment Property, plant and equipment: £88 million; (2015/16: £91 million) – of which £64 million; 2015/16: £70 million relate to land and buildings. *Refer to page 195 to 198 (accounting policy) and pages 214 to 217 (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 at Gayton Road, King's Lynn. As hospital buildings are specialised assets and there is not an active market for them they are valued on the basis of the cost to replace them with an equivalent asset. When considering the cost to build a replacement asset the Trust considers whether the asset would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic. The valuation is completed by an external expert engaged by the Trust using construction indices and so accurate records of the current estate are required. Full valuations are required to be completed every five years, with interim desktop valuations completed in interim periods as required. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied. Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust had a full valuation undertaken at 1 April 2014, and an interim desktop valuation has been performed by Boshier and Company as at the 1 April 2016. The interim desktop valuation has been treated as a clear consumption of economic benefit and therefore an impairment of £5million has been taken in full to the revenue account.	Our procedures included: — **Review of the asset specification:** We tested the accuracy of the estate base data provided to the valuer to complete the interim desktop valuation to ensure it accurately reflected the Trust estate; — **Review of the Trust's valuer:** We assessed the scope, qualifications and experience of the valuer, Boshier and Company, and the overall methodology of the valuation performed to identify whether the approach was in line with industry practice and the valuer was appropriately experienced and qualified to undertake the valuation. — **Review of valuation:** We assessed the assumptions used in preparing the interim desktop valuation completed of the Trust's land and buildings by comparing our own expectations based on our knowledge of the client and experience of the industry in which it operates to ensure they were appropriate. As part of this process we consulted with our in house valuations specialists. We assessed whether the valuation and the accounting treatment of the impairment was compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.

NHS and non-NHS income and receivables Income: £182 million; 2015/16: £171 million. Receivables: £9 million; 2015/16: £7 million. *Refer to page 194 (accounting policy) and page 218 to 219 (financial disclosures).*	**Recognition of NHS and non-NHS income and provision for doubtful debts:** Of the Trust's reported total income, £165million (2015/16, £152m) came from commissioners (Clinical Commissioning Groups (CCGs) and NHS England). One CCG makes up 63% of the Trust's income. The majority of this income is contracted on an annual basis, however actual achievement is based on completing the planned level of activity and achieving key performance indicators (KPIs). If the Trust does not meet its contracted KPIs then commissioners are able to impose fines, reducing the level of income achievement. There is a risk providers recognise income to which they are not entitled and that cannot be supported by actual activity levels undertaken during the year. Insufficient provision may be made for potential fines levied by commissioners, especially where agreement has not been reached during the year 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 £16m (2015/16: £12 million) 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 obtained copies of the signed contracts in place for the largest CCG commissioners and NHS England ; — **Agreement of balances:** We assessed 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 directors to the level of income they were entitled to; — **Income testing:** We agreed a sample of items relating to other activities income back to source documentation and agreed their treatment.

4. Our application of materiality and an overview of the scope of our audit

The materiality for the Group's financial statements was set at £1.8 million (2015/16: £1.7 million), determined with reference to a benchmark of income from operations (of which it represents approximately 1%). We consider income from operations to be more stable than a surplus-related benchmark. We report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £90,000 (2015/16: £85,000), in addition to other identified misstatements that warrant reporting on qualitative grounds.

The Group comprises the Trust and its charity the Queen Elizabeth Hospital King's Lynn Charitable Fund. In auditing the Group financial statements a materiality has been set for the Trust and Charity based on Group materiality.



5. 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.

6. 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 on page 46 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.

KPMG

7. Other matters on which we report by exception – adequacy of arrangements to secure value for money

Under the Code of Audit practice we are required to report by exception if we conclude that we are not satisfied that the Trust put in place proper arrangements to secure value for money in the use of resources for the relevant period.

The Trust has been in breach of its licence with Monitor since April 2013. Following an inspection by the Care Quality Commission (CQC) in June 2015 the Trust was rated as "requiring improvement". In August 2015 the Trust was taken out of special measures but remains in breach of its licence with enforcement undertakings in regard to strengthening its governance, financial control and performance and addressing the improvements identified by the CQC.

In the current year the Trust has incurred a deficit of £23.4 after impairment of £5m meeting their revised plan of £18.3m. The original plan for the year was a deficit of £12.7m

The ongoing breach of licence conditions and deterioration in the Trust's finances against plan is evidence of a weakness in arrangements for effective planning and deployment of resources and in the governance arrangements in place for monitoring performance.

As a result of these matters, we are unable to satisfy ourselves that Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the whole year ended 31 March 2017.

8. We have completed our audit

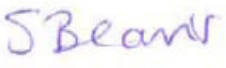
We certify that we have completed the audit of the accounts of Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit

Scope and responsibilities

As described more fully in the Statement of Accounting Officer's Responsibilities on page 59 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.



Stephanie Beavis
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
Dragonfly House, 2 Guilders Way, Norwich, Norfolk, NR3 1UB

23 May 2017

KPMG

Consolidated Statement of Comprehensive Income for the year ended 31 March 2017

		31 March 2017		31 March 2016	
	Note	Foundation Trust £000	Group £000	Foundation Trust £000	Group £000
Operating income from patient care activities	3.1	165,911	165,911	158,943	158,943
Other operating income	3.3	16,130	16,488	12,208	12,137
Total operating income from continuing operations		**182,041**	**182,399**	**171,151**	**171,080**
Operating expenses	4	(203,715)	(204,080)	(182,937)	(183,262)
Operating (deficit) from continuing operations		**(21,674)**	**(21,681)**	**(11,786)**	**(12,182)**
Finance income	10.1	14	44	14	24
Finance expenses	10.2	(1,205)	(1,205)	(720)	(720)
PDC dividends payable		(502)	(502)	(1,297)	(1,297)
Net finance costs		**(1,693)**	**(1,663)**	**(2,003)**	**(1,993)**
Gains/(losses) on disposal of non-current assets	10.4	(69)	(69)	(69)	(69)
(Deficit) for the year		**(23,436)**	**(23,413)**	**(13,858)**	**(14,244)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Revaluations		244	244	0	0
Other reserve movements		0	0	(61)	(61)
May be reclassified to income and expenditure when certain conditions are met:					
Fair value gains/(losses) on available-for-sale financial investments		0	62	0	(5)
Total comprehensive (expense) for the period	(a)	**(23,192)**	**(23,107)**	**(13,919)**	**(14,310)**

Note to Statement of Comprehensive (Expense)/income

		31 March 2017 Foundation Trust £000	31 March 2016 Foundation Trust £000
Total comprehensive (expense) for the period		(23,192)	(13,919)
Add back in year impairments included in the deficit above (a)		5,008	0
Less revaluations		(244)	0
Add back profit/(loss) on asset disposals		69	69
Add Donated assets depreciation		314	353
Less donated income		(113)	(135)
Add back other reserve movements		0	61
Trust Control Total Deficit	(b)	**(18,158)**	**(13,571)**

(b) Represents the primary view used consistently from year to year by the Board of Directors to NHSI the Trust's financial performance.

All income and expenditure is derived from continuing operations.

The notes on pages 192 to 227 form part of these accounts.

Statements of financial position for the Foundation Trust as at 31 March 2017

		31 March 2017		31 March 2016	
	Note	Foundation Trust £000	Group £000	Foundation Trust £000	Group £000
Non-current assets					
Intangible assets	11.1	327	327	43	43
Property, plant and equipment	12.1	87,878	87,878	90,817	90,817
Other investments	13	0	1,472	0	405
Trade and other receivables	16.1	1,022	1,022	760	760
Total non-current assets		**89,227**	**90,699**	**91,620**	**92,025**
Current assets					
Inventories	15	2,366	2,366	2,301	2,301
Trade and other receivables	16.1	8,757	8,761	7,345	7,352
Cash and cash equivalents	17	3,914	3,974	1,660	2,669
Total current assets		**15,037**	**15,101**	**11,306**	**12,322**
Current liabilities					
Trade and other payables	18	(21,528)	(21,646)	(20,411)	(20,498)
Other liabilities	19	(238)	(238)	(735)	(735)
Borrowings	20	(2,385)	(2,385)	(1,273)	(1,273)
Provisions	22	(235)	(235)	(148)	(148)
Total current liabilities		**(24,386)**	**(24,504)**	**(22,567)**	**(22,654)**
Total assets less current liabilities		**79,878**	**81,296**	**80,359**	**81,693**
Non-current liabilities					
Other liabilities	19	(543)	(543)	(548)	(548)
Borrowings	20	(64,082)	(64,082)	(41,338)	(41,338)
Provisions	22	(347)	(347)	(376)	(376)
Total non-current liabilities		**(64,972)**	**(64,972)**	**(42,262)**	**(42,262)**
Total assets employed		**14,906**	**16,324**	**38,097**	**39,431**
Financed by					
Public dividend capital		52,160	52,160	52,160	52,160
Revaluation reserve		11,614	11,614	16,802	16,802
Income and expenditure reserve		(48,868)	(48,868)	(30,865)	(30,865)
Charitable fund reserves		0	1,418	0	1,334
Total taxpayers' and others' equity		**14,906**	**16,324**	**38,097**	**39,431**

The financial statements on pages 186 to 227 were approved by the Board on 23rd May 2017 and signed on its behalf by:

Jon Green – Chief Executive
Date: 23/5/2017

Statement of changes in equity for the year ended 31 March 2017

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	NHS charitable funds reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**52,160**	**16,802**	**(30,865)**	**1,334**	**39,431**
Surplus/(deficit) for the year	0	0	(23,542)	129	**(23,413)**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	0	(5,008)	5,008	0	**0**
Other transfers between reserved	0	(424)	424	0	**0**
Revaluations	0	244	0	0	**244**
Fair value gains/ (losses) on available-for-sale financial investments	0	0	0	62	**62**
Other reserve movements	0	0	107	(107)	**0**
Taxpayers' and others' equity at 31 March 2017	**52,160**	**11,614**	**(48,868)**	**1,418**	**16,324**

Statement of changes in equity for the year ended 31 March 2016

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	NHS charitable funds reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**53,147**	**16,802**	**(16,946)**	**1,725**	**54,728**
Surplus/(deficit) for the year	0	0	(14,243)	(1)	**(14,244)**
Fair value gains/(losses) on available-for-sale financial investments	0	0	0	(5)	**(5)**
Public dividend capital received	13	0	0	0	**13**
Public dividend capital repaid	(1,000)	0	0	0	**(1,000)**
Other reserve movements	0	0	324	(385)	**(61)**
Taxpayers' and others' equity at 31 March 2016	**52,160**	**16,802**	**(30,865)**	**1,334**	**39,431**

Statement of cash flows for the year ended 31 March 2017

	Note	31 March 2017 Foundation Trust £000	31 March 2017 Group £000	31 March 2016 Foundation Trust £000	31 March 2016 Group £000
Cash flows from operating activities					
Operating (deficit)		(21,674)	(21,681)	(11,786)	(12,182)
Non-cash income and expense:					
Depreciation and amortisation	4	5,860	5,860	6,293	6,293
Net impairments and reversals of impairments	6	5,008	5,008	0	0
Income recognised in respect of capital donations		(6)	(6)	0	(469)
(Increase)/decrease in receivables and other assets		(1,681)	(1,573)	(1,843)	(1,771)
(Increase)/decrease in inventories		(65)	(65)	239	239
Increase/(decrease) in payables and other liabilities		1,701	1,733	3,036	3,256
Increase/(decrease) in provisions		57	57	(112)	(112)
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows		(73)	(1,078)	(61)	(98)
Net cash generated from/(used in) operating activities		**(10,873)**	**(11,745)**	**(4,234)**	**(4,844)**
Interest received		14	14	14	14
Purchase of intangible assets		(294)	(294)	(21)	(21)
Purchase of property, plant, equipment and investment property		(8,491)	(8,725)	(11,698)	(11,698)
Sales of property, plant, equipment and investment property		29	156	0	25
Receipt of cash donations to purchase capital assets		0	0	0	469
Investing cash flows of NHS charitable funds		0	30	0	10
Net cash generated from/(used in) investing activities		**(8,742)**	**(8,819)**	**(11,705)**	**(11,201)**
Cash flows from financing acitivities					
Public dividend capital received		0	0	13	13
Public dividend capital repaid		0	0	(1,000)	(1,000)
Movement on loans from the Department of Health		23,929	23,929	19,961	19,968
Capital element of finance lease rental payments		(74)	(74)	(68)	(68)

Interest paid on finance lease liabilities		(18)	(18)	(31)	(31)
Other interest paid		(1,186)	(1,186)	(657)	(657)
PDC dividend paid		(782)	(782)	(1,227)	(1,227)
Net cash generated from/(used in) financing activities		**21,869**	**21,869**	**16,991**	**16,998**
Increase/(decrease) in cash and cash equivalents		**2,254**	**1,305**	**1,052**	**953**
Cash and cash equivalents at 1 April		**1,660**	**2,669**	**608**	**1,716**
Cash and cash equivalents at 31 March	17	**3,914**	**3,974**	**1,660**	**2,669**

Where relevant prior year analysis has been adjusted to be on a consistent basis with the current year.

Notes to the Accounts

Financial Performance

As per prior years the Trust is expecting to incur a deficit during the next 12 months and as a result will require significant additional external funding from the Department of Health. The Regulator is expected to assesses the Trust's Annual plan for 2017/18 and confirm the level of cash support (capital and revenue) that will be available to the Trust for the year. To enable the continuation of services, the Trust has an agreed "interim working capital support facility" from the Department of Health which enables the Trust to take out loans on a monthly basis.

International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management intends, or has no alternative but, to apply to the Secretary of State for the Trust's dissolution without the transfer of its services to another entity.

The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust's Board of Directors has carefully considered the principle of 'Going Concern' and the Directors have concluded that the on-going risk around cash flow support represents a material uncertainty that casts significant doubt upon the Trust's ability to continue as a going concern.

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

Looking Forward to 2017/18 and Beyond

The Trust's financial plan for 2017/18 has been approved by the Board following a comprehensive and robust budget setting process with all clinical and support departments. Cost savings of £8.2m (4%) have been included in the plan along with investments to maintain and enhance patient care.

The financial plan for 2017/18 excludes the receipt of Sustainability & Transformation funding based on the fact that the Trust is still in the process of negotiating the 2017/18 control total with the Regulator.

Summary

During the next twelve months, the Trust will continue to enhance the standard of patient care and services and the Trust's financial plans have identified the requirement for significant additional external funding from the Department of Health of £21m.

An "interim working capital support facility" is in place, providing the Trust with loans on a monthly basis whilst the Trust's annual plan is assessed and formal cash flow support is considered further by the Regulator.

However, the circumstances outlined above represent a material uncertainty that casts significant doubt upon the Trust's ability to continue as a going concern. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

Note 1 Accounting policies and other information

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.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1 Consolidation

The NHS foundation trust is the corporate trustee to The Queen Elizabeth Hospital Charitable Fund (the Charity). The Trust has assessed its relationship to the charity and determined it to be a subsidiary because the Trust has the power to govern the financial and operating policies of the charity as so obtain benefits from its activities itself, its patient or its staff.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the foundation trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

The notes are analysed between Foundation Trust items and Group items, being the consolidation of both entities. Where Group only is disclosed, there is either no income/expenditure associated with the Charitable Funds, or it is immaterial, so therefore not disclosed separately.

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 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 Trust's management have made the following critical judgments in applying the Trust's accounting policies:

The most significant estimate within the accounts is the value of land and building. The interim valuation for 2016/17 was performed by professional Chartered Surveyors Boshier and Company on the basis of market value as at 1 April 2016. Boshier and Company have extensive knowledge of the physical estate and market factors, are independent to the Trust and certified by the Royal Institute of Chartered Surveyors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

The Trust has a financial liability for any annual leave earned by staff but not taken as at 31st March 2017. Under Trust policy staff are allowed to carry over a maximum of 5 working days into the following financial year. The estimated costs of untaken annual leave as at 31st March 2017 was £662,980 (31st March 2016

£609,823).

Assumptions around the timing of cash flows relating to provisions are based on information from the NHS Pensions Agency and internal opinion in the Trust.

1.2.2 Key sources of estimation and uncertainty

The preparation of the financial information in conformity with IFRS requires management to make judgements, estimates and assumptions that affect the application of policies and the reported amounts of income and expenses and of assets and liabilities. The estimates and assumptions are based on historical experience and other factors that are believed to be reasonable under all the circumstances. Actual results may vary from these estimates. The estimates and assumptions are reviewed on an on-going basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods. The estimates and judgements that have had a significant effect on the amounts recognised in the financial statements are outlined below.

1.2.3 Income estimates

In measuring income for the year, management has taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year. Included in the income figure is an estimate for partial spells, i.e. patients undergoing treatment that is only partially complete at twelve midnight on 31 March. The number of partial spells for each specialty is taken and multiplied by the average specialty price and adjusted for the proportion of the spell which belongs to the current year.

1.2.4 Expense accruals

In estimating expenses that have not yet been charged for, management have made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted.

1.2.5 Provisions

In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rate as stated, as appropriate. Management have also taken into account all available information for disputes and possible outcomes.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4 Expenditure on 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 financial statements to the extent that employees are permitted to

carry-forward leave into the following period.

1.4.2 Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

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

1.6.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.
- The item has a cost of at least £5,000;
  or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control;
  or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.6.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of

financial position at their revalued amounts, being the fair value at the date of valuation less any subsequent accumulated depreciation and impairment losses.

Revaluations are performed every 5 years and reviewed with sufficient regularity in between to ensure carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

The Trust conducted an interim valuation of land and buildings as at 1 April 2016. The valuation was performed by Boshier and Company Chartered Surveyors.

Properties in the course of construction for service administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

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.

1.6.4 Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction contract are not depreciated until the asset is brought into use.

1.6.5 Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.6.6 Impairments

In accordance with the DH GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

1.6.7 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:

  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.6.8 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.7 Intangible assets

1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

1.7.2 Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

1.7.3 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

1.7.4 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.7.5 Useful economic life of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Intangible assets - purchased		
Software	5	5
Licences & trademarks	5	5

1.8 Revenue government and other grants

Government grants are grants from Government bodies other than income from Care Commissioning Groups or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

1.10 Financial instruments and financial liabilities

1.10.1 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), or that are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt

or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above/below.

1.10.2 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.10.3 Classification and measurement

Financial assets are categorised as either available for sale, at fair value through income and expenditure, loans and receivables or held to maturity.

1.10.4 Financial assets and financial liabilities at 'fair value through income and expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Assets and liabilities in this category are classified as current assets and current liabilities.
These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

1.10.5 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

1.10.6 Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment

or intangible assets is not capitalised as part of the cost of those assets.

1.10.7 Determination of fair value

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.10.8 Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.11 Leases

1.11.1 Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

1.11.2 Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

1.11.3 Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.12 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the

discount rates published and mandated by HM Treasury.

1.12.1 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed in note 19.1 but it is not recognised in the Trust's accounts.

1.12.2 Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital used by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.14 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Corporation Tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly in relation to specified activities of a Foundation Trust (s519 (3) to (8) ICTA 1988). None of the Trust's activities in the period are subject to corporation tax liability.

1.16 Foreign Exchange

The functional and presentational currencies of the trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

1.20 Accounting standards that have been issued but have not yet been adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers –– Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.

Note 2 Operating Segments

IFRS 8 requires income and expenditure to be broken down into the operating segments reporting to the Chief Operating Decision Maker (the Board). The Trust has 6 clinical directories and a corporate services directorate to support the first 6.

2016/17	Women & Children	Surgery 1	Surgery 2	Medicine 1	Medicine 2	Cancer, Diagnostics & Therapies	Corporate	Total
Segment								
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical income	22,976	6,692	53,019	48,518	10,116	12,895	11,695	**165,911**
Non-Clinical income	297	414	529	446	98	4,443	9,797	**16,024**
Charitable Fund income	0	0	0	0	0	0	464	**464**
Pay	(14,685)	(18,286)	(22,733)	(24,342)	(14,992)	(16,245)	(23,599)	**(134,882)**
Nonpay	(2,079)	(9,462)	(3,611)	(3,090)	(1,748)	(11,575)	(37,268)	**(68,833)**
Charitable Fund expenditure	0	0	0	0	0	0	(365)	**(365)**
Operating surplus/ (deficit)	**6,509**	**(20,642)**	**27,204**	**21,532**	**(6,526)**	**(10,482)**	**(39,276)**	**(21,681)**

2015/16	Women & Children	Surgery 1	Surgery 2	Medicine 1	Medicine 2	Cancer, Diagnostics & Therapies	Corporate	Total
Segment								
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical income	21,813	1,759	48,720	44,757	13,542	14,086	14,267	**158,943**
Non-Clinical income	351	182	277	398	160	1,144	9,312	**11,823**
Charitable Fund income							314	**314**
Pay	(13,334)	(17,259)	(21,676)	(21,364)	(13,801)	(15,974)	(22,007)	**(125,415)**
Nonpay	(1,729)	(8,906)	(3,136)	(2,967)	(1,672)	(7,837)	(31,275)	**(57,522)**
Charitable Fund expenditure							(325)	**(325)**
Operating surplus/ (deficit)	**7,101**	**(24,224)**	**24,185**	**20,824**	**(1,771)**	**(8,581)**	**(29,714)**	**(12,182)**

The table above shows the Trust's Operating Segments as per managerial control for direct resources. It is not a Service Line Report to show service area contribution or profitability.

The "Corporate" category includes all other income and expenditure for the Trust, including cost and income associated with pass through drugs and services & CQUIN income as well as all the pay and non-pay costs for support services such as catering, domestic & cleaning, portering, estate staff, finance and Human Resources etc.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	31 March 2017		31 March 2016	
	Foundation Trust	Group	Foundation Trust	Group
	£000	£000	£000	£000
Elective income	30,004	30,004	29,474	29,474
Non elective income	56,685	56,685	52,370	52,370
Outpatient income	32,311	32,311	29,945	29,945
A&E income	7,469	7,469	6,931	6,931
Other NHS clinical income	38,229	38,229	37,861	37,861
All services:				
Additional income for delivery of healthcare services	0	0	1,000	1,000
Private patient income	780	780	857	857
Other clinical income	433	433	505	505
Total income from activities	**165,911**	**165,911**	**158,943**	**158,943**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:

	31 March 2017		31 March 2016	
	Foundation Trust	Group	Foundation Trust	Group
	£000	£000	£000	£000
CCGs and NHS England	164,593	164,593	152,101	152,101
Non-NHS: private patients	780	780	819	819
Non-NHS: overseas patients (chargeable to patient)	51	51	53	53
NHS injuryscheme (was RTA)	433	433	497	497
Non NHS: other	54	54	4,473	4,473
Additional income for delivery of healthcare services	0	0	1,000	1,000
Total income from activities	**165,911**	**165,911**	**158,943**	**158,943**
Of which:				
Related to continuing operations		165,911		158,943
Related to discontinued operations		0		0

Note 3.3 Other operating income

	31 March 2017		31 March 2016	
	Foundation Trust	Group	Foundation Trust	Group
	£000	£000	£000	£000
Research and development	587	587	0	0
Education and training	5,376	5,376	6,033	6,033
Charitable and other contributions to expenditure	112	6	620	235
Non-patient care services to other bodies	1,048	1,048	1,091	1,091
Rental revenue from operating leases	5	5	10	10
Income resources received by NHS charitable funds	0	464	0	314
Other income**	9,002	9,002	4,454	4,454
Total other operating income	**16,130**	**16,488**	**12,208**	**12,137**
Of which:				
Related to continuing operations	16,130	16,488	12,208	12,137
Related to discontinued operations	0	0	0	0

** Analysis of other operating income: Other

	31 March 2017		31 March 2016	
	Foundation Trust	Group	Foundation Trust	Group
	£000	£000	£000	£000
Car parking	1,338	1,338	1,135	1,135
Estates recharges	85	85	0	0
IT recharges	0	0	0	0
Pharmacy sales	59	59	65	65
Staff accomodation rentals	224	224	9	9
Staff contributions to employee benefit schemes	17	17	23	23
Clinical excellence awards	212	212	0	0
Catering	528	528	310	310
Property rentals	29	29	41	41
Pathology grossing up consortium arrangements	3,195	3,195	0	0
Other	3,315	3,315	2,871	2,871
Total	**9,002**	**9,002**	**4,454**	**4,454**

Note 3.4 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	31 March 2017		31 March 2016	
	Foundation Trust	Group	Foundation Trust	Group
	£000	£000	£000	£000
Income regonised this year	51	51	53	53
Amounts written off in-year	0	0	17	17
	51	**51**	**70**	**70**

Note 3.5 Income from activities arising from commissioner requested services

Under the terms of its provider license, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners would need to be protected in the event of provider failure. This information is provided in the table below:

	Group	
	2016/17	2015/16
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	162,067	151,892
Income from services not designated as commissioner requested services	3,844	7,051
Total	**165,911**	**158,943**

Note 4 Operating expenses

	31 March 2017		31 March 2016	
	Foundation Trust	Group	Foundation Trust	Group
	£000	£000	£000	£000
Services from NHS foundation trusts	3,563	3,563	2,838	2,838
Services from NHS trusts	629	629	1,449	1,449
Purchase of healthcare from non NHS bodies	2,220	2,220	2,109	2,109
Employee expenses - executive directors	1,349	1,349	1,040	1,040
Remuneration of non-executive directors	123	123	121	121
Employee expenses - staff	133,410	133,410	124,254	124,254
Supplies and services - clinical	15,021	15,021	12,801	12,801
Supplies and services - general	2,797	2,797	2,545	2,545
Establishment	1,592	1,592	1,383	1,383
Transport	928	928	782	782
Premises	5,761	5,761	4,917	4,917
(Decrease) in provision for impairment of receivables	(19)	(19)	70	70
Increase/(decrease) in other provisions	112	112	(91)	(91)
Drug costs	16,998	16,998	16,301	16,301
Rentals under operating leases	479	479	492	492
Depreciation on property, plant and equipment	5,850	5,850	6,273	6,273
Amortisation on intangible assets	10	10	20	20
Net impairments	5,008	5,008	0	0
Audit fees payable to the external auditor				
audit services - statutory audit	64	69	64	64
other auditor remuneration (external auditor only)	66	66	15	15
Clinical negligence	3,709	3,709	3,170	3,170
Consultancy costs	465	465	129	129
Internal audit costs	124	124	103	103
Training, courses and conferences	587	587	625	625
Patient travel	20	20	22	22
Car parking & security	260	260	254	254
Hospitality	45	45	37	37
Insurance	112	112	112	112
Other services, eg external payroll	109	109	137	137
Losses, ex gratia & special payments	20	20	5	5
Other resources expanded by NHS charitable funds	0	360	0	325
Other	2,303	2,303	960	960
Total	**203,715**	**204,080**	**182,937**	**183,262**
Of which:				
Related to continuing operations	203,715	204,080	182,937	183,262
Related to discontinued operations	0	0	0	0

Note 5.1 Other auditor remuneration

	Group	
	31 March 2017	31 March 2016
	£000	£000
Other auditor remuneration paid to the external auditor:		
Taxation compliance services	17	15
Other non-audit services	49	0
Total	**66**	**15**

Note 5.2 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £1m (2015/16: £1m).

Note 6 Impairment of assets

	Group	
	31 March 2017	31 March 2016
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	5,008	5,008
Total net impairments charged to operating surplus / deficit	**5,008**	0
Impairments charged to the revaluation reserve	0	0
Total net impairments	**5,008**	**0**

Note 7 Employee expenses

	Group			
	2016/17			2015/16
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	98,790	1,083	**99,873**	96,721
Social security costs	8,973	346	**9,319**	7,355
Employer's contributions to NHS pensions	10,677	411	**11,088**	10,729
Termination benefits	41	0	**41**	108
Agency/contract staff	0	14,438	**14,438**	10,381
Total gross staff costs	**118,481**	**16,278**	**134,759**	**125,294**
Recoveries in respect of seconded staff	0	0	**0**	0
Total staff costs	**118,481**	**16,278**	**134,759**	**125,294**
Of which				
Costs capitalised as part of assets	0	0	0	0

Note 7.1 Retirements due to ill-health

During 2016/17 there were two early retirements from the Trust agreed on the grounds of ill-health (five in the year ended 31 March 2016). The estimated additional pensions liabilities of these ill-health retirements if £84k (£168k in 2015/16).

The cost of these ill-health retirements will be borne in the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and 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 is to be 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.

Note 9 Operating leases

Note 9.1 Operating lease revenue

This note discloses income generated in operating lease agreements where Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is the lessor.

	Group	
	31 March 2017	31 March 2016
	£000	£000
Operating lease revenue		
Minimum lease receipts	5	10
Total net impairments	**5**	**10**

	31 March 2017	31 March 2016
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	5	5
- later than one year and not later than five years;	25	25
- later than five years	513	518
Total	**543**	**548**

Note 9.2 Operating lease expense

This note discloses costs and commitments incurred in operating lease arrangements where The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust FT is the lessee.

	Group	
	31 March 2017	31 March 2016
	£000	£000
Operating lease revenue		
Minimum lease receipts	479	492
Total net impairments	**479**	**492**

	31 March 2017	31 March 2016
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	561	604
- later than one year and not later than five years;	376	937
- later than five years	0	0
Total	**937**	**1,541**

Note 10 Finance

Note 10.1 Finance income

Finance income represents interest received on assets and investments in the period.

	Group	
	31 March 2017	31 March 2016
	£000	£000
Interest on bank accounts	14	14
Investment income on NHS charitable funds financial assets	30	10
Total	**44**	**24**

Note 10.2 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	Group	
	31 March 2017	31 March 2016
	£000	£000
Interest expense:		
Loans from the Department of Health	1,186	664
Finance leases	18	50
Total interest expense	**1,204**	**714**
Other finance costs	0	0
Total	**1,204**	**714**

Note 10.3 The late payment of commercial debts (interest) Act 1998

	Group	
	31 March 2017	31 March 2016
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0

Note 10.4 Gains/losses on disposal/derecognition of non-current assets

	Group	
	31 March 2017	31 March 2016
	£000	£000
Loss on disposal of non-current assets	(69)	(69)
Net profit/(loss) on disposal of non-current assets	**(69)**	**(69)**

Note 11 Intangible assets

Note 11.1 Intangible assets - 2016/17

	Software licences
Group	**£000**
Valuation/gross cost at 1 April 2016 - brought forward	**279**
Additions	294
Gross cost at 31 March 2017	**573**
Amortisation at 1 April 2016 - brought forward	**236**
Provided during the year	10
Amortisation at 31 March 2017	**246**
Net book value at 31 March 2017	**327**
Net book value at 1 April 2016	**43**

Note 11.2 Intangible assets - 2015/16

Group	Software licences
	£000
Valuation/gross cost at 1 April 2015 - brought forward	**258**
Additions	21
Disposals/derecognition	0
Gross cost at 31 March 2016	**279**
Amortisation at 1 April 2015 - brought forward	**216**
Provided during the year	20
Disposals/derecognition	0
Amortisation at 31 March 2016	**236**
Net book value at 31 March 2016	**43**
Net book value at 1 April 2015	**42**

Note 12 Propety, plant and equipment

Note 12.1 Propety, plant and equipment - 2016/17

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**4,366**	**71,525**	**5,075**	**27,344**	**443**	**16,767**	**675**	**126,195**
Additions	0	0	7,807	81	0	9	3	**7,900**
Reclassifications	0	4,191	(8,476)	2,954	0	1,331	0	**0**
Revaluations	244	0	0	0	0	0	0	**244**
Impairments	0	(10,961)	0	0	0	0	0	**(10,961)**
Disposals/derecognition	0	(127)	0	(1,150)	(13)	0	0	**(1,290)**
Valuation/gross cost at 31 March 2017	**4,610**	**64,628**	**4,406**	**29,229**	**430**	**18,107**	**678**	**122,088**
Accumulated depreciation at 1 April 2016 - brought forward	**0**	**5,953**	**0**	**17,459**	**409**	**11,082**	**475**	**35,378**
Provided during the year	0	2,410	0	2,312	12	1,092	24	**5,850**
Impairments	0	(5,953)	0	0	0	0	0	**(5,953)**
Disposals/derecognition	0	0	0	(1,052)	(13)	0	0	**(1,065)**
Accumulated depreciation at 31 March 2017	**0**	**2,410**	**0**	**18,719**	**408**	**12,174**	**499**	**34,210**
Net book value at 31 March 2017	**4,610**	**62,218**	**4,406**	**10,510**	**22**	**5,933**	**179**	**87,878**
Net book value at 1 April 2016	**4,366**	**65,572**	**5,075**	**9,885**	**34**	**5,685**	**200**	**90,817**

Note 12.2 Propety, plant and equipment - 2015/16

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**4,366**	**62,861**	**6,043**	**25,968**	**465**	**14,116**	**609**	**114,428**
Additions	0	382	10,022	1,473	11	457	49	**12,394**
Reclassifications	0	8,364	(10,990)	237	0	2,372	17	**0**
Disposals/derecognition	0	(82)	0	(334)	(33)	(178)	0	**(627)**
Valuation/gross cost at 31 March 2016	**4,366**	**71,525**	**5,075**	**27,344**	**443**	**16,767**	**675**	**126,195**
Accumulated depreciation at 1 April 2015 - brought forward	**0**	**2,911**	**0**	**16,043**	**431**	**9,800**	**453**	**29,638**
Provided during the year	0	3,048	0	1,732	11	1,460	22	**6,273**
Disposals/derecognition	0	(6)	0	(316)	(33)	(178)	0	**(533)**
Accumulated depreciation at 31 March 2016	**0**	**5,953**	**0**	**17,459**	**409**	**11,082**	**475**	**35,378**
Net book value at 31 March 2016	**4,366**	**65,572**	**5,075**	**9,885**	**34**	**5,685**	**200**	90,817
Net book value at 1 April 2015	**4,366**	**59,950**	**6,043**	**9,925**	**34**	**4,316**	**156**	84,790

Note 12.3 Property, plant and equipment financing - 2016/17

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned	4,610	57,986	4,406	9,846	22	5,928	161	**82,959**
Finance leased	0	0	0	159	0	0	0	**159**
Donated	0	4,232	0	505	0	5	18	**4,760**
NBV total at 31 March 2017	**4,610**	**62,218**	**4,406**	**10,510**	**22**	**5,933**	**179**	**87,878**

Note 12.4 Property, plant and equipment financing - 2015/16

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016								
Owned	4,366	61,312	5,075	9,101	34	5,685	180	**85,753**
Finance leased	0	0	0	238	0	0	0	**238**
Donated	0	4,260	0	546	0	0	20	**4,826**
NBV total at 31 March 2016	**4,366**	**65,572**	**5,075**	**9,885**	**34**	**5,685**	**200**	**90,817**

Note 12.5 Economic life of purchased intangible assets

	Min life years	Max life years
Software	5	5

Note 12.6 Economic life of property, plant and equipment

	Min life years	Max life years
Buildings excluding dwellings	15	80
Dwellings	15	80
Plant and machinery	5	15
Transport equipment	7	7
Information technology	5	8
Furniture and fittings	5	15

Note 13 Other investments

	Group	
	31 March 2017	31 March 2016
	£000	£000
Carrying value at 1 April	**405**	**410**
Acquisitions in year	1,005	0
Movement in fair value	62	(5)
Disposals	0	0
Carrying value at 31 March	**1,472**	**405**

Note 14 Analysis of charitable fund reserves

	31 March 2017	31 March 2016
	£000	£000
Unrestricted funds:		
Unrestricted income funds	1,107	1,066
Restricted funds:		
Restricted income funds	266	223
Permanent endowment funds	45	45
	1,418	**1,334**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustees discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 15 Inventories

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Drugs	800	891	800	891
Consumables	1,475	1,341	1,475	1,341
Energy	91	69	91	69
Total inventories	**2,366**	**2,301**	**2,366**	**2,301**

Inventories recognised in expenses for the year were £29,893k (2015/16: £28,342k). Write down of inventories recognised as expenses for the year were £0k (2015/16: £0k).

Note 16 Trade Receivables

Note 16.1 Trade receivables and other receivables

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Current				
Trade receivables due from NHS bodies	6,438	5,234	6,438	5,234
Provision for impaired receivables	(939)	(958)	(939)	(958)
Prepayments	1,388	1,653	1,388	1,653
PDC dividend receivables	280	0	280	0
VAT receivable	716	529	716	529
Other receivables	874	887	874	887
Trade and other receivables held by NHS charitable funds	4	7	0	0
Total current trade and other receivables	**8,761**	**7,352**	**8.757**	**7,345**
Non-current				
Other receivables	1,022	760	1,022	760
Total non-current trade and other receivables	**1,022**	**760**	**1,022**	**760**

Note 16.2 Provision for impairment of receivables

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
At 1 April as previously stated	**958**	**888**	**958**	**888**
Increase in provision	(19)	70	(19)	70
At 31 March	**939**	**958**	**939**	**958**

All receivables have been impaired in line with Trust debtors policy.

Note 16.3 Analysis of impaired receivables

Group	31 March 2017		31 March 2016	
	Trade and other receivables	Investments and other financial assets	Trade and other receivables	Investments and other financial assets
	£000	£000	£000	£000
Ageing of impaired receivables				
0 - 30 days	0	0	0	0
30 - 60 days	0	0	0	0
60 - 90 days	0	0	0	0
90 - 180 days	784	0	47	0
Over 180 days	1,069	0	1,424	0
Total	**1,853**	**0**	**1,471**	**0**
Ageing of non-impaired receivables past their due date				
0 - 30 days	1,174	0	2,219	0
30 - 60 days	600	0	116	0
60 - 90 days	404	0	220	0
90 - 180 days	743	0	180	0
Over 180 days	634	0	123	0
Total	**3,555**	0	**2,858**	**0**

Trust	31 March 2017		31 March 2016	
	Trade and other receivables	Investments and other financial assets	Trade and other receivables	Investments and other financial assets
	£000	£000	£000	£000
Ageing of impaired receivables				
0 - 30 days	0	0	0	0
30 - 60 days	0	0	0	0
60 - 90 days	0	0	0	0
90 - 180 days	784	0	47	0
Over 180 days	1,069	0	1,424	0
Total	**1,853**	**0**	**1,471**	**0**
Ageing of non-impaired receivables past their due date				
0 - 30 days	1,174	0	2,219	0
30 - 60 days	600	0	116	0
60 - 90 days	404	0	220	0
90 - 180 days	743	0	180	0
Over 180 days	634	0	123	0
Total	**3,555**	**0**	**2,858**	**0**

Note 17 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value; these are subject to an insignificant risk of change in value.

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
At 1 April	**2,669**	**1,716**	**1,660**	**608**
Net change in year	1,305	953	2,254	1,052
At 31 March	**3,974**	**2,669**	**3,914**	**1,660**
Broken down into:				
Cash at commercial banks and in hand	47	319	47	319
Cash with the Government Banking Service	3,927	2,350	3,867	1,341
Total cash and cash equivalents as in SoFP	**3,974**	**2,669**	**3,914**	**1,660**
Total cash and cash equivalents as in SoCF	**3,974**	**2,669**	**3,914**	**1,660**

Note 17.1 Third party assets held by the NHS foundation trust

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust held cash and cash equivalents that relate to monies held by the Foundation Trust on behalf of patients and other patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

The Trust held £320 of patients' monies as at 31 March 2017 (31 March 2016: £690).

Note 18 Trade and other payables

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Current				
NHS trade payables	2,572	2,813	2,572	2,813
Other trade payables	5,950	5,481	5,950	5,481
Capital payables	1,589	2,420	1,589	2,420
Social security costs	1,397	1,150	1,397	1,150
Other payables	2,609	3,794	2,609	3,794
Accruals	7,411	4,753	7,411	4,753
Trade and other payables held by NHS charitable funds	118	87	0	0
Total current trade and other payables	**21,646**	**20,498**	**21,528**	**20,411**

Note 19 Other liabilities

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Current				
Other deferred income	238	735	238	735
Total other current liabilities	**238**	**735**	**238**	**735**
Non-current				
Other deferred income	543	548	543	548
Total other non-current liabilities	**543**	**548**	**543**	**548**

Note 20 Borrowings

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Current				
Loans from the department of health	2,303	1,199	2,303	1,199
Obligations under finance leases	82	74	82	74
Total current borrowings	**2,385**	**1,273**	**2,385**	**1,273**
Non-current				
Loans from the Department of Health	63,992	41,167	63,992	41,167
Obligations under finance leases	90	171	90	171
Total non-current borrowings	**64,082**	**41,338**	**64,082**	**41,338**

Analysis of loans with Department of Health:

The Trust holds ten loans outstanding with the Department Of Health these are provided in the table below.

Loan	Details	Loan Value	Term	Expiring
		£000	(years)	
1	Capital Loan	1,050	10	2020/21
2	Capital Loan	1,896	10	2021/22
3	Capital Loan	867	15	2029/30
4	Revenue Support Loan	16,800	5	2019/20
5	Revenue Loan	17,630	5	2019/20
6	Revenue Loan	15,625	5	2020/21
7	Capital Loan	6,184	13	2028/29
8	Revenue Loan	1,000	3	2019/20
9	Revenue Loan	2,468	3	2019/20
10	Revenue Loan	2,775	3	2019/20
Total loans as at 31 March 2017		**66,295**		

Note 21 Finance lease obligations

Obligations under finance leases where The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is the lessee.

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Gross lease liabilities	**172**	**245**	**172**	**245**
of which liabilities are due:				
- not later than one year	82	74	82	74
- later than one year and not later than five years	90	171	90	171
- later than five years	0	0	0	0
Net lease liabilities	**172**	**245**	**172**	**245**
of which payable:				
- not later than one year	82	74	82	74
- later than one year but not later than five years	90	171	90	171
- later than five years	0	0	0	0
Total of future minimum sublease payments to be received at the SoFP date	**0**	**0**	**0**	**0**
Contingent rent recognised as an expense in the period	0	0	0	0

Note 22 Provisions for liabilities and charges analysis

	31 March 2017			31 March 2016
Group	Pensions - early departure costs	Other	Total	Total
	£000	£000	£000	£000
At 1 April	**117**	**407**	**524**	630
Change in the discount rate	7	27	**34**	0
Arising during the year	1	85	**86**	88
Utilised during the year	(13)	(42)	**(55)**	(109)
Reversed unused	0	(8)	**(8)**	(91)
Unwinding of discount	0	1	**1**	6
At 31 March 2016	**112**	**470**	**582**	**524**
Expected timing of cash flows:				
- not later than one year	8	227	235	148
- later than one year and not later than five years	53	57	**110**	139
- later than five years	51	186	**237**	237
Total	**112**	**470**	**582**	**524**

Other provisions relate to employers and public liability claims.

Assumptions around the timing of cashflows relating to provisions are based on information from the NHS Pensions Agency and internal opinion of the Trust with regards to when the cost will be incurred.

Note 23 Clinical negligence liabilities

At 31 March 2017, £47,240k was included in provisions of the NHSLA in respect of clinical negligence liabilities of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (31 March 2016: £24,015k).

Note 24 Contractual capital commitments

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Property, plant and equipment	484	2,716	484	2,716
Total	**484**	**2,716**	**484**	**2,716**

Note 25 Financial instruments

Note 25.1 Financial assets

Group	Loans and receivables	Held to maturity	Total
	£000	£000	£000
Assets as per SoFP as at 31 March 2017			
Trade and other receivables excluding non financial assets	6,642	0	**6,642**
Cash and cash equivalents at bank and in hand	3,914	0	**3,914**
Financial assets held in NHS charitable funds	64	1,472	**1,536**
Total at 31 March 2017	**10,620**	**1,472**	**12,092**

Group	Loans and receivables	Held to maturity	Total
	£000	£000	£000
Assets as per SoFP as at 31 March 2016			
Trade and other receivables excluding non financial assets	4,926	0	**4,926**
Cash and cash equivalents at bank and in hand	1,660	0	**1,660**
Financial assets held in NHS charitable funds	1,009	0	**1,009**
Total at 31 March 2016	**7,595**	**0**	**7,595**

Note 25.2 Financial liabilities

Group	Other	Total
	£000	£000
Liabilies as per SoFP as at 31 March 2017		
Borrowings excluding finance lease liabilities	66,295	**66,295**
Obligations under finance leases	172	**172**
Trade and other payables excluding non financial liabilities	8,541	**8,541**
Financial liabilities held in NHS charitable funds	118	**118**
Total at 31 March 2017	**75,126**	**75,126**

Group	Other	Total
	£000	£000
Liabilies as per SoFP as at 31 March 2016		
Borrowings excluding finance lease liabilities	42,366	**42,366**
Obligations under finance leases	245	**245**
Trade and other payables excluding non financial liabilities	12,340	**12,340**
Financial liabilities held in NHS charitable funds	87	**87**
Total at 31 March 2016	**55,038**	**55,038**

Note 25.3 Maturity of financial liabilities

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
In one year or less	11,044	12,428	11,044	12,428
In more than one year but not more than two years	220	1,273	220	1,273
In more than two years but not more than five years	59,723	37,240	59,723	37,240
In more than five years	4,139	4,097	4,139	4,097
Total	**75,126**	**55,038**	**75,126**	**55,038**

Note 25.4 Fair values of financial assets at 31 March 2017

	Group		Trust	
	Book value	Fair value	Book value	Fair value
	£000	£000	£000	£000
Non-current trade and other receivables excluding non financial assets	1,022	1,022	1,022	1,022
Total	**1,022**	**1,022**	**1,022**	**1,022**

Note 25.5 Fair values of financial liabilities at 31 March 2017

	Group		Trust	
	Book value	Fair value	Book value	Fair value
	£000	£000	£000	£000
Non-current trade and other payables excluding non financial liabilities	543	543	543	543
Loans	63,992	63,992	63,992	63,992
Other	90	90	90	90
Total	**64,625**	**64,625**	**64,625**	**64,625**

Note 26 Losses and special payments

	31 March 2017		31 March 2016	
Group and Trust	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	14	3	4	2
Fruitless payments	14	49	15	63
Bad debts and claims abandoned	355	6	337	20
Stores losses and damage to property	0	0	1	0
Total losses	**383**	**58**	**357**	**85**
Special payments				
Compensation payments	3	12	6	23
Special severence payments	11	50	18	50
Ex-gratia payments	31	43	13	3
Total special payments	**45**	**105**	**37**	**76**
Total losses and special payments	**428**	**163**	**394**	**161**

Note 27 Revaluation Reserve movements

	31 March 2017				31 March 2016
	£000				£000
	Land	Buildings	Other	Total	Total
Revaluation Reserve at April 1	2,087	14.291	424	16,802	16,802
Impairments	0	(5,008)	0	(5,008)	0
Revaluations	244	0	0	244	0
Transfers to income & expenditure reserves	0	0	(424)	(424)	0
Revaluation Reserve at March 31	**2,331**	**9,283**	**0**	**11,614**	**16,802**

Note 28 Related parties

	Receivables		Payables	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Other NHS bodies	6,427	5,214	2,484	2,735
Other Government bodies including Local Authorities	775	549	1,492	1,228
Department of Health	280	0	0	0
Charitable funds	4	7	118	87
Total	**7,486**	**5,770**	**4,094**	**4,050**

	Income		Expenditure	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Other NHS bodies	178,233	161,641	9,862	9,344
Other Government bodies including Local Authorities	84	0	21,100	18,885
Department of Health	0	1,000	1,186	671
Charitable funds	464	314	360	325
Total	**178,781**	**162,955**	**32,508**	**29,225**

List of related parties:

- NHS North Norfolk CCG
- NHS South Norfolk CCG
- NHS West Norfolk CCG
- NHS Norwich
- NHS Cambridgeshire & Peterborough CCG
- Cambridgeshire Community Services
- NHS Lincolnshire East CCG
- NHS Lincolnshire West CCG
- NHS South West Lincolnshire CCG
- NHS South Lincolnshire CCG
- Department of Health
- NHS Litigation Authority
- NHS Purchasing and Supply Agency (NHS Supply Chain)
- Cambridgeshire University Hospital NHS Foundation Trust
- Kings Lynn and West Norfolk Borough Council
- NHS Business Service Authority
- NHS Pension Scheme
- HM Revenue & Customs
- East of England Ambulance Service
- NHS England
- Cambridge & Peterborough NHS Foundation Trust
- NHS Commissioning Board
- Norfolk County Council Public Health
- Cambridgeshire Community Services Public Health
- Norfolk and Norwich University Hospital
- Dr I Hosein (Husband of the CEO and working on contract as the interim Associated Medical Director)

The Trust also received revenue and capital payments amounting to £122,304 from The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust Charitable Fund, the Trustees for which make up the Trust Board. A copy of The Queen Elizabeth King's Lynn NHS Trust Charitable Fund Accounts can be obtained on request (01553 613981).

The Trust conducted transactions with other Health Authorities and NHS bodies, which individually are not regarded as material, during the normal course of the Trust's activities.

Note 29 Financial Risk Management

International Financial Reporting Standard 7 and International Accounting Standard 32 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Foundation Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trusts internal auditors.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity Risk

The Trust's operating costs are incurred under contracts with primary care Trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.