#Proud of the Paget

NHS
James Paget University Hospitals
NHS Foundation Trust

# Annual Report
## and Accounts
## 2017/18

# James Paget University Hospitals NHS Foundation Trust

## Annual Report and Accounts 2017/18

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

# Contents

# Remaining ambitious for our patients and staff

**By Anna Davidson**
**Trust Chair**

## It has been a year of challenge, progress – and, importantly, ambition.

I became Chair in May 2017, taking over from David Wright who stepped down after helping us achieve a 'Good' rating from the Care Quality Commission (CQC), the independent regulator of health and social care in England. This meant I took up the reins with the Trust in a really strong position, with our care praised by the CQC, our staff demonstrating their commitment to patients and our patients routinely complimenting our quality of service.

However, I was determined that we should not rest on our laurels but continue to explore ways in which we could further develop services for the benefit of our patients and staff.

That's why we developed a set of seven strategic ambitions for 2017/18, which showed key areas where we wanted to make progress during the course of the year. They covered everything from innovation and service improvement to finance and partnerships.

One of the ambitions related to effective partnership working to improve services for our patients, which is absolutely crucial both now and in the future. We have been collaborating with local health and social care partners through the Norfolk and Waveney Sustainability and Transformation Partnership (STP) and during the course of the year we have seen positive progress as, together, we create the right healthcare systems for tomorrow's patients.

In essence, our plans aim to help people stay healthy by avoiding conditions such as diabetes while providing more care in the community, allowing hospitals to focus more closely on patients who need specialist or emergency care. Work on these plans continues but in the meantime, we need to ensure our hospital continually evolves to meet the needs of our patients.

During the course of the year, we embarked on an ambitious programme of development in the hospital, which includes the expansion of our Emergency Department to meet increasing patient demand and the modernisation of our catering facilities, to bring benefits for our staff and visitors alike.

I look forward to seeing these plans come to fruition in the year ahead, alongside those being developed with our partners to provide sustainable services for tomorrow's patients.

# Performance report

## Overview and analysis

# Meeting demand while enjoying success

By Christine Allen
Chief Executive

It will come as no surprise when I say that it has been a year dominated by ever-increasing pressure on our services, with the impact on our patients' scheduled operations, and our financial position. Over the past 12 months, our urgent care services have experienced numerous surges in demand - particularly over Christmas and into the New Year - with the sheer volume of patients that need our care putting strain on our bed capacity.

Fortunately, we had plans in place which helped us meet this challenge, through a range of initiatives aimed at ensuring our patients received the right level of care and did not spend any more time in hospital than was needed. These included initiatives such as Red2Green, aimed at helping our patients move through the hospital to get home more quickly, and the introduction of GP streaming in A&E. This ensures that patients arriving at the hospital are seen by the right healthcare professional, avoiding our Emergency Department whenever possible.

We also worked closely with our partners to introduce the 'Discharge Hub' which is based in the hospital and brings together key staff from health, social care and voluntary organisations. The aim is to help patients leave hospital more quickly which in turn increases bed capacity and our ability to manage more easily those patients arriving in A&E. These initiatives all played a part in helping us get through the peaks in demand but, once again, it was the dedication of our staff that really made the difference.

This year we have seen higher than expected mortality rates, which we have taken extremely seriously. We have been working hard to understand this very complex data. Our Medical Director is leading on significant improvements to Trust processes, with more detail later in this report and within the Quality Report.

Whilst the Trust achieved its financial plan and control total for the first three quarters of the year it was unable to achieve this in the fourth quarter. We identified to our regulators in the summer that we were unlikely to meet our plan for the full year. The Board of Directors took decisive action and sought external support to see if there were further opportunities to reduce costs. Our processes have been enhanced, with our staff working with us to improve efficiency where this does not impact on patient safety. This lead to an improvement of nearly £3m, putting us in a stronger position as we move into 2018/19, with a forecast deficit of £13.9m. Over the medium term the Trust will be taking action to return to financial balance.

The Trust really values its workforce and during the course of the year, we conducted a series of engagement initiatives with our staff to find out how we could improve their working lives. Feedback helped us introduce a range of improvements, including health and wellbeing events and new schemes such as Employee of the Month, to recognise those that go the 'extra mile' to provide a quality service.

Our success in numerous national awards during the year simply underlined just how many staff across our organisation go that extra mile and how they are committed to providing the best possible care and support for our patients and their families.

# Our purpose, strategy, objectives and risks

This section of the report provides a summary of what we set out to do in the last year and our progress in achieving our plans.

The hospital was built in 1981. We were the first Foundation Trust in Norfolk and Suffolk, authorised on 1 August 2006, and since known as the James Paget University Hospitals NHS Foundation Trust.

We are governed by a Board of Directors and the Council of Governors. Externally, our activities are overseen by NHS Improvement (NHSI) and by legislation. Our quality of care is assessed by the Care Quality Commission (CQC).

We provide a full range of district general hospital services for the population of Great Yarmouth, Lowestoft and the surrounding areas. This includes the many visitors to this popular holiday destination. The Trust currently serves a population of 230,000. With 40,000 new homes predicted across Norfolk and Suffolk a significant impact is anticipated across all health and social care services.

## Our vision is

To be an innovative organisation delivering compassionate and safe patient care through a well led and motivated workforce.

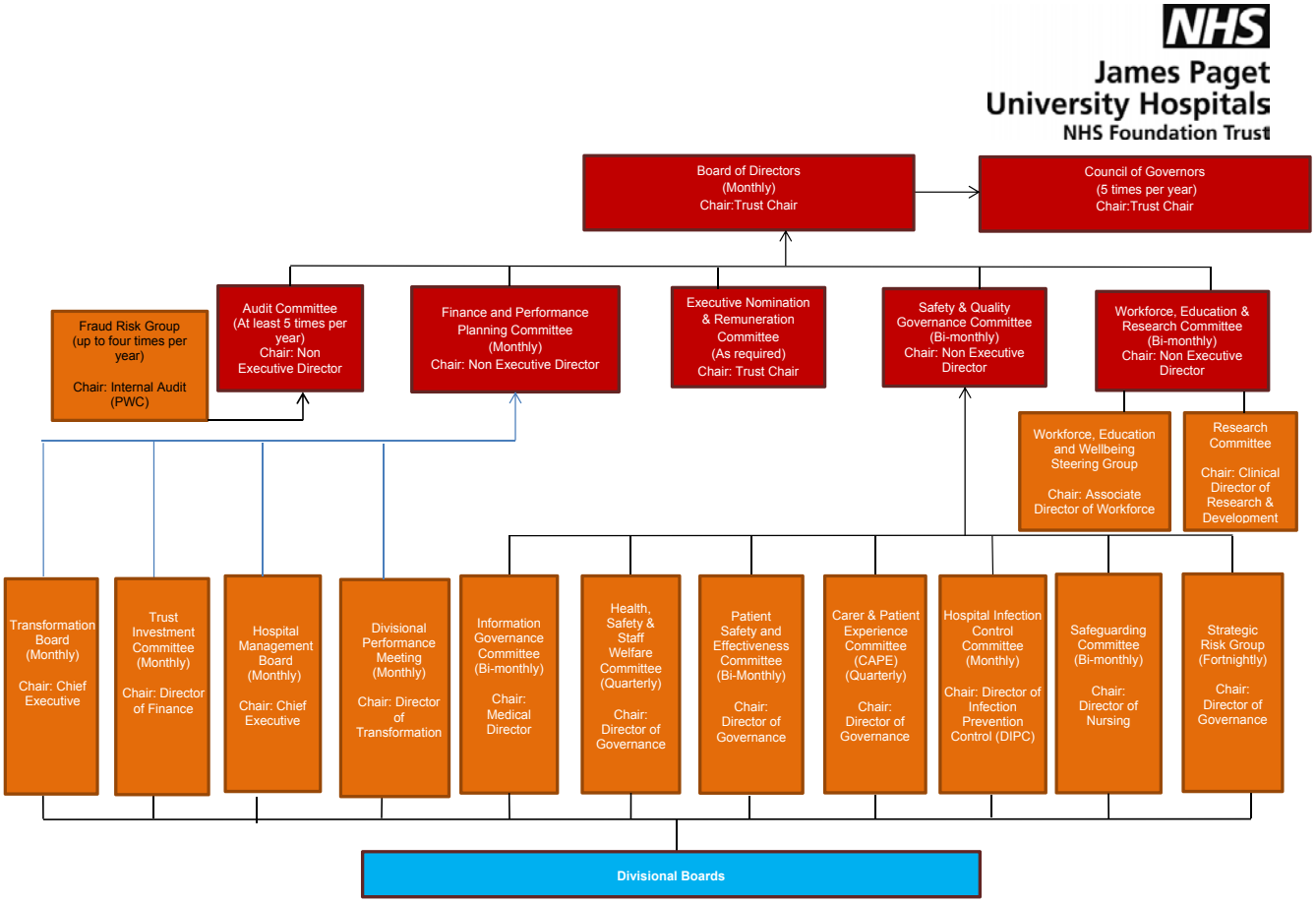
#Proud of the Paget

Like all NHS Foundation Trusts, there are three components:

- The Membership Community: This includes staff, patients and carers and the public. Membership is open to anyone over 16 who has either been a patient or carer at our hospital, is a member of staff, or who lives in our defined catchment area. We have over 11,000 public and staff members
- Council of Governors: We have 28 Governors including the Chair of the Board who also chairs the Council. This includes elected public and staff Governors and representatives of NHS partner and local authority organisations
- Board of Directors: Non Executive and Executive Directors, including four non voting members and the Trust Secretary.

The strategic ambitions underpin everything that we do and enable us to achieve our vision.

The current structure is set out below:




## Our objectives


Our priority is the care we provide to our patients. Each year the Board sets objectives for the next 12 months to ensure an appropriate focus on what we want to achieve, in line with our strategic ambitions. We oversee progress each month through the Board Assurance Framework (BAF) which is considered at the Board of Directors' meeting, with sections reviewed at the relevant Board Committee. The BAF has been developed by identifying the key risks to achievement of these objectives and hence the mitigation required and assurance to Board on progress.

It has been a challenging year, and whilst not all objectives were fully achieved, significant progress has been made. This is despite the focus on managing the day to day operational demands of increasing emergency admissions. Our financial challenge has also worsened this year, with an increasing deficit, despite long term good financial management and control.

| Objective | Assessment |
|---|---|
| **Strategic Ambition 1: Deliver safe and effective personal care.** | |
| 1a. Deliver the 2017/18 quality priorities set out in the Trust's Quality Strategy with a focus on Patient Experience, Patient Safety and Clinical Effectiveness. | **Achieved**<br>Further detail is included in the Quality Report. |
| 1b. Deliver any outstanding actions agreed to be followed up from the Care Quality Commission (CQC) inspection | **On track to achieve**<br>Requires Improvement actions judged by the Trust as achieved in the Medical and End of Life Core Services for Safety. To be assessed by the CQC during their 2018 inspection. |
| **Strategic Ambition 2: Provide the right care at the right time in the right place for all patients** | |
| 2a. Conduct a systematic review of all our services including private patients, incorporating Service Line Reporting, exploring options to redesign patient pathways to increase efficiency and quality, factoring in health promotion activity where relevant, with consideration given to alternatives to an 'acute only' model of care. | **Achieved**<br>This was a two year programme of work to develop the tools and systems for the reviews, with a focus on Orthopaedics, and reference to the Getting it Right First Time and the Carter Review. A programme of reviews will be undertaken during 2018/19.<br><br>Cardiology, Radiology and Urology services are being considered as part of the Norfolk Acute Hospitals (NAHG) Group review across all three acute trusts with a final proposal confirmed. The aim is to ensure sustainable services for patients as part of the Norfolk and Waveney STP. |
| 2b. Develop and complete a detailed capacity and demand assessment to ensure the Trust is able to deliver its future contractual and regulatory activity requirements, addressing any known shortfalls in our workforce and fully utilising our infrastructure | **Achieved - forms part of 2a above**<br>A two year programme, with development of the tool underpinning the Orthopaedics review initially prior to roll out to other specialties in 2018/19. |
| **Strategic Ambition 3: Use our financial resources efficiently and effectively** | |
| 3a. Deliver the Trust's financial regulatory and use of resource requirements as set out in the regulatory framework. | **Partially Achieved**<br>The Trust achieved in the first three quarters. Whilst not achieving the original plan in quarter 4 we did achieve the revised forecast outturn with full involvement of regulators. The Trust remains a segment 2 trust, compliant with its Provider Licence. |
| **Strategic Ambition 4: Demonstrate outstanding leadership at all levels throughout the hospital** | |
| 4a. Deliver all of the 2017/18 actions from the Trust's Well Led Governance Review Action Plan | **Achieved**<br>Three reports to Board in-year outlining the actions undertaken with closure of the action plan at the March 2018 meeting. |
| 4b. Demonstrate 'Outstanding' for Well Led as measured by the Care Quality Commission (CQC) well led review (anticipated in 2017/18). | **Not able to assess**<br>Actions taken to develop leadership but not yet measured by the CQC. |
| 4c. Review and test the effectiveness of our clinical leadership models. | **Achieved**<br>Links to 4a/b. Full review of model with revised structure confirmed by Hospital Management Board and included in the Medical Director's report to Board in April 2018. |

| Objective | Assessment |
|---|---|
| 4d. Deliver the Trust's Five Year People Strategy 2017/18 objectives | **Achieved**<br>Good progress being made with a full update provided to Board in February 2018. |
| Strategic Ambition 5: Deliver success through effective partnerships | |
| 5a. Work with the Norfolk Acute Hospitals Group to secure service sustainability through the Acute Services Review, supporting the STP and with a particular focus on new ways of working through new roles. | **Achieved**<br>Significant work undertaken to review Cardiology, Radiology and Urology services. See 2a. |
| 5b. Work with the Norfolk Provider Partnership (NPP) to secure efficiencies through corporate service consolidation in the five agreed programme areas, supporting the STP. | **No longer applicable**<br>The Norfolk Provider Partnership is no longer in existence with this work forming part of the STP. |
| 5c. Agree and publish the Trust's revised 5 Year strategy | **Achieved**<br>A refresh of the strategy was approved by the Board in April 2018 ahead of launch in May 2018 and a programme of stakeholder engagement as part of our ongoing strategy review. |
| **Strategic Ambition 6: Maximise the benefit of innovation, research and education** | |
| 6a. Deliver the 2017/18 actions from the Trust's draft Commercial Strategy, once published in Quarter 1 of 2017/18. | **Achieved**<br>Commercial strategy approved by Board in June 2017 with strategic oversight committee in place to monitor progress. Foyer re-development moving forward. |
| 6b. Develop and publish the Trust's clinical strategy, to incorporate innovative new models of working and delivering care, aligning consistently with the emerging integration opportunities within the Norfolk Hospitals Group and across the wider STP. | **Partially Achieved**<br>Significant work undertaken in the last six months of the year on a clinically led strategy. Whilst it is in draft and has been discussed with Board members further refinement is required to ensure full delivery of the approved five year strategy and that it reflects the work of the NAHG and the STP – see 5a. A programme of stakeholder engagement will be implemented over the coming months as part of our ongoing strategy review. |
| Strategic Ambition 7: Make the best use of our estate and infrastructure | |
| 7a. Deliver the 2017/18 actions from the Trust's Site Development & Estate Strategy and deliver our commitments towards the future sustainability agenda. | **Achieved**<br>Soft market testing completed for a strategic estates partner to help us deliver our long term plan. A Prior Information Notice has been published to progress this in 2018/19. |
| 7b. Establish an integrated and clinically led Strategic Board for Information Technology (IT) and Information Services (IS), leading to a new integrated IM&T 5 Year Strategy, ensuring alignment with the development of the Norfolk Hospitals Group and the wider STP. | **Achieved**<br>Committee established and work progressing. |

## Risks

The Board of Directors was fully informed of the key issues and risks that could affect the Trust in delivering its objectives. The risks this year related to Referral to Treatment (RTT) targets, mortality indices and our financial situation.

The impact of increased demand in urgent care is under review at the time of writing.

Further detail is included within the Annual Governance Statement in the financial statements.

# Our strategic plans and working in partnership

This year we have focused on revising our Five Year Strategy and developing a range of clinical and quality improvement strategies to deliver that, whilst ensuring that this fits with the Norfolk and Waveney STP plans. The refresh of the longer term strategy reflects the issues that are important for us in providing effective services to our patients.

With the demand challenges seen across organisations locally and nationally, partnership working has increased significantly at times of pressure to ensure our patients are at the centre of everything that we do and that they are cared for in the most appropriate place.

A full review of the organisation's information needs has also been a priority in response to increased demand for a range of data and analysis, both internally and externally. A new Information Centre has been set up with the aim of matching information supply and demand with a clear overview of how best to capture, process, deliver and use the information we have for the benefit of patients and staff.

in good health

## Norfolk and Waveney Sustainability and Transformation Partnership

We have continued to play a full role in the development of the Norfolk and Waveney STP.

**Sustainability and Transformation**
Partnerships were set up across England to help make health and care services fit for the future. They have a focus on three national challenges:

- Addressing health inequalities
- Ensuring the quality and performance of health and social care services
- Making sure the health and social care system is efficient and financially sustainable.


Our STP is a partnership of health and care organisations from across Norfolk and Waveney, working together to improve the health and wellbeing of local people. Partners include our three main hospitals, the mental health trust, the community health trusts and Norfolk County Council. Colleagues in the voluntary, community and social enterprise sector are also involved in the work we are doing.

We're working together on making changes that will make a real difference to your life, such as making it easier to get an appointment at your GP surgery, improving care for people with cancer, providing more services near to where you live, as well as providing the support you need to keep yourself healthy and well.

**Our vision is to provide high quality services that support more people to live independently at home, especially older people and those with long-term conditions, like heart disease, breathing problems, diabetes or dementia.**

We've divided our work into the following areas:

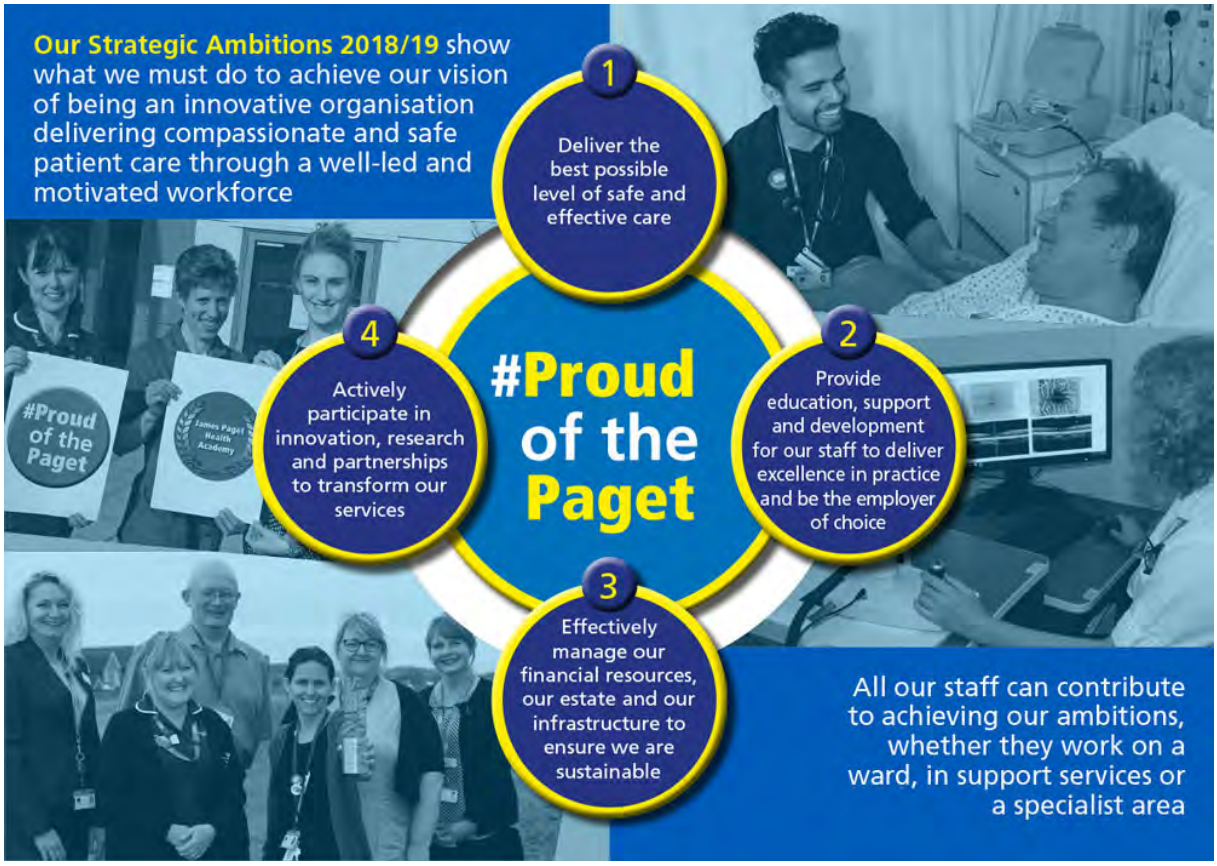
- Prevention
- Primary and Community Care
- Mental Health
- Hospital services and urgent & emergency care, including cancer and maternity services

Over the past year we have further developed our plans and been engaging with local people, patients, health and care staff and local organisations.

You can find out more about the Norfolk and Waveney Sustainability and Transformation Partnership on the Healthwatch Norfolk website: www.healthwatchnorfolk.co.uk/ingoodhealth

## 2018/19

Prior to 1 April 2018 there was engagement with staff and Governors to inform revisions to the strategic ambitions. These have now been reduced to four, with objectives agreed for the coming year.




**Ambition 1:**

1. Deliver the 2018/19 quality priorities set out in the Quality Improvement Strategy with a focus on Patient Experience, Patient Safety and Clinical Effectiveness. This would be supported through a data driven approach to transformation and quality improvement.
2. Develop a capacity and demand assessment to ensure the Trust's delivery of contractual and regulatory activity requirements, addressing any known shortfalls in our workforce and fully utilising our infrastructure.

**Ambition 2:**

1. Deliver the Trust's Five Year People Strategy objectives.
2. Demonstrate an effective and efficient leadership model for Well Led as measured by the Care Quality Commission (CQC).

**Ambition 3:**

1. Deliver the Trust's financial and use of resource requirements as set out in the regulatory framework, taking account of the developing ICS (Integrated Care System) / ICO (Integrated Care Organisation) models and associated system control totals in due course.
2. Deliver the actions from the Trust's Site Strategy to ensure the site is fit for purpose moving forward.
3. Deliver the actions from the Trust Commercial Strategy to release income opportunities.
4. Commence planning for an Electronic Patient Record (EPR) system, consistent with the Trust's needs and in support of the care record needs of the emerging ICO and ICS for Norfolk and Waveney.

**Ambition 4:**

1. Redesign service pathways both within the Trust and across the wider system to achieve patient focused sustainable services.
2. Develop an Integrated Care Organisation (ICO) model in Great Yarmouth and Waveney.

# How we have performed
# Our analysis

A three year activity trend clearly shows the increase in demand in A&E.

| Activity | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|
| Elective Inpatients | 5,364 | 5,189 | 4,022 |
| Day Cases | 30,538 | 31,599 | 31,342 |
| Non-Elective | 24,501 | 25,894 | 27,525 |
| Outpatients | 215,408 | 210,920 | 204,515 |
| A&E | 71,548 | 74,820 | 77,678 |

The final position for the year against the main performance indicators we measure is set out below:

| Indicator | | | Threshold 2017/18 | JPUH 2017/18 |
|---|---|---|---|---|
| 1 | Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway | | 92% | 85.58% |
| 2 | A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge | | 95% | 90.49% |
| 3 | All cancers: 62 day wait for first treatment from: | urgent GP referral for suspected cancer | 85% | 88.40% |
| | | NHS Cancer Screening Service referral | 90% | 95.31% |
| 4 | All cancers: 31 day wait for second or subsequent treatment, comprising: | surgery | 94% | 100% |
| | | anti-cancer drug treatments | 98% | 100% |
| | | radiotherapy | 94% | N/A |
| 5 | All cancers: 31-day wait from diagnosis to first treatment | | 96% | 99.81% |
| 6 | Cancer: two week wait from referral to date first seen, comprising | all urgent referrals (cancer suspected) | 93% | 97.00% |
| | | for symptomatic breast patients (cancer not initially suspected) | 93% | 94.76% |
| 14 | *C difficile* – meeting the *C. difficile* objective | | 17 cases | 16* |
| 20 | Certification against compliance with requirements regarding access to health care for people with a learning disability | | Compliance | Compliance |

* There have been 16 C.difficile cases in total since 1 April 2017. Of these, 10 cases have been successfully appealed; hence six were considered hospital attributable.

### Going concern

The Board of Directors has been regularly updated on the financial plans of the Trust, via the Trust's Finance and Performance Committee. The Audit Committee also specifically reviewed the Trust's position in relation to going concern at its meeting held in February 2018, where it considered continuation of service and financial sustainability in reaching its recommendation to the Board of Directors to adopt the going concern basis in preparing the Financial Statements. The Board of Directors has agreed budgets for 2018/19 and this also forms the basis of the annual financial plan which was submitted to NHS Improvement as part of the 2018/19 Operating Plan. This includes the Trust requiring Department of Health loans which we expect will be available when needed during the year. The Operating Plan considers the future financial, operational and environmental conditions and associated risks, and is based upon signed contracts with commissioners for the continued provision of NHS services.

Having received this information the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the Financial Statements.

## Sustainability

As the largest public sector emitter of carbon emissions, the health system has a duty to respond to meet these targets which are entrenched in law. We continue to make significant progress to improve the impact on the environment and improve sustainability.

### Reducing our use of fossil fuels

- Using Combined Heat and Power plant to produce 'green' heating and electricity generating 'green' electricity locally with our Photovoltaic Solar Farm
- 51% of the Trust's electrical power was generated from 'green' technologies in 2017/18
- Installing efficient theatre ventilation systems which recover heat from extract air
- Turning off computers automatically when they are inactive

### Promoting Sustainable Procurement

- Ensuring we purchase goods and services from local and sustainable sources
- Buying food from local sources and cooking meals in our hospital
- Designing and constructing buildings to the latest BREAM standards

### Promoting Sustainable Travel and Transport

- Establishing a Health and Wellbeing group which promotes walking and cycling to work
- Providing bicycle storage facilities for staff and visitors
- Discouraging unnecessary vehicle use by charging for car parking
- Promoting the use of low emission vehicles
- Providing low emission and electric cars within the staff car pool
- Promoting low emission vehicles for all lease cars

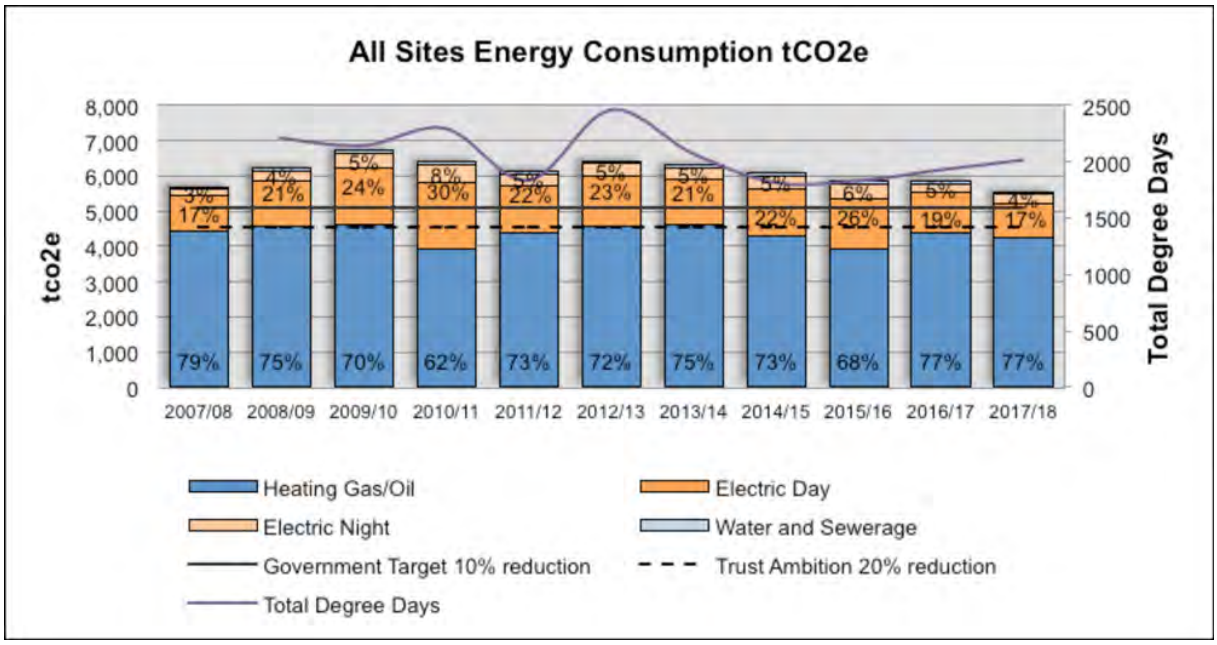
### Reducing waste

- Reducing printing by the use of electronic documents and tablets etc.
- Recycling confidential waste paper
- Recycling cardboard
- Recycling old used batteries
- Recycling cooking oil from the hospital kitchens
- Recycling printer cartridges, etc.

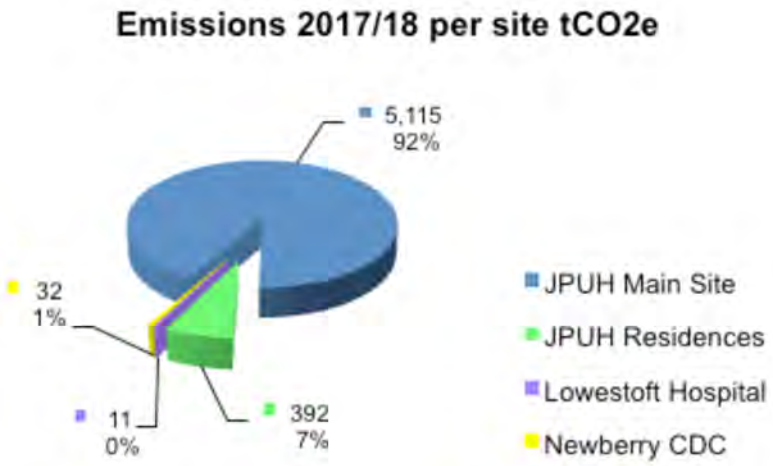
## Reducing our emissions

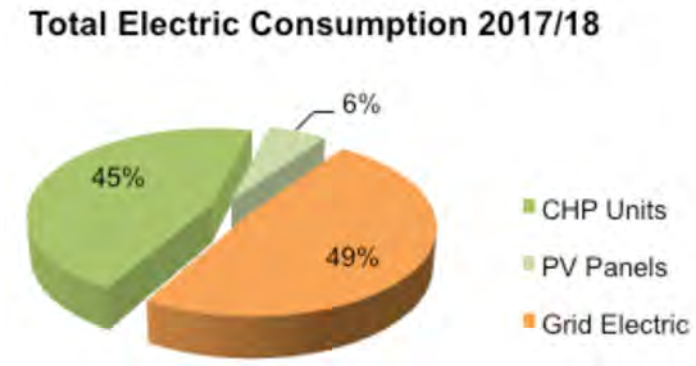
We have made significant capital investment to help reduce CO2 emissions since the introduction of a baseline and reduction target in 2007.

Over the past 12 months the total emissions produced by the Trust from imported gas, oil and electricity have reduced from 5,780 tCO2e to 5,554 tCO2e despite additional business activity and a harsh winter. The CO2 emissions have been reduced by improved utilisation of renewable energy sources (e.g. Combined Heat & Power Generators, PV Solar panels and efficient boiler plant) and as a result of site rationalisation.




The James Paget Hospital site is responsible for 92% of the Trust's overall CO2 emissions. The Staff Residences, Lowestoft Hospital and Newberry Child Development Centre collectively equate to 8% of the Trust's total emissions.



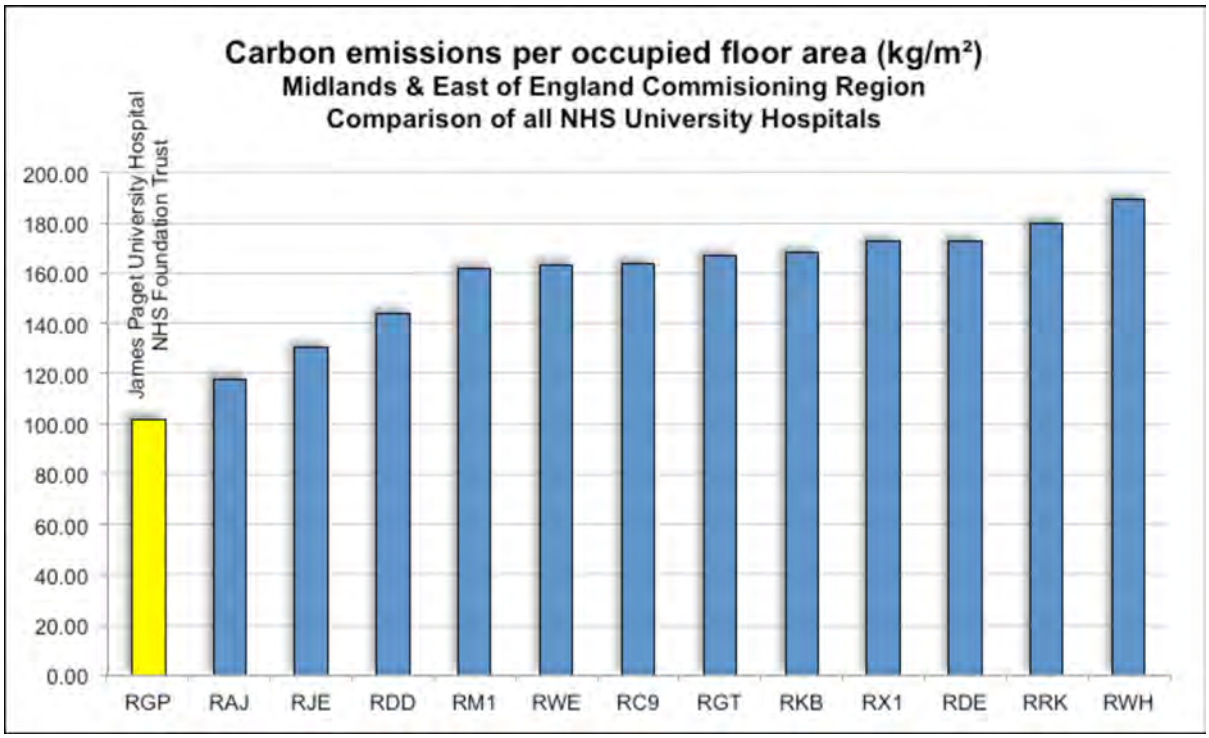




In the 2017/18 reporting period 51% of the Trust's electrical power requirement was generated from 'green' technologies including PV Solar generation and Combined Heat & Power plant.

## Comparative sites

It is possible to compare the Trust with similar organisations via the annual ERIC (Estates Return Information Collection) returns.

The ERIC data is collected by the Health and Social Care Information Centre and is published on behalf of the Department of Health. The following graph shows the total amount of Carbon Emissions per occupied floor area for NHS University Hospitals for the latest published reporting period.




*Data Source: Estates and Returns Information Collection: England 2016/17*

## Future developments

Salix Finance Ltd (Salix) provides interest-free Government funding to the public sector to improve their energy efficiency, reduce carbon emissions and lower energy bills. Salix is funded by the Department for Business, Energy and Industrial Strategy, the Department for Education, the Welsh Government and the Scottish Government and was established in 2004 as an independent, publicly funded company, dedicated to providing the public sector with loans for energy efficiency projects.

We are reviewing a number of opportunities which may be funded via Salix in 2018/19 including:

- Optimisation and upgrade of the Building Management System
- Removal of the steam heating system and installation of an energy efficient heat source for ICU/HDU
- Replacement of existing internal and external lighting with efficient LED lighting.

## Post year end events

The Trust will be considering and responding as appropriate to local commissioners NHS Great Yarmouth and Waveney Clinical Commissioning Group (CCG) as they seek changes in the delivery of a wide range of predominantly out of hospital services.

**Christine Allen**
**Chief Executive and Accounting Officer**
**21 May 2018**

# Accountability report:

## Directors' report

### The Code of Governance

The following disclosures relate to the Trust's governance arrangements and illustrate the application of the main and supporting principles of NHS Improvement's Code of Governance (the Code). The 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.

In accordance with the Code, the Directors consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, the regulator and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. The Directors confirm their responsibility for preparing the Annual Report and Accounts.

The Trust has applied all the principles of the Code which underpin the governance processes in place. A full assessment of compliance against each element of the Code was conducted on first publication and updated in line with the revised version, July 2014, and again in 2016/17.

There have been no changes this year that would impact on the Trust's compliance with the Code. The main elements are set out within this section of the report:

**Code section A/B: The role of the Board of Directors and its responsibilities; Governors**

- Full details of the Board role, its membership, appointment dates and areas of responsibility are set out on page 20
- 10 meetings of the Board of Directors have been held in public, with justification required for any report considered in private
- Some changes have been made in the way that the Council of Governors works to provide additional Non Executive assurance. Further information can be found at page 68
- Appointments and performance reviews are included within the Remuneration Report at page 38
- Non Executive Director independence is considered annually with more detail at page 25. In reviewing Board diversity, there has been engagement with NHSI on their NExT Director scheme. Following a successful pilot in London this programme, which involves placing an aspiring Non Executive Director with a Trust for a 12 month period, has been widened. We are keen to participate in this programme and will continue to work with NHSI to take this forward. We will also consider other ways of enhancing the diversity of input into Board discussion as we move through the year.

**Section C: Accountability**

- Requirements are discharged through this annual report and regulatory submissions to NHSI
- Information on the Audit Committee can be found at page 33

**Section D: Director remuneration**

- Contained within the Remuneration Report.

**Section E: Relations with stakeholders**

- A full review of our stakeholder relations is undertaken at least every six months to ensure that we continue to focus on these important links
- We are a key partner within the Norfolk and Waveney STP, with the Chief Executive leading on the acute work
- The Trust chairs the Norfolk Acute Hospitals Group that is looking at how services can be redesigned across the acute sector in Norfolk
- From April 2018 changes are being made to Board meetings to enable additional opportunities to engage with staff and patients, ahead of our staff engagement strategy being finalised in 2018/19
- More information can be found within our patient care section on page 27 and the membership section on page 72.

The elements that are not applicable in year are:

- An explanation if neither external search nor open advertising was used to appoint a Chair or Non Executive Director – external advert used in all recruitment
- Use of the Council's power to require one or more of the directors to attend a governors' meeting – not required as the agenda setting ensures attendance when required to provide more information on specific subject areas
- No Executive Directors have been released to serve as a Non Executive Director elsewhere.

## Meet the Board of Directors

### The Board's role

The Board provides leadership and sets the tone for the organisation. As a unitary board, the Non Executive Directors share responsibility with the Executive Directors for ensuring that resources are in place to meet the objectives set. In an emergency, powers are exercised by the Chief Executive and Chair after having consulted at least two Non Executive Directors.

The Chair leads both the Board and the Council of Governors, ensuring that there are effective processes in place for the Board and Governors to work together and, with the Chief Executive, that there is an accurate record of decision making. Terms of reference, which are reviewed annually, set out the detailed responsibilities including promoting the success of the organisation to maximise the benefits for members and the public.

The Board sets the strategic direction and the objectives, having taken account of staff and stakeholder views, and oversees the running of the Trust by annually assessing that the conditions of the Provider Licence are being met.

The Board meets every month, with more informal monthly Board Seminars for briefing, mandatory training and development.

Membership and attendance at the Board of Directors is set out below:

| | | Meeting Date | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name of Person | Role | 28/04/17 | 22/05/17 | 26/05/17 | 30/06/17 | 28/07/17 | 29/09/17 | 20/10/17 | 24/11/17 | 26/01/18 | 23/02/18 | 06/03/18 |
| Trust Board of Directors | | | | | | | | | | | | |
| David Wright | Chairman | 1 | | | | | | | | | | |
| Anna Davidson | Chair from 1/5/17 | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Christine Allen | Chief Executive | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 |
| Mark Flynn | Director of Finance | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Julia Hunt | Director of Nursing | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Nick Oligbo | Medical Director | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Graham Wilde | Chief Operating Officer | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Hazel Stuart | Medical Director from 5/3/18 | | | | | | | | | | | 1 |
| Anna Davidson | Deputy Chair to 30/4/17 | 1 | | | | | | | | | | |
| Peter Hargrave | Non Executive Director Senior Independent Director | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 |
| David Ellis | Non Executive Director | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | | | |
| Paula Kerr | Non Executive Director | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Roger Margand | Non Executive Director | | | | | | 1 | 1 | 1 | 1 | 1 | 1 |
| Professor David Scott | Non Executive Director | | | | | | 1 | 0 | 1 | 1 | 1 | 1 |
| Professor Nicola Spalding | Non Executive Director | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Non voting members | | | | | | | | | | | | |
| Dawn Cumby | Associate Director of Workforce (to December 2017) | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 0 | | | |
| Linda Burton | Associate Director of Workforce (from March 2018) | | | | | | | | | | | 1 |
| Anna Hills | Director of Governance | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Andrew Palmer | Director of Transformation | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 |
| Jon Barber | Director of Strategy (six month fixed term from February 2018) | | | | | | | | | | 1 | 1 |
| Ann Filby | Head of Communications and Corporate Affairs (Trust Secretary) | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

1 = Attended 0 = Did not attend

The Executive Team meets separately, chaired by the Chief Executive as the Accounting Officer.

The Chair ensures that meetings take place with the Non Executive Directors only, without the Executive Directors, as necessary.

The Trust Secretary oversees the functions of the Board of Directors and the Council of Governors to ensure that they work effectively and in line with the Code. She leads on the Trust's Constitution and the wider Corporate Governance Framework, both of which set out how we work. This ensures that all our processes fit together and that our Governors are consulted at the right time on any 'significant transactions' and any major changes to services that could affect our patients. There is a clear process in place for Governors to raise issues and, if these are not resolved satisfactorily, the Senior Independent Director will deal with any disputes.

# Meet the Board of Directors

The Board membership for 2017/18 is set out below:

## Voting Board Members

**Anna Davidson - Chair**

Appointed Chair by the Council of Governors in May 2017. Joined the Trust as a Non Executive Director in February 2016, becoming Deputy Chair in November 2016.

Anna has worked predominantly within the public and private sectors, most recently as a senior executive director within the Norse Group, which she left in August 2015. During her 10 years at Norse Property Services (NPS), Anna was a key member of the Strategic Leadership Team and her responsibilities included business development, strategic planning and the development of new joint ventures and consultancy services.

She has previously been a Director on the boards of three subsidiary companies within the Norse Group as well as being a Director on the Board of the North Lincolnshire Local Education Partnership, where NPS was a founding partner.

Responsibilities: Chair of Board of Directors; Chair of Council of Governors and Committees; Chair of Charitable Fund Trustees; Chair of Executive Nomination and Remuneration Committee; Non Executive lead for safeguarding, STP partnerships, business developments and joint ventures.

## Executive Directors

**Christine Allen - Chief Executive**

Appointed July 2013

Christine has worked for the NHS for over 30 years, including as Deputy Chief Executive at Northampton General Hospital NHS Trust prior to joining the Trust.

She also held both operational management and strategic planning roles at board level and has led significant transformational change and service redesign in clinical services.

Responsibilities: Accounting Officer including Freedom to Speak Up processes.

**Mark Flynn - Director of Finance**

Appointed April 2014

Mark has worked at the hospital since 2007 inititally as Deputy Director of Finance and then as Director of Finance from 2014. Mark previously held senior finance roles within the social housing sector, with over 20 years finance experience gained in both the public and private sectors.

Mark is a Governor at the Lowestoft Sixth Form College and chairs their Audit Committee. He is a Fellow Chartered Certificated Accountant (FCCA) and is also a member of the Association of Accounting Technicians (MATT).

Responsibilities: Finance; Contracting; Procurement; Commercial Strategy; Estates and Facilities; Sustainability: Energy Carbon Management; Charitable Fund; Counter Fraud.

**Julia Hunt – Director of Nursing**

Appointed December 2016 (Acting role from May 2016)

Julia is a registered nurse who has worked in the NHS for over 28 years. She has spent the majority of her career at James Paget University Hospitals performing a variety of roles including; Clinical Nurse Specialist in Palliative Care and Head Nurse for Safeguarding Adults.

The majority of Julia's nursing practice has been in emergency medicine.

Responsibilities: Lead for Nursing, Midwifery and AHPs; Co-Director/Joint Executive with Medical Director for Clinical Practice; Director of Infection Prevention and Control (DIPC); Safeguarding Lead; Nurse/Midwifery Revalidation; End of Life; Learning Disabilities; Dementia; Non-medical education; Chaplaincy.

**Nick Oligbo - Medical Director to 31/3/18**

Appointed April 2013

Nick has been a consultant obstetrician and gynaecologist at the hospital since 2001 and has presented and published widely in gynaecology, both nationally and internationally.

He is a Fellow of the Royal College of Obstetricians and Gynaecologists where he sits on the patient information committee. In addition he is a member of the International Continence Society, as well as the International Urogynaecological Association.

Responsibilities: Lead for Medical and Dental practitioners including medical education; Co-Director/Joint Executive (with Director of Nursing) for Clinical Practice; Medicines Management Lead (incl lead for pharmacy); Clinical Audit and Effectiveness; Radiation; Seven day services; Caldicott Guardian; Mortality; Medical revalidation; Cancer; Research.

**Hazel Stuart - Medical Director**

Appointed from 5 March 2018

Hazel has been a Consultant Anaesthetist at the Trust since 1999 and was Deputy Medical Director at the hospital from 2013, before being appointed as Medical Director in March 2018.

Born in Great Yarmouth general hospital, she went to Great Yarmouth Grammar School before beginning her medical career at the James Paget hospital in 1981 as a nursing auxiliary, prior to going to medical school. Qualifying in 1987, Hazel's work then saw her training in obstetrics and gynaecology, paediatrics and emergency medicine and her varied career has seen her working at St George's hospital in London, as well as in the Australian outback.

Responsibilities: Lead for Medical and Dental practitioners including medical education; Co-Director/Joint Executive (with Director of Nursing) for Clinical Practice; Medicines Management Lead (incl lead for pharmacy); Clinical Audit and Effectiveness; Radiation; Seven day services; Caldicott Guardian; Mortality; Medical revalidation; Cancer; Research.

**Graham Wilde - Chief Operating Officer**

Appointed March 2017 (Acting role from September 2016)

After spending 12 years in the RAF as an engineer, and eight years as a Baptist Minister, Graham joined the NHS in 2000 as a Hospital Chaplain. Graham moved in to general management. Graham has held senior roles in both Acute sector provision and commissioning; these include Divisional General Manager roles in both Medicine and Surgery in the Acute Sector, and was a Director of Strategy and Partnership in North East Lincolnshire Care Trust Plus, which was an organisation responsible for commissioning and providing Community Health and Social Care.

Graham first joined the Paget's team in June 2015.

Responsibilities: Operational delivery and performance, Hospital Management Board; Emergency Preparedness and Business Continuity; Health and Safety; Security Director; Decontamination.

**Linda Burton - Associate Director of Workforce**

Appointed March 2018

Linda is responsible for the design and implementation of the Trusts' Workforce and OD strategy, that supports and strengthens the organisation in providing a patient focused service whilst meeting its key strategic and operational targets. This includes having appropriate policies and procedures in place to attract and retain our people whilst meeting the Trust objectives. She provides expert advice and support to our leaders and managers on all workforce related matters with a strong focus on engagement and partnership working.

Linda has worked for a number of different NHS organisations since October 2001, including acute trusts and more latterly for NHS Property Services, an organisation set up to focus on the estates and facilities management of over 4,000 NHS properties.

Her background is in both the private sector having worked within HR for Price Waterhouse, Tesco and Whitbread as well as the NHS. She is a member of the CIPD.

Responsibilities: Employee relations and staff engagement; Apprenticeships; Medical staffing; Recruitment and training; Organisational and leadership development; Workforce strategy and planning; Operational HR functions; Library services; Equality and Diversity.

**Andrew Palmer – Director of Strategy and Transformation; Director of Transformation from February 2018**

Appointed on the Board from December 2013 as Associate Director; Director role from January 2015
Andrew has worked in a variety of senior management roles over the last 24 years in both the public and private sectors, with the last 16 years working for the NHS.
Responsibilities: Performance management framework; Information Technology & Security; Information Governance; Senior Information Risk Owner (SIRO); Data Protection Officer (DPO); Chief Information Officer; Informatics; Health Records; Finance Project Management Office (PMO): financial recovery; Service transformation.

**Jonathan Barber – Director of Strategy**

Appointed February 2018 (six months fixed term)

Jonathan has worked at the hospital since 2014, initially as a joint appointment with the Great Yarmouth and Waveney CCG. He has been Deputy Director of Strategy and Transformation since 2016 and became the Director of Strategy in February 2018 as a result of changes in Executive portfolios. Jonathan previously held senior management roles in both local and central government and holds an MBA in public sector management.

Jonathan is Vice Chair of a Housing Association and has held a number of other non-executive positions.

Responsibilities: Strategic Planning, Trust lead for the Norfolk and Waveney Sustainability and Transformation Partnership; Partnership working; Transformation team.

**Anna Hills – Director of Governance**

Appointed on the Board from December 2013 as Associate Director;
Director role from October 2015, Deputy Chief Executive from 1 April 2018

Anna has worked at the Trust since 2010 and has held a number of previous roles within the NHS and private sector leading quality, assurance and service development activities. Anna has a clinical background, having originally trained as an orthoptist. Anna has responsibilities for a range of portfolios including patient safety, patient experience, clinical audit, medico-legal services, health and safety, compliance, risk and governance and communications.

Responsibilities: Accountable Officer for Controlled Drugs; Clinical governance/compliance; Care Quality Commission registration Corporate governance; Communications; Corporate Affairs; Freedom of Information Act;
Executive oversight of Workforce; Health and Safety/Fire.

## Trust Secretary

**Ann Filby - Head of Communications and Corporate Affairs**

Appointed to Trust 2006; Head of Communications from September 2010

Ann joined the Trust in 2006 to manage the Monitor assessment process for becoming a Foundation Trust, having previously worked in a community NHS Trust and a Primary Care Trust in Norwich. Ann has since held a number of slightly different roles, but all encompassing elements of communications and has managed Board processes since joining the Trust. From 2015 Ann has taken over responsibility for the Trust's corporate office supporting the Board of Directors and management of Freedom of Information requests.

Ann is an accredited PR practitioner and Member of the Chartered Institute of Public Relations.

Responsibilities: Trust Secretary: Board of Directors, Council of Governors, Trust membership; Trust's corporate office: compliance and constitutional issues; Conflicts of Interest and Hospitality policy; Fit and Proper Person requirement implementation; Internal/ external communications; Freedom of Information Act; Corporate publications and Patient information.

## Non Executive Directors

**Paula Kerr - Non Executive Director**

Appointed by the Council of Governors for her first three year term of office from 1 November 2016 until 31 October 2019

A former group director at pharmaceutical company SmithKline Beecham and chair of a national charity Paula has experience at board level in private, public and voluntary sector organisations in the fields of health, social care and education.

She joins the Trust after spending more than three years working as a trustee, vice chair and chair of trustees at Livability, a national charity providing disability and community services. Prior to that, Paula has had Non Executive roles in an acute hospital, a Mental Health Trust and a Strategic Health Authority.

Responsibilities: Business and marketing strategy; Trust sustainability and transformation; Procurement.

**Professor Nicola Spalding - Non Executive Director, representing the University of East Anglia**

Appointed by the Council of Governors for her first three year term of office from 1 April 2016 until 31 March 2019

Nicola is an occupational therapist, who previously worked at the James Paget Hospital for nine years specialising in orthopaedics and palliative care. For over 20 years she has worked as a lecturer in occupational therapy, and was appointed as Professor of Occupational Therapy in 2013. Nicola teaches preregistration occupational therapy students, and also lecturers on a Masters programme in clinical education to support health and social care professionals who want to enhance their role as educators in the workplace.

As well as lecturing Nicola has had a number of leadership roles at the university, including Course Director for both the BSc and MSc preregistration Occupational Therapy programmes, Teaching Director for the School of Allied Health Professions, Associate Dean for the Faculty of Medicine and Health Sciences and Deputy Head of the School of Health Sciences.

Responsibilties: Chairs the Board's Workforce, Education and Research Committee; workforce; chairs the Trust's Remarkable People Organising Committee.

**Peter Hargrave - Non Executive Director and Senior Independent Director**

Appointed by the Council of Governors for his first three year term of office, until October 2016. Reappointed for a second three year term until 13 October 2019

Peter has worked across a number of Non Executive roles, including Vice Chair of Broadland Housing Group, and Board member of NHS Great Yarmouth and Waveney, Great Yarmouth Port Authority and the Ministry of Defence Police and Guarding Agency.

His professional background is in accountancy and management, having worked across public, private and not-for-profit sectors.

Responsibilities: Chair of the Board's Audit Committee; Counter fraud; Raising Concerns/Freedom to Speak up Guardianship; Security; Emergency Preparedness, Resilience and Response.

**Roger Margand - Non Executive Director**

Appointed by the Council of Governors for his first three year term of office from 1 September 2017 until 31 August 2020

A partner at Spire Solicitors LLP in Norwich, Roger has extensive experience in commercial legal transactions, advising management teams and drafting and reviewing commercial contracts. He has worked with charity and non-profit organisations alongside property developers, surveyors, banks and pension funds and has provided regulatory advisory and support for a variety of boards as well as company secretarial services.

A graduate of the University of East Anglia, he was admitted to the roll of the Law Society in 1996 after qualifying as a solicitor and also holds Chartered Institute of Marketing and Advanced Employment Law qualifications.

Responsibilities: Chair: Board's Finance and Performance Committee.

**Professor David Scott - Non Executive Director**

Appointed by the Council of Governors for his first three year term of office from 1 September 2017 until 31 August 2020

Previously an honorary senior lecturer in Rheumatology at the University of East Anglia and at the Royal London Hospital Medical College, David is a consultant rheumatologist and fellow of the Royal College of Physicians. David has undertaken a range of roles during his career including director of research and development at the Norfolk & Norwich University and Clinical Director of Norfolk & Suffolk Comprehensive Local Research Network.

Responsibilities: Chair's Board's Safety and Quality Governance Committee; Mortality; Care of the Dying (End of Life); Medical Revalidation; CEA Awards; Quality; Infection Prevention.

## Other Board members during the year

David Wright, Chairman, left the Trust on 30 April 2017 having tendered his resignation in December 2016. David had served almost two years of his second three year term of office.

Dr David Ellis, Senior Independent Director, served his two three year terms of office. David led the Board's Safety and Quality Governance Committee, leaving the Trust on 30 November 2017.

Dawn Cumby, Associate Director of Workforce, retired at the end of December 2017, after over two years in the role.

## Board member interests

A new Conflicts of Interest and Hospitality Policy was implemented in year in line with national guidance, which also reflects the potential for bribery. For some years, to ensure transparency, Board member interests have been included as part of the Board meetings in public, which are available on the Trust's website. This has been enhanced to include all decision makers.

On appointment, new Board members complete a declaration with any changes during the year declared to the Head of Communications & Corporate Affairs (Trust Secretary) immediately and formally included at the next meeting. This process forms part of the annual review of the CQC's Fit and Proper Person Requirement for directors, with the Chair reviewing the evidence for all Board members. Further details are available from the Trust Secretary on request.

## Non Executive Director independence

In line with regulatory guidance the Chair must, on appointment, meet the independence criteria, which forms part of the recruitment process. The Board of Directors considers on an annual basis whether the Chair and the other Non Executive Directors continue to meet this criteria.

The Board has previously agreed that the annual review of the Declarations of Interests would be sufficient for confirming independence. There have been no significant changes in the commitments that would affect the Chair's ability to carry out her role, and in considering all other declarations, the independence of the Chair and all Non Executive Directors is confirmed for the year to 31 March 2018.

## NHS Improvement's well-led framework

In 2016/17 the Trust instructed the Capsticks governance team to undertake a governance review in line with this framework. This met regulatory requirements to commission an external review every three years and was in addition to the detailed review of the Board, its Committees and the Council of Governors undertaken each year. The outcome was reported to the Board of Directors on 16 December 2016.

The report was positive whilst there was work undertaken to further enhance Trust processes with Board members agreeing the action plan following discussion at two Board Seminars in early 2017. A report was presented to the Board of Directors in April and October 2017 with the Trust Secretary ensuring progress on the actions in-year.

Significant progress has been made to refine processes and ensure continuous improvement on the priority themes of:

- Staff and stakeholder engagement
- Divisional
- Strategy
- Board experience, capacity and capability to lead
- Board reporting and processes
- Board Committees.

This work included how we take account of junior doctors' views, enhanced Board engagement, changes to internal communications mechanisms, a relaunch of the Speak Up Guardians, a review of the clinical leadership structure, additional support to Divisional governance processes, more strategic use of Board Seminar time, Board Committees reporting on their work in public, a new Committee focused on workforce, education and research, effective use of talent mapping and support to the Council of Governors.

This year's Board seminar programme was linked to the strategic ambitions and was more effective and much more strategic in nature, limiting discussion on operational matters. Effectiveness was considered at a Seminar in March 2018 which concluded that these sessions saw more challenge and debate, with a much better, balanced discussion in this less formal setting. There was good, constructive challenge between both Executive and Non Executive Directors and a sense of common purpose.

A new Meeting Effectiveness Policy has been implemented Trust-wide from April 2018 following a full review of existing processes. This policy provides standard templates, processes and timetables for agendas, minutes, action logs and an annual work programmes. It also clarifies the role of the meeting administrator, chair and attendees to ensure good use of time and effective decision making at any formal meeting. The Board follows the processes already with all Committees now brought into line.

In early 2018 the Board structure and effectiveness was further considered to reduce duplication and enable more effective use of Board resource for the new financial year 2018/19. Having a structured approach to managing Board time, optimising efficiency and enabling sufficient assurance to be provided, remains a priority. To enable this a change to the current meeting structure has been agreed following benchmarking against trusts rated as Outstanding by the CQC.

From 1 April 2018 Board meetings will be held in public on a bi-monthly basis, in May, July, September, November, January and March representing a reduction of four per year. This will allow for additional opportunities to engage with the staff providing services and the patients receiving them, in addition to the long standing Board to Ward visits undertaken prior to each Board meeting.

A programme of enhanced engagement visits will be implemented early in 2018/19 with individual services also meeting with the Board as part of a rolling programme. This will enable Divisional and corporate management teams to present service improvements that have had a positive impact on our patients. It will increase the opportunities for our staff to talk to members of the Board so that we can really understand the issues that affect them and their working lives. When the Board is not meeting in public the majority of reports will continue to be published on the Trust's website and circulated by email to the Council of Governors.

Whilst the final report to the Board in March 2018 closed the action plan on the governance review we will continue to review the effectiveness of the governance and meeting structure that enables decision making. Changes will be made where this is felt to be necessary.

There is further work to do on the use of Model Hospital data to benchmark and drive improvements and implementation of the new clinical leadership structure. Refinements to performance reporting to the Board will take effect from May 2018.

Further information on our governance processes can be found within the Annual Governance Statement.

## Patient care: developing our services and our facilities

We continue to learn and improve the quality of service we offer and to go the extra mile for our patients through listening to the feedback we receive. We are committed to continuous improvement and that means developing our services so that they meet the changing needs of our patients.

A rolling programme of Sustainability and Service Reviews internally started this year. These will propose options to redesign services, ensuring improved outcomes for patients whilst securing efficiency savings.

We are continuing to develop our services and plan for the new CQC annual assessment. The Trust is currently rated as Good with two Outstanding ratings for quality of care for end of life and leadership of urgent and emergency services. We expect the CQC to assess us during summer 2018. Further detail on the work undertaken following their previous visit can be found in the Quality Report.

During 2017/18 we have seen higher than expected mortality rates, which we have taken extremely seriously. Our governance arrangements for learning from deaths have been continuously reviewed and an internal audit review has provided assurance that we were on track to achieve completion of our system and process changes, including our Learning from Deaths Policy which we published in September 2017. The Learning from Deaths Policy sets out our arrangements for identifying and reviewing mortality cases. Alongside this we have been working through a Mortality Action Plan which is monitored at the Mortality Surveillance Group (MSG) monthly and reported to the Safety and Quality Governance Committee. More detail can be found in the Quality Report.

We work with local groups through our patient experience lead, with a new Service User Group meeting for the first time early in 2018/19. We meet regularly with HealthWatch and ensure that the Norfolk, Suffolk and Great Yarmouth Scrutiny Committees are fully informed on our work. Senior managers provide reports and attend meetings as required.

The Commercial Strategy has been approved this year which enables the Trust to work in partnership with commercial companies. This provides opportunities for more cost effective services whilst maintaining the quality of care needed by our patients. This year we began work on improvements to our hospital foyer which will continue during 2018/19.

We are working to do the very best we can to provide the services that our population want and need, with a stronger emphasis placed upon staff having the requisite skills and competence to recognise when someone is entering the latter stages of life and to support them. Our focus is on working with other organisations to provide the model of care that enables patients to make the right choices for themselves and their families and ultimately enables them to die in their place of choice, supported by the right people. Our aim is to provide The Gold Standards Framework training throughout the Trust, supported by our palliative care team. We hope to work with the community services provided to enable as many patients as possible to be discharged home if that is their wish. This work will continue to develop in 2018/19.

Here are some examples of service developments introduced over the past year - further detail on this year's quality improvements and plans for the coming year can be found in the Quality Report.

## New Bowel Cancer Screening Service

A new service for local patients was launched at the hospital in the autumn. Bowel cancer is one of the most common cancers in the UK, with more than 40,000 people being diagnosed every year, but it is treatable and curable if it's diagnosed early. Bowel scope screening is a new test aimed at detecting bowel cancer at an early stage in people with no symptoms, when treatment is more likely to be effective. It looks at the lower bowel to detect and remove small growths known as polyps, which can go on to develop into bowel cancer. The screening is carried out by the hospital's Endoscopy team and uses a thin, flexible tube with a tiny camera on the end to look at the large bowel. It only takes a few minutes to complete.
The new test is being offered to all men and women aged 55 as part of the NHS Bowel Screening Programme.

## Sight-saving eye treatment

New eye clinic facilities which offer a sight-saving treatment have opened at Beccles Hospital. The Trust's ophthalmology team are using the facilities to offer patients a range of services, including a procedure to combat the effects of wet Age-relative Macular Degeneration (AMD), which is the most common cause of blindness.
The facilities include a treatment room where patients receive the injections into the eye ball which combat AMD. Wet AMD affects the macular, which is the central part of the retina that allows people to see by detecting light. It is caused by scar tissue which is created as part of an out of control healing process when tiny blood vessels grow and leak at the back of the eye.

Symptoms include distortion of vision, which means that straight lines look bent, and this leads to blindness within five years without the injection treatment, which only became available10 years ago. The injections are helping save patients' sight when previously they would have gone blind – and rates of blindness have halved since they were introduced. More than 2000 patients receive the injections at the Eye Clinic in Gorleston – with more being referred every week.

The Eye Clinic facilities at Beccles Hospital will help meet this growing demand while providing a service closer to home for residents in Beccles, Bungay, Halesworth and the villages of the Waveney Valley. This has been made possible through working in partnership with NHS Great Yarmouth and Waveney CCG, with support from the Friends of Beccles Hospital.

### The latest in Digital Radiography

Our hospital now has the very latest X-ray equipment to help with the diagnosis of a range of conditions. The equipment was installed in early 2018 in a dedicated area inside the hospital's Diagnostic Imaging department – and helps our team see more patients than was possible using the previous system. At the touch of a button, operators can precisely position the entire system (pictured), which features a patient table and wall stand.


The system is wireless, meaning that images are transferred in seconds from camera to computer. These images can then be enhanced and reviewed, before being entered on hospital computer systems. It is mobile too. There are two imaging machines which can be taken anywhere in the hospital, so ideal for patients with little or no mobility. The units are incredibly versatile, can be positioned in seconds and are easy to move as they have electronic assistance.

## Developing our facilities


Along with other hospitals across the country, we have seen an increase in the number of patients coming through the doors of A&E, putting increased pressure on our bed capacity. We are working closely with our healthcare partners to meet this current demand and will look to develop new healthcare models that will see our hospital focus more closely on patients who need specialist or emergency care.

In the meantime, we are developing our hospital to meet current demand. A multi-phased programme of refurbishment will increase the capacity of our Emergency Department and other improvements will help us ensure that patients who no longer need our care can leave hospital as soon as possible.

### Short Stay Medical Unit


During the course of last year, we moved our Short Stay Medical Unit (SSMU) to the ground floor of the hospital immediately next to the Emergency Assessment and Discharge Unit, with easy access to Ambulatory Care (AmbU), and close to the Emergency Department

This has resulted in greater continuity of care for patients whose stay in hospital is predicted to be 72 hours or less, helping improve patient flow while reducing delays in discharge.

## GP streaming


We introduced GP streaming to help reduce pressure on our A&E department while ensuring patients receive the right level of care. A senior nurse assesses all who come through the doors of our A&E department and 'streams' them according to their healthcare needs, with some going into the Emergency Department while others are sent to see a GP in dedicated consulting rooms which we constructed towards the end of the year.

## Discharge Hub

We set up our Discharge Hub, which is home to a multi-disciplinary team with staff from the hospital, NHS Great Yarmouth and Waveney CCG, Norfolk County Council, Suffolk County Council and local voluntary organisations.

The team works across the hospital to identify those patients who no longer need a hospital bed but may require care services, to ensure that they are discharged home and then assessed for their ongoing care once they have left hospital.

This approach – known as 'discharge to assess' – helps reduce delays in patient discharge, helping people get home more quickly so that they receive the right level of care in the right setting and do not spend any more time than is necessary in a hospital bed.

## Ambulatory Care

We began work on converting office space so that we can expand AmbU. This is an outpatient service that brings healthcare teams to the patient. The unit is designed to be a 'one stop shop' for patients as it facilitates diagnosis, observation, consultation, treatment and rehabilitation services to take place in one area of the hospital. The aim is to improve efficiency of patient care, reduce patient time in hospital and prevent admission.


Ambulatory care is nationally recognised as an effective way of delivering safer care for an increasing number of conditions, while improving patient experience and clinical outcomes. At our hospital, AmbU has helped reduce admissions but has seen a huge increase in activity, above and beyond its capacity.

Our plans are to more than double the size of our unit so that it can cater for more patients each day and more people can benefit from receiving their care in this way.

## Ward redecoration

We have progressed with the redecoration of our ward areas, which includes painting the bays in different colours to create a dementia-friendly environment.

## Improving the hospital foyer

During the year we unveiled our plans to improve the foyer of our hospital, as part of our Commercial Strategy, which will see the creation of new catering facilities to improve patient choice.

We are working with a major retailer on plans for a new store which will provide a range of fresh hot and cold food and sell other items such as toiletries, while offering patients, their families, visitors and staff modern, fresh, facilities including a 'barista' style coffee shop and a brand new seating area.

The new facility will replace Paget's Café and its seating, which has served patients, visitors and staff well for more than a decade but is cramped and now in need of refurbishment. Creating the new catering facility, at no cost to the Trust, will in the future provide a source of income that will be used to support healthcare at our hospital.

This has meant that we are saying goodbye to the League of Friends shop that has been a feature of our foyer for a number of years. Whilst alternative fundraising office options were offered, the Friends have made the decision to close their charity. We recognise their disappointment at this change and our sincere thanks have been passed to all the Friends for their dedication over a number of years. We are hopeful that some of them will join our own volunteering team in the coming months and continue to provide vital support to our staff and patients.


Pictured are Outpatient Manager Jeanette Taylor and nursing auxiliary Mary Lewis with two urinary flow machines, purchased with a £7000 donation by the League of Friends. This is one of the many generous donations the League of Friends have given to the JPUH over the years.

## Improvements in patient/carer information

This year there has been a renewed focus on the accuracy of content on the Trust website. The communications team has sought staff support Trust-wide to maintain specific sections, or just to let us know when there is something out of date. A number of new pages have been launched, with significant revisions to others. We are currently reviewing the home page and main sections to consider ways in which the content could be rearranged or images could be used to make it easier for patients and visitors to find what they need.

The Accessible Information Standard is being implemented with a policy in place. Posters are on display in all areas to support the communication needs of service users and to raise information awareness for staff and patients.


Patient passports are in use which detail information specific to those patients who have additional needs.

Staff are providing patients with contact details on discharge should further support be required.

The Patient Information Committee processes have been reviewed to enhance the governance related to patient leaflet/ information development.

Action plans are developed to address themes from the findings of national surveys which include information and communication improvement actions. Bespoke local surveys have been carried out to measure the patient experience, aligned to national survey findings specific to improving communication and information. Further detail about specific actions taken can be found in the Quality Report.

## Complaints handling

This is carried out in line with the NHS Complaints procedure. Written acknowledgement is sent to the complainant within three working days. Telephone contact is made by the Complaints Investigator, wherever possible, to discuss the issues and assess response timescales, depending upon the complexity of the issues raised.

The complaints team works in collaboration with the Divisional teams to ensure that there is an agreed, informative response provided which covers all the concerns. Complaints are reviewed by members of the Executive Team before final Chief Executive sign off.

At both the initial contact with a complainant, and at the point a closing response letter is sent, we offer the opportunity for the complainant/family/carer to meet with the senior management team involved in order to support resolution.

As a Trust, we use complaints handling Key Performance Indicators (KPIs) to monitor performance. An annual complaints process experience survey is also undertaken.

The number of complaints, themes and trends are discussed in detail within our governance processes/meetings to ensure that learning takes place and actions are implemented where complaints are upheld/partially upheld. An annual report is presented to the Board of Directors.

## The Audit Committee

Peter Hargrave, Non Executive Director, was Chair of the Audit Committee throughout 2017/18. The Director of Finance, the Director of Governance, the Head of Internal Audit, a Local Counter Fraud Specialist and a representative of the External Auditors normally attend meetings of the Committee. The Trust Chair and Chief Executive attend by invitation.

Meetings are held not less than five times a year. The Committee receives reports and assurance from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

In particular, the Committee reviews the adequacy of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board of Directors
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the disclosure notices
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, and
- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the NHS Counter Fraud Authority.

The Committee receives a monitoring report at each meeting on the progress of the internal audit programme in accordance with the agreed audit plan. The overall effectiveness of the work of the internal auditors is reviewed through annual monitoring against agreed KPIs.

Assurance is sought from a number of areas, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness:

- The work of Internal Audit
- The work of the Local Counter Fraud Specialists
- External Audit
- Through the representations given by directors and managers as appropriate, and
- The findings of other significant assurance functions, both internal and external to the Trust, i.e. reviews by Department of Health Arms Length Bodies or Regulators/ professional bodies.

The significant issues considered by the Audit Committee in relation to the financial statements, operations and compliance are discussed in further detail within the Annual Governance Statement from page 3-9 of the financial statements. During 2017/18 the Trust had no serious incidents relating to information governance, data loss or confidentiality breach.

The Trust has an internal audit function which is outsourced from an external third party provider, PricewaterhouseCoopers LLP (PwC). Their role is to provide the Trust with assurances around the effectiveness of internal controls. The internal audit plan is structured around corporate level objectives and risks and audit work is performed in alignment with Public Sector Internal Audit Standards. For further information see page 13.

The external auditors for the Trust for 2017/18 were KPMG LLP who were appointed by the Council of Governors in September 2016 following a competitive tendering process. The current best practice is for a three to five year period of appointment, of which the 2017/18 audit is year two of KPMG's appointment.

Effectiveness of the external audit process is assessed by the Audit Committee, through direct receipt of reports from the external auditors to the Committee, and also through a formal management report on the work. The Trust's external auditors did not provide any non-audit services during the year.

Attendance at the Committee this year is set out below:

| | | Meeting Date | | | | | |
|---|---|---|---|---|---|---|---|
| Name of Person | Role | 12/04/17 | 17/05/17 | 05/07/17 | 20/09/17 | 06/12/17 | 07/02/18 |
| Committee Members | | | | | | | |
| Non Executive Directors | | | | | | | |
| Peter Hargrave | Senior Independent Director/Chair | 1 | 1 | 1 | 1 | 1 | 1 |
| Paula Kerr | Non Executive Director | 1 | 1 | 1 | 1 | 1 | 0 |
| David Ellis | Non Executive Director | 1 | 1 | 1 | 1 | | |
| Roger Margand | Non Executive Director | | | | 1 | 1 | 1 |
| David Scott | Non Executive Director | | | | 1 | 0 | 1 |
| Regular Attendees | | | | | | | |
| Mark Flynn | Director of Finance | 1 | 1 | 1 | 1 | 1 | 1 |
| Anna Hills | Director of Governance | 1 | 1 | 1 | 1 | 1 | 1 |
| Edmund Taylor | Deputy Director of Finance | 1 | 1 | 1 | 1 | 0 | 1 |
| Gareth Davies | Financial Accountant | 0 | 1 | 1 | 1 | 1 | 1 |

1 = Attended 0 = Did not attend

## Our financial disclosures

### Cost allocation and charging

The Trust can confirm that it has complied with the cost allocation and charging guidance issued by HM Treasury.

### Political donations

The Trust has made no political donations to any individual, body or organisation during 2017/18 or 2016/17.

### Better payment practice

The Better Payment Practice Code requires that all valid invoices be paid by their due date or within 30 days of receipt. During the year the Trust paid invoices totalling £60.8m, of which 59% were paid within 30 days (2016/17: £60.1m, of which 65% were paid within 30 days). This comprised 43,267 bills, of which 52% were paid within 30 days (2016/17: 42,856 separate bills, of which 64% were paid within 30 days).

## Fees and charges (income generation)

The Trust does not levy any fees and charges raised under legislation, where the full cost exceeds £1m, or where the service is otherwise material to the accounts. Full disclosure of other non-patient care income is included within note 4.2 of the financial statements on page 29.

## Income disclosure

Under the requirements of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) the Trust can confirm that income from the provision of goods and services for the purpose of health services in England is greater than the income generated from the provision of goods and services for any other purpose. Income to the Trust from non-NHS sources has a positive impact on the provision of goods and services for the purposes of the health service, as all income is used for the benefit of NHS patients.

## Disclosure to auditors

So far as the Directors are aware, there is no relevant audit information of which the Trust's auditors are unaware. The Directors have taken all of the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

## Income and expenditure

The Trust reported a deficit of £(7.3)m for 2017/18 excluding the impact of consolidating its charitable funds (2016/17 deficit: £(4.0)m). Excluding the impact of non-recurrent STF income of £4.3m (2016/17 £6.5m), and in 2016/17 only, an impairment charge of £6.5m, the underlying net deficit for 2017/18 is £(11.6)m (2016/17 £(4.0)m deficit). This is illustrated as set out below:

| | **2017/18 £m** | **2016/17 £m** |
|---|---|---|
| Deficit per financial statements - non-consolidated | 7.3 | 4.0 |
| Impairments charged to SoCI from revaluation exercise | n/a | 6.5 |
| Deficit/surplus excluding impairments | (7.3) | 2.5 |
| STF income | (4.3) | (6.5) |
| **Underlying net deficit** | **(11.6)** | **(4.0)** |

Non-operating income includes £4.3m of Sustainability and Transformation Fund (STF) income which is performance related and non-recurrent in nature. An interim desktop valuation of land and buildings as of 1 March 2017 was carried out by the professional valuers and was the principle reason for the £6.5m impairment charge against the Trust's revenue position in the 2016/17 comparatives.

The scheme for allocating STF income to provider trusts during 2017/18 was based on a combination of financial and operational performance targets. The financial performance element was to achieve a specified Control Total surplus, whilst the operational performance element was related to A&E performance targets. The Trust achieved the financial target for the first three quarters of the year, and the performance target elements were achieved for the first two quarters of the year.

## Capital investments

The Trust's key capital investments during 2017/18 are shown below. A total of £6.2m was invested during the year including £1.3m on improvements to the Trust's Emergency Department. As part of a project to be completed during 2018/19, this investment will create a redesigned emergency floor, including GP streaming, to meet current standards of best practice and the expectations of clinical staff and patients.

Other significant investments include £0.7m on mammography equipment and a further £1.6m on other essential equipment replacements.

| Capital investments 2017/18 | £'000 |
|---|---|
| Equipment replacement | 1,641 |
| A&E improvements | 1,291 |
| IT investment | 1, 036 |
| Mammography equipment | 701 |
| Clinical portal | 579 |
| Estates work | 430 |
| Early Pregnancy Assessment Unit | 371 |
| Pharmacy improvements | 131 |
| Total | 6,180 |

## Cash and financing

The Trust's non-consolidated cash position reduced by £2.0m during 2017/18, with cash and cash equivalents of £9.6m held at 31 March 2018. Of the £6.2m of capital expenditure, £1.5m was funded through new Public Dividend Capital issued to the Trust by the Department of Health, mostly relating to the development of the Trust's Emergency Department. A further £1.6m of capital funding was obtained from either finance leases or in the form of grants from the hospital's charitable funds.

As at 31 March 2018 the Trust has £2.9m of borrowings, all of which are finance lease liabilities. The largest contracts include a managed service contract for the provision of PACS (Picture Archiving and Communication System) services, recorded in the accounts as a finance lease with a liability of £0.9m as at 31 March 2018. The Trust also has finance lease contracts in place for radiology equipment of £1.5m in total.

## Efficiencies and transformation

The Trust has delivered £6.9m in savings during the year against a transformation plan which originally set an ambitious target of delivering £13.9m. Whilst the target was not achieved, the savings delivered represents 3.4% of the Trust's expenditure before efficiencies which is comparable with NHS acute sector averages.

The Trust identified early in the financial year that delivery of the original savings target was under threat and, in response, an initial financial recovery action plan was in place by the end of quarter two. The original in-year reforecast before the impact of the recovery plan was for a 2017/18 deficit of £(10.2)m, which subsequently improved by £2.9m to the actual outturn deficit of £(7.3)m.

## NHS Improvement's Single Oversight Framework

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

- Quality of care
- Finance and use of resources (UoR)
- Operational performance
- Strategic change, and
- 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 Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the first two quarters of 2016/17 relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHSI's guidance for annual reports.

### • Segmentation

Since its introduction on 1 October 2016 the Trust has been classified as being within segment 2 and there has been no enforcement action taken. This segmentation information is the Trust's position as at 21 May 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHSI website.

### • Finance and use of resources

This 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 UoR is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust will not necessarily be the same as the overall finance score here. The UoR scores for the Trust since its introduction in quarter 3 of 2016/17 are shown in the table below.

| Area | Metric | 2017/18 Scores | | | | 2016/17 Scores | |
|---|---|---|---|---|---|---|---|
| | | Q4 | Q3 | Q2 | Q1 | Q4 | Q3 |
| Financial sustainability | Capital service capacity | 4 | 2 | 4 | 4 | 1 | 2 |
| | Liquidity | 1 | 1 | 1 | 1 | 1 | 1 |
| Financial efficiency | I&E margin | 4 | 4 | 4 | 4 | 1 | 3 |
| Financial controls | Distance from financial plan | 4 | 2 | 2 | 1 | 1 | 1 |
| | Agency spend | 1 | 1 | 1 | 1 | 2 | 2 |
| **Overall scoring** | | **3** | **3** | **3** | **3** | **1** | **2** |

**Christine Allen**
**Chief Executive**
**21 May 2018**

# Remuneration Report

## Annual statement on remuneration

The Trust has two Committees dealing with Executive pay and appointments, one for Executive Directors and the other for Non Executive Directors. Succession planning, appointments and remuneration are a key focus for each Committee.

Non Executive Directors' remuneration has been reviewed against similar trusts using benchmarking information, with no increases this year.

For Executive Directors salaries are also evaluated each year. In 2016 benchmarking was considered, however, given the financial environment within which the Trust was working, a commitment was made that a full review must be undertaken in 2017. That has now taken place. The Committee recognised the importance of a stable Executive Team to ensure focus on the quality of care provided to our patients. Pay restraint over a number of years had led to salaries being far below those of trusts similar to our own and there have been salary increases for permanent Directors to bring them into line with other benchmark organisations.

There were no significant awards made to past senior managers during 2017/18, nor were there any service contract obligations which would impact on remuneration payments.

The level of remuneration for senior management in the Trust is currently assessed under the terms and conditions and pay arrangements for Agenda for Change staff. This involves a rigorous process of job evaluation to assess the banding level and associated pay scale and also aligns this to like positions with similar levels of job demands and responsibilities, across the wider NHS nationally.

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## Senior managers' remuneration policy

The policy is reviewed each year and is as set out below:

### Executive Remuneration Policy 2017/18

### 1.0 Policy statement

1.1 This policy has been agreed by the relevant Committees – Executive Nomination & Remuneration Committee for Executive Directors and Governors' Nomination & Remuneration Committee for Non Executive Directors. Both are chaired by the Chair of the Trust.

1.2 This policy is reviewed each year and is included in the Trust's annual report in line with regulatory requirements.

### 2.0 Executive Directors

2.1 The remuneration policy for Executive Directors is set by the Executive Nomination & Remuneration Committee.

2.2 The policy for setting the appropriate level of remuneration for Executive and Non Executive Board members is to pay a fair market rate. This is assessed through annual benchmarking against the published review by NHS Employers

of Executive and Non-Executive remuneration in the NHS and is also reflective of the organisational and individual performance.

2.3 The exact salary is determined by the Committee based on the Trust's performance and the individual's contribution.

2.4 A report will be presented annually following completion of the annual Fit and Proper Person review, by the Chief Executive for the Executive Directors and the Chairman for the Chief Executive, using the annual performance review as the basis for decision.

2.5 Rates of pay should be uplifted annually on 1 April in line with the general inflationary increase for other staff in the NHS, aligning with Agenda for Change pay increases. During periods of economic difficulty, this will be reviewed as to appropriateness.

2.6 Newly appointed Executive Director remuneration will be assessed at the time of appointment and reviewed thereafter in the annual round as set out in this policy, subject to a minimum tenure of one year's service with the Trust being accrued at the time of that review.

2.7 Executive remuneration levels, benefits and pension entitlements are published in the Trust's annual report.

## 3.0 Senior Managers' Remuneration

3.1 The national Agenda for Change NHS pay system applies to the first layer of management below Board level. Any exceptions in relation to interim appointments will be approved by the Chief Executive within the authority delegated by the Executive Nomination and Remuneration Committee.

**Confirmed by Executive Nomination & Remuneration Committee, 30 August 2017**

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## 4.0 Chair and Non Executive Directors

4.1 The Council of Governors has responsibility for setting remuneration, following the recommendations of the Governors' Nomination & Remuneration Committee. This forms part of the review of all terms and conditions, including expenses to be claimed.

4.2 As with Executive remuneration these rates are assessed through annual benchmarking against the published review by NHS Employers of Executive and Non-Executive remuneration in the NHS.

4.3 The current rates of pay are as set out overleaf:

| Board role | Requirement | Days per month | Salary |
|---|---|---|---|
| Trust Chair | Statutory | 12 | £35,000 - £60,000 (range) |
| Deputy Chair | Trust Constitution - the Council of Governors may appoint to this role.<br>Agreed November 2017 not to appoint at this stage with time commitment and salary to be reviewed if there is a requirement in future | N/A | N/A |
| Non Executive Director | Statutory (majority on the Board) | 3 | £12,800 |
| Additional responsibilities | | | |
| Chair, Audit Committee | Statutory – Foundation Trust Code of Governance July 2014 C.3.1 | 3 | £14,000 |
| Chair, Safety and Quality Governance Committee | Whilst not statutory the Committee has an assurance role in relation to systems of control and governance and specifically for clinical quality and safety; with the Audit Committee instigates action to deal with any risks identified. This role also carries additional lead responsibilities for Mortality, End of Life and medical revalidation requiring external representation | 3 | £14,000 |
| Chair, Executive Nomination & Remuneration Committee | Statutory – Foundation Trust Code of Governance July 2014 D.2.1 | | Included within Chair's role |
| Senior Independent Director | Statutory – Foundation Trust Code of Governance July 2014 A.4.1 – in addition to the Non Executive Director role | 3 | £14,000 |

4.4 Where the posts of Deputy Chair, Senior Independent Director and Chair of the Safety & Quality Governance or Audit Committees are held by the same person, only one of these posts will be recognised for payment.

**Confirmed by Governors' Nomination & Remuneration Committee 9 January 2018**

**Approved by Council of Governors, 19 January 2018**

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## Annual report on remuneration

## Governors' Nomination & Remuneration (N&R) Committee

The Committee has led on two Non Executive appointments this year using local advert, NHS Jobs, the Trust's website, circulation to a number of networks and through social media. The Committee and the Council of Governors first considers the Board's assessment of the skills required prior to a Non Executive position being advertised.

Each appointment is made in line with the Council approved selection process, initially for a three year term of office, with the potential of reappointment for a further three year term following review of an individual's most recent performance assessment.

Professor David Scott replaced Dr David Ellis who had served his two three year terms of office. Roger Margand was recruited at the same time to take the vacancy following Anna Davidson's move from the Deputy Chair to Chair role from 1 May 2017. Both joined the Trust on 1 September 2017.

Removal of the Chair or another Non Executive Director requires the approval of three quarters of the members of the Council of Governors, on the recommendation of its N&R Committee. This action would only be taken in extreme circumstances once all other options had been explored.

Committee membership and attendance is set out below:

**Governors' Nomination and Renumeration Committee attendance 2017/18**

| | | Meeting Date | | | |
|---|---|---|---|---|---|
| Name of Person | Role | 18/04/17 | 06/06/17 | 28/11/17 | 09/01/18 |
| Anna Davidson | Chair | | 1 | 1 | 1 |
| Anna Davidson | Deputy Chair | 1 | | | |
| David Wright | Chairman | 1 | | | |
| Public Governors | | | | | |
| Martin Arnold | | 0 | 0 | | |
| Andrew Gowen | | | | 1 | 1 |
| Michael Field | | | | 1 | 1 |
| Lyn Gibbs | Deputy Lead Governor | | | 1 | 1 |
| Jane Harvey | Lead Governor | | | 1 | 0 |
| Jean Macheath | | | | 1 | 1 |
| Marion Small | | | | 1 | 1 |
| Angela Woodcock | Lead Governor to 31/7/17 | 1 | 1 | | |
| Jean Goffin | Deputy Lead Governor to 31/7/17 | 1 | 1 | | |
| Alison Mills | | 1 | 0 | | |
| Mick Castle | | 1 | 1 | | |
| Staff Governors | | | | | |
| Sharon Boothby | | 1 | 0 | | |
| Keith Wilson | | 1 | 1 | | |
| Steven Duffell | | | | 0 | 1 |
| Devender Khurana | | | | 0 | 1 |
| Appointed Governors | | | | | |
| Julie Brociek-Coulton | | 0 | | | |
| Neil James | | | | 0 | 0 |
| Tony Goldson | | 0 | 0 | 0 | 0 |
| In attendance: | | | | | |
| Dawn Cumby | Associate Director of Workforce | 1 | 1 | 1 | |
| Rachel Nudd | Interim Assistant Director of Workforce | | | | 1 |
| Ann Filby | Head of Communications & Corporate Affairs | 1 | 1 | 1 | 1 |

1 = Attend  0 = Did not attend

## Induction and performance reviews

Each Board member undertakes a full induction programme. This is reviewed and updated ahead of each new appointment to ensure that latest NHS and Trust developments are included in the briefing information. This is supported by a full induction pack.

Individual annual performance reviews are undertaken from March to May with the objective setting focused on achieving the Trust's strategic ambitions and objectives to meet our longer term strategy and the performance requirements expected of us. This supports the annual Fit and Proper Person assessment for all Board members.

The Senior Independent Director, with the Lead Governor's support, appraises the Chair, taking the wider views of all members of the Board and the Council of Governors into account. The Chair appraises the Chief Executive on behalf of the Executive N&R Committee members. This is based on the objectives set for the organisation for the coming year and includes any development requirements. The Chief Executive then appraises all those directly reporting to her, including all Executive Directors. The Chair appraises the Non Executive Directors.

The outcome of all Non Executive reviews is considered in detail with the Governors' N&R Committee, together with the proposed objectives, all of which is discussed and approved at the Council of Governors in July. This forms the basis of any reappointments during the year. The process is then fully reviewed and changes made as felt to be necessary ahead of the next year's review cycle.

The reviews of Executive Directors underpin any changes in remuneration as considered by the Executive N&R Committee, in line with the agreed remuneration policy.

Any gaps or additional learning for the Board as a whole is addressed through the Board Seminars with the Board's mandatory training held in January and February. Work is continuing to enhance the Board development programme for the coming year.

## Executive Nomination and Remuneration Committee

Two Executive appointments have been made this year and an interim appointment for a fixed term of six months. All permanent appointments are made using external advert with the recruitment process including stakeholder focus groups and formal interview and external representation on the panel.

The Medical Director indicated that after five years in the role he would be returning to full time clinical work. The Deputy Medical Director was appointed as Medical Director from March 2017 to enable some handover.

The Associate Director of Workforce retired in December 2017 with a new Associate Director appointed from 1 March 2018.

Prior to the start of the year the Committee agreed to a process to recruit to the Deputy Chief Executive role. This opportunity was open to permanent Executive Directors. During the year, Anna Hills, Director of Governance, and Andrew Palmer, then Director of Strategy and Transformation, undertook the role for a six month period. Following an interview process Anna Hills undertakes the role of Deputy Chief Executive/Director of Governance on a permanent basis from 1 April 2018.

Both Committees have utilised the Capsticks Board skills review in-year as part of their succession and recruitment planning and considering what is required from

new appointments. The Committees are also supported by a senior member of the Workforce team and the Trust Secretary. A further review of Board skills is being undertaken in early 2018/19.

Removal of an Executive Director is led by the Executive N&R Committee in line with Trust policies.

Membership and attendance at the Committee is set out below.

**Executive Nomination and Renumeration Committee attendance 2017/18**

| | | Meeting Date |
|---|---|---|
| Name | Role | 30/08/17 |
| David Wright | Chairman | |
| Anna Davidson | Deputy Chair to 30/4/17; Chair from 1/5/17 | 1 |
| David Ellis | Non Executive Director | 1 |
| Peter Hargrave | Non Executive Director | 1 |
| Paula Kerr | Non Executive Director | 1 |
| Roger Margand | Non Executive Director | |
| David Scott | Non Executive Director | |
| Nicola Spalding | Non Executive Director | 0 |
| Executive Directors in attendance | | |
| Christine Allen | Chief Executive | 1 |
| Dawn Cumby | Associate Director of Workforce | 1 |
| In attendance | | |
| Ann Filby | Head of Communications & Corporate Affairs (minute taker) | 1 |

1 = Attend  0 = Did not attend

## Expenses

Governor and Board expenses during the year are set out below:

| Table of disclosure | 2017/18 | 2016/17 |
|---|---|---|
| **Governors** | | |
| The total number of governors in office | **27** | 27 |
| The number of governors receiving expenses in the reporting period; and | **4** | 3 |
| The aggregate sum of expenses paid to governors in the reporting period. | **£1,447.25** | £1,970.17 |
| **Directors** | | |
| The total number of directors holding office during the year | **17** | 17 |
| The number of directors receiving expenses in the reporting period; and | **12** | 7 |
| The aggregate sum of expenses paid to directors in the reporting period. | **£10,165.59** | £6,716.00 |

Further details of each Board member and their term of office can be found on page 22

## Senior Managers salaries and benefits

| | Year Ended 31st March 2018 Salary (bands of £5,000) £ 000 | Year Ended 31st March 2018 Expenses payments (taxable) (nearest £100) £ | Year Ended 31st March 2018 All pension –related benefits (bands of £2,500) £ 000 | Year Ended 31st March 2018 Total (bands of £5,000) £ 000 | Year Ended 31st March 2017 Salary (bands of £5,000) £ 000 | Year Ended 31st March 2017 Expenses payments (taxable) (nearest £100) £ | Year Ended 31st March 2017 All pension –related benefits (bands of £2,500) £ 000 | Year Ended 31st March 2017 Total (bands of £5,000) £ 000 |
|---|---|---|---|---|---|---|---|---|
| Mrs C Allen<br>Chief Executive | 185 - 190 | 0 | 0 | 185 - 190 | 175 - 180 | 0 | 0 | 175 - 180 |
| Mr M Flynn<br>Director of Finance | 120 - 125 | 0 | 57.5 - 60.0 | 180 - 185 | 110 - 115 | 0 | 27.5 - 30.0 | 135 - 140 |
| Dr D Ellis<br>Non Executive Director, Senior Independent Director until 30/11/17 | 05 - 10 | 0 | 0 | 05 - 10 | 10 - 15 | 0 | 0 | 10 - 15 |
| Mr P Franzen<br>Non Executive Director Until 31/10/16 | | | | | 15 - 20 | 600 | 0 | 15 - 20 |
| Mr P Hargrave<br>Non Executive Director, Senior Independent Director from 1/12/17 | 15 - 20 | 1,300 | 0 | 15 - 20 | 15 - 20 | 1,400 | 0 | 15 - 20 |
| Mrs A Hills<br>Director of Governance from 1/12/17 | 100 - 105 | 0 | 50.0 - 52.5 | 150 - 155 | 95 - 100 | 100 | 57.5 - 60.0 | 150 - 155 |
| Mrs J Hunt<br>Director of Nursing | 105 - 110 | 0 | 62.5 - 65.0 | 170 - 175 | 95 - 100 | 100 | 215.0 - 217.5 | 310 - 315 |
| Mrs E Libiszewski<br>Director of Nursing until 19/5/16 | | | | | 15 - 20 | 0 | 0 | 15 - 20 |
| Mr N Oligbo<br>Medical Director until 31/3/18 | 215 - 220 | 100 | 27.5 - 30.0 | 245 - 250 | 205 - 210 | 100 | 70.0 - 72.5 | 275 - 280 |
| Mr A Palmer<br>Director of Transformation | 100 - 105 | 0 | 55.0 - 57.5 | 155 - 160 | 95 - 100 | 0 | 27.5 - 30.0 | 125 - 130 |
| Mrs S Watkinson<br>Director of Operations until 4/11/16 | | | | | 65 - 70 | 0 | 0 | 65 - 70 |
| Mr D Wright<br>Chair until 30/4/17 | 00 - 05 | 0 | 0 | 00 - 05 | 45 - 50 | 0 | 0 | 45 - 50 |
| Mrs D Cumby<br>Associate Director of Workforce until 31/12/17 | 70 - 75 | 0 | 0 | 70 - 75 | 85 - 90 | 0 | 135.0 - 137.5 | 215 - 220 |
| Ms A Davidson<br>Chair from 1/5/17;<br>Deputy Chair until 30/4/17 | 45 - 50 | 3,100 | 0 | 50 - 55 | 15 - 20 | 1,400 | 0 | 15 - 20 |
| Mr G Wilde<br>Chief Operating Officer | 115 - 120 | 100 | 0 | 115 - 120 | 90 - 95 | 0 | 0 | 90 - 95 |
| Mrs PR Kerr<br>Non Executive Director | 10 - 15 | 1,600 | 0 | 10 - 15 | 05 - 10 | 700 | 0 | 05 - 10 |
| Professor N Spalding<br>Non Executive Director | 10 - 15 | 800 | 0 | 10 - 15 | 10 - 15 | 0 | 0 | 10 - 15 |
| Mr J Barber<br>Director of Strategy from 12/2/18 | 05 - 10 | 0 | 2.5 - 5.0 | 10 - 15 | | | | |
| Mrs L Burton<br>Associate Director of Workforce from 1/3/18 | 05 - 10 | 0 | 2.5 - 5.0 | 10 - 15 | | | | |
| Dr WH Stuart<br>Medical Director from 5/3/18 | 10 - 15 | 0 | 5.0 - 7.5 | 15 - 20 | | | | |

None of the senior managers above were in receipt of performance-related bonuses or long-term performance-related bonuses during the reporting period. No employees received remuneration in excess of the highest paid director in 2017/18 (2016/17 None).

The annual increase in pension related benefits disclosed above represents the increase or (decrease), adjusted for inflation, between the amounts as at 31 March 2017 and the amounts as at 31 March 2018

The pension related benefit is calculated following a prescribed formula issued by HMRC, derived from s229 of the Finance Act 2004, modified by paragraph 10(1)(e) of schedule 8 of SI 2008/410 (as replaced by SI 2013/1981). The calculated pension benefit figure is repsresentative of the benefits that would be payable to the senior manager if they became entitled to it at the end of the financial year. The calculation is based upon 20 x annual pension income, plus the lump sum payable.

### Ratio of Highest Paid Director to Other Staff

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. The mid point of the banded remuneration of the highest-paid director in the Trust in the financial year 2017/18 was £217,500 (2016/17 - £207,500). This was 9.22 times (2016/17 - 8.88) the median remuneration of the workforce, which was £23,597 (2016/17 - £23,363). Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind, but it does not include employer pension contributions and the cash equivalent transfer value of pensions. All salaries are annualised and on a full time equivalent basis, so as to eliminate the distorting effects of staff who join or leave part way through the year, or who work part time.

Remuneration ranged from £15,400 to £219,400 (2016/17: £15,200 to £209,100).

## Senior Managers pension entitlements

| Name and title | Real increase in pension at pension age (bands of £2,500) | Real increase in pension lump sum at pension age (bands of £2,500) | Total accrued pension at pension age at 31 March 2018 (bands of £5,000) | Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) | Cash Equivalent Transfer Value at 1 April 2017 | Real increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31 March 2018 | Employer's contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Mrs D Cumby<br>Associate Director of Workforce until 31/12/17 | 2.5 - 5.0 | 7.5 - 10.0 | 30 - 35 | 90 - 95 | 620 [1] | 0 | 0 | - |
| Mr M Flynn<br>Director of Finance | 2.5 - 5.0 | 2.5 - 5.0 | 15 - 20 | 35 - 40 | 186 | 53 | 241 | - |
| Mrs A Hills<br>Director of Governance from 1/12/17 | 2.5 - 5.0 | 2.5 - 5.0 | 25 - 30 | 65 - 70 | 353 | 61 | 419 | - |
| Mrs J Hunt<br>Director of Nursing<br>from 7 May 2016 | 2.5 - 5.0 | 10.0 - 12.5 | 35 - 40 | 115 - 120 | 716 | 112 | 835 | - |
| Mr N Oligbo<br>Medical Director until 31/3/18 | 0.0 - 2.5 | 0.0 - 2.5 | 35 - 40 | 95 - 100 | 640 | 43 | 689 | - |
| Mr A Palmer<br>Director of Transformation | 2.5 - 5.0 | 2.5 - 5.0 | 25 - 30 | 60 - 65 | 307 | 61 | 371 | - |
| Mr J Barber<br>Director of Strategy from 12/2/18 | 0.0 - 2.5 | 0 | 5 - 10 | 0 - 5 | 75 | 3 | 94 | - |
| Mrs L Burton<br>Associate Director of Workforce from 1/3/18 | 0.0 - 2.5 | 5.0 - 7.5 | 20 - 25 | 60 - 65 | 408 | 5 | 473 | - |
| Dr WH Stuart<br>Medical Director from 5/3/18 | 2.5 - 5.0 | 10.0 - 12.5 | 50 - 55 | 160 - 165 | 1,047 | 6 | 1,138 | - |

[1] Mrs D Cumby retired and began drawing on the pension during the year.

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

In calculating the actuarial value of the CETV as at 31 March 2018 the NHS Pensions Agency has used factors which include the indexation of pension benefits in line with the Consumer Price Index (CPI) and not the Retail Price Index (RPI). This follows the Government announcement in July 2010 that pension benefits from 2011 will be indexed in line with CPI and not RPI. The change in inflation assumption led to a decrease in the CETV value as at 31 March 2011 compared with the CETV as at 31 March 2010. Revised guidance was issued by HM Treasury on 26 October 2011 regarding the calculation of CETVs in public service pension schemes. Based on this guidance the NHS Pensions Agency, with effect from 8 December 2011, has used revised and updated actuarial factors produced by GAD when calculating CETVs within the NHS Pension Scheme

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

Senior managers' pension entitlement disclosures are subject to external audit.

## The policy for payment for loss of office

All senior managers' service contracts are set out with clear notice periods. The Trust may terminate an appointment by notice in writing without compensation, other than payment in lieu of notice as required by the contract.

**Christine Allen**
**Chief Executive**
**21 May 2018**

# Staff Report

## Recognising our staff

The Trust is the largest employer in the Great Yarmouth and Waveney area with over 3,000 people working for us.

We are #Proud of the Paget. Our staff are caring and compassionate and treat our patients, relatives and carers with dignity and respect – dedicated to getting it right. Without them we would not be able to make improvements in the way our services are provided.

In the last year we have celebrated their achievements whenever we can, beginning with our first Long Service Awards in April formally recognising more than 6,700 years of dedicated patient care. More than 190 staff received a certificate, paperweight and badge for completing either 25 or 40 years' service at the hospital during presentation ceremonies. Also recognised were 47 staff who had clocked up similar levels of service both at the Paget and other NHS organisations.

It was the first time we had staged long service awards, which were hosted by Trust Chief Executive Christine Allen and the previous Chairman David Wright.

Among those receiving their awards were Claire Martin, Maria Jarvis, Johanna Nash and Ann-Marie Wood, who are all specialist nurses in the hospital's pain management team. Together, they had given 111 years' service at the Trust, helping patients manage their pain and advising the staff who care for them.

Claire, who is the Lead Clinical Nurse Specialist, said: "It was great to have our service recognised in this way and made the whole team feel valued. We are really proud to work at the Paget."

The awards were such a success that we are continuing to hold them each year.

# Trust Awards 2017

Outstanding achievements, dedication and quality care were once again celebrated at the Trust's annual 'Remarkable People' staff awards. Some 200 guests attended a glittering awards ceremony, held at the Wherry Hotel, Oulton Broad, in October.

There were a record 460 nominations from patients and staff for the awards.


James Paget University Hospitals NHS
NHS Foundation Trust

Paget's Remarkable People

TRUST AWARDS 2017

FINALISTS

**Ward of the Year**
Ward 18; Ward 6; Ward 9

**Department of the Year**
IT; Linen Room; Radiology

**Team of the Year**
Car Parking; Paediatric Diabetes team; Critical Care Outreach Team

**Employee of the Year**
Sarah Hay; Jodie Yerrell; Gemma Lister

**Non Clinical Individual of the Year**
Samantha Burton; Yvonne Miller; Lyn Parr

**Clinical Individual of the Year**
Jane Preston; Andreia Borges; Molly Eaglen; Carlo Canepa

**Educator Award**
Chris Homes; Sharon Crowle; Jenny Southgate

**Volunteer of the Year**
Rachel Crane; Roy Bullen; Harry the PAT dog and owner Sally

**Apprentice of the Year**
Kate Harris; Charlotte Taylor; Laura Durrant

**Sir James Paget Award for Innovation**
Claire Whitehouse; Justine Goodwin/Shrias Thayath

**EDP Gold 'Patient's Choice' Award**
Roz Green; Emilia Shurmur; Abdul Muhith

**Governors' Award for Outstanding Service**
To be announced on the night

**Chairman and Chief Executive Commendation**
To be announced on the night

**The winners in each category were:**

- Ward of the Year: Ward 9
- Department of the Year: IT
- Team of the Year: Car Parking
- Employee of the Year: Sarah Hay
- Non-Clinical Individual of the Year: Samantha Burton
- Clinical Individual of the Year: Jane Preston
- Educator Award: Sharon Crowle
- Volunteer of the Year: Rachael Crane
- Apprentice of the Year: Laura Durrant
- Sir James Paget Award for Innovation: Claire Whitehouse
- Governors' Award for Outstanding Service: Ward 18
- EDP Gold 'Patients' Choice' Award: Emilia Shurmur
- Chair and Chief Executive's Commendations: Myra Saunders and Anna Blackburn


The awards were hosted by Trust Chair Anna Davidson and Chief Executive Christine Allen.

## Employee of the Month

In October we introduced a new staff recognition scheme – Employee of the Month – to recognise those who have shown a particular dedication to supporting our services and patients.

The scheme was developed following feedback from the 2016 National Staff Survey. We wanted to enhance ways in which we can acknowledge and recognise staff who not only do their best from day to day in sometimes difficult circumstances, but also show exceptional qualities.

Karen Flores, Breast Care Nurse

Jack Webb, Junior Doctor

Helena Ellis, Audiologist

Kim Crosswell, Dementia Pathway Coordinator


There was also an award for all JPUH staff.

The Trust is proud of the knowledge, skills, experience and commitment of all of its staff, both clinical and non-clinical – and the scheme allows formal recognition of those staff who have "gone that extra mile" through their actions and acknowledge them as the very best examples of our values and behaviours.

| Courtesy and respect | Attentively kind and helpful | Responsive communication | Effective and professional |
|---|---|---|---|
| • A welcoming and positive attitude<br>• Polite, friendly and interested in people<br>• Value and respect people as individuals | • Look out for dignity, privacy and humanity<br>• Attentive, responsive and take time to help<br>• Visible presence of staff to provide care | • Listen to people and answer their questions<br>• Keep people clearly informed<br>• Involve people | • Safe, knowledgeable and reassuring<br>• Effective care / services from joined up teams<br>• Organised and timely, looking to improve |
| So people feel welcome | So people feel cared for | So people feel in control | So people feel safe |

## Staff supporting our patients – local and national award winners

Our staff are proud of the care they provide for their patients. The past year has been exceptional with staff from across our hospital, whether individually or as teams, being shortlisted for a wide variety of awards – with some notable successes:

- **Health Service Journal (HSJ): Patient Safety**

An innovative campaign to raise awareness of life-threatening Sepsis won the Patient Safety award, gathering national recognition at the ceremony which celebrates achievement in the NHS and highlights outstanding practice.


Some of the 'Kissing Goodbye to Sepsis' team with their award.

Sepsis occurs when the body's response to an infection injures its own tissues and organs. It can lead to shock, multiple organ failure and death if it is not recognised early and treated promptly. Sepsis is one of the biggest killers. Every year there are 150,000 cases of Sepsis in the UK resulting in 44,000 deaths - more than bowel, breast and prostate cancer combined.

Our 'Kissing Goodbye to Sepsis' campaign raised awareness of the condition to help identify and treat it quickly – crucial to patient care and recovery. Since introducing the campaign, which encouraged all health professionals within the hospital to be alert for the symptoms, we have seen a positive change in culture.

## British Journal of Nursing: Nurse of the Year


Clinical project manager Joan Pons Laplana won the British Journal of Nursing's Nurse of the Year award. Joan won the award after being nominated for his role in encouraging change and promoting patient safety at the hospital, driving the award-winning Kissing Goodbye to Sepsis campaign and working to ensure staff at the hospital have their flu vaccination.

## Nursing Times: Learning Disabilities Nursing

The Trust picked up a prestigious Nursing Times award, winning the Learning Disabilities Nursing category for our VIP Pathway 'you are important to us' which provides a bespoke service for the most vulnerable patients admitted to the hospital.

The winning team of the Nursing Times award for the Learning Disabilites Nursing category.

The pathway is designed to provide a seamless and personalised approach to ensure vulnerable adults admitted for theatre procedures are looked after at every stage. Staff at the hospital work closely with family carers and community colleagues to make the experience for those with learning disabilities, autism or dementia as caring and comfortable as possible.

Prior to the pathway being put in place some theatre cases were cancelled at the anaesthetic phase due to patient anxiety. Now family members and carers are invited into anaesthetic and recovery rooms as standard and there is the opportunity to visit in advance of the appointment to familiarise patients with what will happen.

## Fab Awards


Our Dementia Team picked up the Hartly Larkin Award at the Fab Awards 2017 for their blue zimmer project. The Fab Awards recognise people and teams bringing innovation and best practice to the NHS. The blue zimmer project was launched by Dementia Care Lead Ali Thayne - pictured - after she conducted research which showed that perception of colour has an impact on patient safety and wellbeing.

As a result, blue zimmer frames were introduced in the hospital to help reduce patient falls while encouraging mobility and independence.

## Learning Technologies Silver Award

Professor Jerome Pereira (centre holding award) with the Paget's award winning team.

The Trust collected a Learning Technologies Silver Award for a pioneering way of training the surgeons of the future. The annual Learning Technologies Awards recognise outstanding projects and products from across the globe. The Trust faced competition from the likes of AXA, Barclaycard, Waitrose and Transport for London in the 'Best Use Of Blended Learning' category.

Initiated by renowned surgeons at the hospital, the training has shown significant success in an online trial and may now be rolled out nationally. The programme sees online lectures about operative procedures and best practice, discussion boards to solve problems and access to a variety of expert opinion via the internet. This is all designed to enhance skills as well as making it easier for busy, often time poor, junior doctors to supplement their understanding and hone surgical techniques.

This work has also been shortlisted in the Education category of the BMJ Awards 2018 taking place in May 2018.

## EDP Stars of Norfolk and Waveney 2017

We had another successful year with two nominees in the Hospital Hero/Heroine of the Year with employee of the year, Sarah Hay, and midwife Samantha Jones. Samantha won; and with other members of the team she was crucial in getting Rachael Crane to the ceremony, where she received a special award - and was speechless when her face appeared on the screen. Rachael was the Trust's volunteer of the year and now a member of staff. The EDP Award judges felt that the work she did to support breastfeeding was worthy of recognition, giving up her own time to support mums.

Winner Samantha Jones with Rachael Crane and Finalist Sarah Hay.


Rachael Crane receives her special award. Picture courtesy of Eastern Daily Press.

## Developing tomorrow's workforce

We are always looking at new and innovative ways of developing our workforce today and for the future. Recruitment of all employee groups remains an area of challenge for the NHS and this Trust is no exception. We have considered skill-mix and improving the recruitment processes, including implementation of a new software system in 2018.

For nursing staff in particular, safe and effective staffing is a focus, with discussion at each of our Board meetings. A detailed nurse establishment review in January 2018, covering workforce planning, bed modelling and recruitment, including our 'Grow your Own' approach, led to a revised nurse establishment framework. This took account of latest guidance and the use of escalation beds during times of increasing pressure.

We constantly review the existing workforce, enabling the development of new and exciting pathways in line with service needs and with good practice, such as the Carter report.  As part of workforce planning the following roles have been developed in conjunction with local universities.

- Associate Physicians – Six posts have been recruited from March 2018
- Assistant Practitioners – the third cohort commenced in February 2018
- Two and four year nursing apprentice two year programme commenced in February 2018
- Clinical Practitioners developed in the Emergency Department (ED)
- Nursing Associates – exploring opportunities
- Introduction of the Nurse Scholarship
- Senior and junior academy introduced.

We are also analysing workforce data including age profiling as part of our Five Year People Strategy to ensure that we continue to have a skilled professional workforce.

An Equalities Policy and a Policy and Procedure on Recruitment and Selection, explains our commitment to giving full and fair consideration to applications for employment. Candidates who apply for positions here are required to meet the minimum criteria on the person specification with valid, current qualifications where appropriate. All candidates will go through a robust employment process followed by a Trust-wide induction and local induction. This provides assurance that the Trust's workforce is fit for purpose. Managers are fully trained to provide them with the required skills and competencies to implement all required processes, including recruitment

Our Health Ambassadors attended a range of Skills Fairs and Careers events including the Norfolk Skills Festival aimed at 14-24 year olds to inspire them for their future career. This event was attended by 5,000 students from across the region. We also hold our own Careers Fair on the hospital grounds, giving local people the chance to see the range of roles we have in our organisation.

Our Education and Practice Development team are heavily involved in looking at new ways of attracting young people into healthcare and, over the last year, have come up with a number of developments:

## The new Health Academy

The hospital has linked up with East Norfolk Sixth Form College on a project to create a new Health Academy. Anyone at the college interested in a future career in healthcare, whether this be as a nurse, doctor or other health professional, will be invited to apply for the Academy, which will formally launch in September 2018.

Those successful in their applications will continue their studies at the College but will be released for a few days over a six month period to take part in sessions at the hospital's on-site Education and Training Centre. The sessions are designed to give more information about potential careers, opportunities to progress and what working in a busy hospital is like.

There will also be a Junior Health Academy, with the James Paget team currently working with six local high schools on this. Structured sessions will be offered to up to 40 students at a time, again to give an insight into the routes into the health profession and what students can expect.

## Paget Nursing Scholarship

This new scholarship is aimed at funding local people to join the nursing profession. The scholarship will initially provide financial support to two students so they can complete the three-year course to qualify as registered nurses.

This has been set up by the Trust and the University of East Anglia, where the students will study when not on placement in the hospital. It is aimed at people from the Great Yarmouth and Waveney area who have always harboured an ambition to become a nurse at their local hospital but may have been put off from going onto the three-year course because of the tuition fees.

There are two intakes of student nurses each year, in September and February. The September intake attracts students who have just completed other academic study, such as a first degree. However, the February intake is popular with people from a wider variety of backgrounds, including those who have chosen other career paths – and the scholarships are designed for these students.

There was significant interest in this opportunity. The scholarship will be evaluated and it may be possible to increase the number of places in the future.

Students Rhiannon Forder and Gabrielle Massey with confirmation of their scholarship award with the Education Team.

## Our Five Year People Strategy

As a district general hospital we face many challenges. We believe that we can thrive and succeed in giving our patients the very best care through having a workforce that is responsive and adaptable. In order to meet these challenges and continue to deliver high quality services, it is essential that our workforce supports a modern NHS fit for the 21st century. There is a workforce element to the STP work to make sure our services meet the needs of our community.

Work continues on the Trust's People Strategy which underpins everything that we do to attract, recruit, develop, retain, support, engage and reward employees and teams to meet future goals so that we can all be 'Proud of the Paget'. Significant progress has been made this year; in addition to the staff recognition already highlighted:

**Aim One – To attract and recruit sufficient numbers of 'Remarkable People' to our workforce with the right skills, at the right time, to create a sustainable workforce delivering high quality, safe and compassionate care.**

- Manager training programme, including equality and diversity, designed and implemented
- Revised vacancy approval process to reduce time to hire, with electronic recruitment being implemented in 2018/19
- Awarded the 'Fair Train' Gold Award for achievements in work experience placements having welcomed over 200 students this year
- Reduced agency spend with work ongoing to reduce further.

**Aim Two – To retain and develop our people through offering supported learning and professional development opportunities. Our succession plans will inform the leadership development we will provide for our leaders of the future in preparing them for their next role through appropriate development opportunities.**

- Mandatory training compliance increased
- New roles successfully embedded as part of our workforce
- Positive student and university feedback received
- Completed a Health Education England (HEE) quality review of education with positive results and identified as an excellent education provider.

**Aim Three – To have Information and Governance systems supported by the appropriate tools and software technology providing quality information to lead us in our decision making for both future workforce planning and policy development.**

- E-roster being fully utilised across nursing and midwifery with roll out plan and training continuing. ESR national staff records system upgraded
- Regular reporting on workforce KPIs with others in development
- Workforce polices updated and new policies introduced to support re-organisation and transformation programmes
- Template letters and support information now attached to policies when introduced and added as existing ones reviewed and updated.
- High level scrutiny/standardisation for booking agency/temporary staff.

**Aim Four – To enrich employee experience through building on our healthy working environment to support employees in maintaining health, wellbeing and resilience.**

- New Occupational health provider with revised processes to support better absence management
- Achieved Health and Wellbeing CQUINs (Commissioning for Quality and Innovation) with the highest flu vaccination uptake to date and a largescale programme of health and wellbeing events and healthy living ongoing.



**Aim Five – To implement our Organisational Development plan to support delivery of the Trust's strategic intentions ensuring compatibility with the wider Norfolk healthcare vision.**

- Revised appraisal process introduced in April 2017
- Above average employee engagement scores in the National Staff Survey
- The Trust's Talent Management Scheme was introduced in autumn 2017. This is enabling a focus on the talent that we already have and, for those that wish to continue to develop in their careers, we are supporting them to do so
- An annual workforce plan in place with planning and review of workforce for all employee groups currently being developed.

## About our staff

- **Employee numbers**

| Workforce – 31 March 2018 | Male (fte) | Female (fte) | Total (fte) |
|---|---|---|---|
| Directors and Very Senior Managers | 7.00 | 11.40 | 18.40 |
| Employees | 634.89 | 2,049.91 | 2,684.80 |
| **Total** | **641.89** | **2,061.31** | **2,703.20** |

### Staff costs

| Employee expenses and numbers | Permanent £ 000 | Year Ended 31 March 2018 Other £ 000 | Total £ 000 | Year Ended 31 March 2017 |
|---|---|---|---|---|
| Salaries and wages | **99,996** | **1,559** | **101,555** | 95,427 |
| Social security costs | **9,885** | **-** | **9,885** | 9,382 |
| Apprenticeship levy | **499** | **-** | **499** | - |
| Employer contributions to NHS Pensions | **11,772** | **-** | **11,772** | 11,179 |
| Pension cost - other | **10** | **-** | **10** | 9 |
| Agency/contract staff | **-** | **6,938** | **6,938** | 9,003 |
| | **122,162** | **8,497** | **130,659** | **125,000** |
| Employee expenses recharged to other organisations | **(401)** | **-** | **(401)** | (442) |
| Employee expenses capitalised as part of assets | **(213)** | **-** | **(213)** | (155) |
| **Total** | **121,548** | **8,497** | **130,045** | **124,443** |

- **Sickness absence data: Trust-wide 12 month summary**

Sickness is managed in line with the Trust's policy, with the Workforce team supporting line managers with any issues that they have. Reports on the latest position are presented to the Board of Directors' meeting held in public.

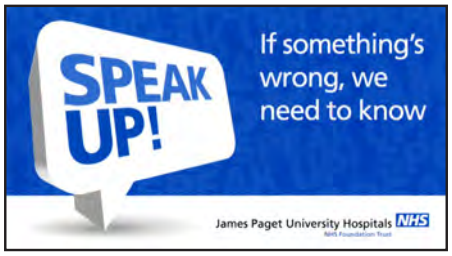
| | 2017/18 | 2016/17 |
|---|---|---|
| Percentage of Long Term (over 28 days) | 2.45% | 2.64% |
| Percentage of Short Term | 1.85% | 1.44% |
| Average Working Days Lost (ESRBI Average Absence Days (FTE) per FTE) | 15.71 | 14.92 |
| Percentage of employees with no sick leave | 31.29% | 31.02% |

| Top sickness reasons | 2017/18 | | 2016/17 | |
|---|---|---|---|---|
| | % (of all sickness) | % (of all available) | % (of all sickness) | % (of all available) |
| S10 Anxiety/stress/depression/other psychiatric illnesses | 22.80 | 0.98 | 21.8 | 0.89 |
| S99 Unknown causes / Not specified | 10.80 | 0.46 | 10.4 | 0.42 |
| S25 Gastrointestinal problems | 9.7 | 0.42 | 9.9 | 0.39 |
| S28 Injury, fracture | 8.8 | 0.38 | 7.6 | 0.31 |
| S13 Cold, Cough, Flu - Influenza | 8.6 | 0.37 | 7.0 | 0.28 |
| S11 Back Problems | 6.6 | 0.28 | - | - |
| S12 Other musculoskeletal problems | 0 | 0 | 7.3 | 0.30 |

- **Staff policies and actions taken in-year**

All Trust policies are in line with the legal requirements and national guidance. We believe in continuous improvement and regularly review and adapt processes and ways of working to meet any new recommendations. Activity in-year is set out below:

- 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 – **Recruitment Policy, Equality and Diversity Policy**
- 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 – **Equality and Diversity Policy, Managing Attendance Policy**
- Policies applied during the financial year for the training, career development and promotion of disabled employees – **Equality and Diversity Policy**
- Actions taken in the financial year to provide employees systematically with information on matters of concerns to them as employees – **Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy.** In addition to these policies active promotion of the newly introduced team of 'Speak Up Guardians' has taken place along with promotional materials and communications to highlight how staff can access support and raise concerns. This forms part of a refresh of the programme first discussed with staff in 2015. In addition to our Staff Governors, the new Trust Chaplain is also now a Speak Up Guardian





- Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests – **Change Management, Redeployment and Redundancy Policy.** Regular formal meetings continue with employee representatives for non-medical employee groups through our Joint Partnership Forum; the Medical Staff Committee for medical workforce, and regular informal meetings
- Information on health and safety performance and occupational health – **Health and Safety Policy, Occupational Health - Surveillance Policy.** The frequency and trends of all patient and employee safety incidents and other reportable incidents, including serious untoward incidents and RIDDOR, are monitored. The Workforce, Education and Research Committee presents significant issues to the Safety and Quality Governance Committee with further escalation to the Board as required
- Information on policies and procedures with respect to counter fraud and corruption – **Anti Fraud and Corruption Policy.** The Trust is committed to reducing fraud, bribery and corruption in the NHS and will seek to take appropriate disciplinary, regulatory, civil and criminal sanctions against fraudsters. Where possible, the Trust will also attempt to recover any losses incurred, taking all available and appropriate civil and criminal measures to do so. Procedures are in place that reduce the likelihood of fraud occurring including standing orders, standing financial instructions, documented procedures, a system of internal control and a system of risk assessment. In addition, the Board of Directors aims to ensure that a risk and fraud awareness culture exists in the Trust through our Local Counter Fraud Specialist.

## Staff survey and our improvements

Following the 2016 Staff Survey our staff have played a direct role in making improvements through the Big Chat which took place during the summer. This gave staff the opportunity to give their opinions on a variety of issues which had been highlighted in the annual survey. We held Big Chat engagement sessions and put up graffiti boards in areas across the hospital to gather views. The graffiti boards in particular proved popular and provided lots of useful feedback.

In addition to the changes already described with regard to our manager training, recruitment processes and the new Employee of the Month scheme, a series of improvements were confirmed as a direct result of staff views for implementation in 2017 and 2018, with some to be introduced in the longer term:

- Upgrading the Trust's wi-fi
- Identifying ways of improving our communication about Trust news and developments to all staff. Extending leadership brief to all staff from January 2018 will enable more to hear the latest news and information about the Trust directly from the Executive Team. This is using a totally different format, with audio and video to present on the work underway in a range of our services
- Improved working between our HR and Payroll departments so that they can resolve pay issues more promptly
- Reviewing our bullying and harassment training and ensuring that staff are fully aware of the ways in which they can report incidents.

Longer term, there are other developments we will be looking at as a result of staff feedback including some preliminary work to explore a new Intranet system.

Our weekly 'Friday Notices' have also been revised with a much shorter and easy to read format, with positive feedback.

There is a significant amount of work already taking place to enhance engagement with our staff. Members of the Executive Team distribute our staff magazine Making Waves just before Christmas with chocolates and fruit as a small thank you. They host a mince pies/sausage rolls event in Aubergine, our staff restaurant, and a staff BBQ in the summer. For those staff that aren't able to leave their areas food is delivered direct to them.

Christine Allen, Anna Hills and Dawn Cumby serving our staff.

Staff enjoying the BBQ.

The Executive Team is keen to do all they can to support staff through the financial recovery and the increasing demands of working in the NHS. They are attending team meetings to seek ideas for changes that may enhance patient care or save money, and to talk through the 'issues of the day'. Some themes are emerging, with feedback to be provided through the Paget Brief as we recognise the importance of 'closing the loop', particularly where it might not be possible to resolve a particular staff concern.

## Our 2017 survey results

The annual NHS survey asks those working for healthcare organisations for their views on their job and where they work. This helps us measure the wellbeing of those who work for us and to help us improve the working lives of employees, and so help provide even better care for patients.

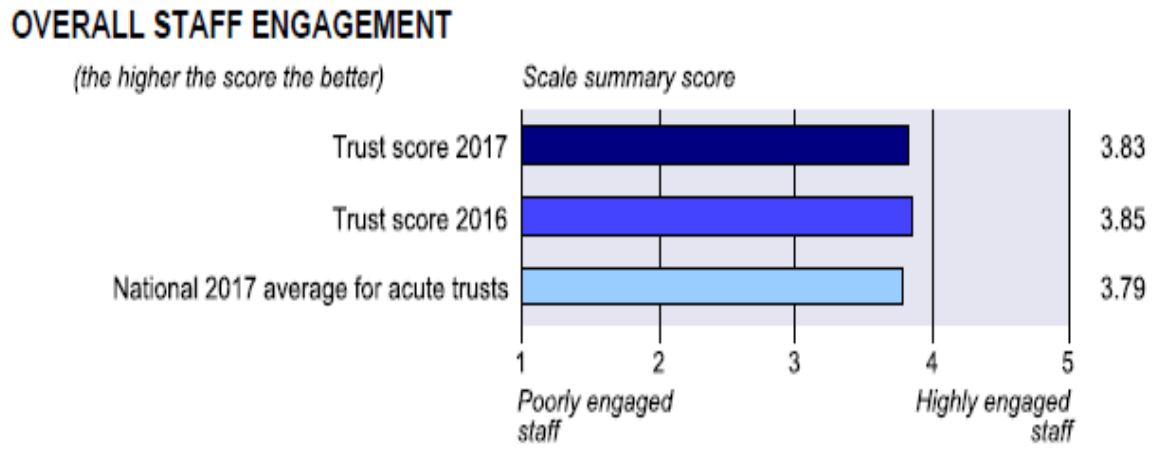
A sample of employees are asked a series of questions under the headings of "your job", "your managers", "your health and well-being", "personal development" and "your organisation". The sample size of this year's survey was 1,250 with 525 respondents and a response rate of 42%. Whilst this is a lower percentage than last year's 43%, the sample size had increased from 800.

The majority of respondents (33%) have worked for the Trust for over 15 years. The gender and age split is reflective of our workforce as a whole with 79% being female and 35% over the age of 51. This was split by ethnicity with 89% White, 7% Asian/ Asian British, 1% mixed and 2% Chinese and other ethnic background, which is reflective of our current overall workforce data.

Data gathered by the survey is used by the CQC, the Department of Health and other NHS bodies for benchmarking and improvement. For example, survey data was used by NHSI when it published the first annual 'Learning from Mistakes League' to identify openness and transparency in NHS provider organisations. The results detailed compare our data with the official sample data from other acute trusts involved in the survey, and where applicable, gives a comparison with our 2016 data.

- **Overall employee engagement**

Possible scores range from 1 to 5, with 1 indicating that employees are poorly engaged (with their work, their team and their trust) and 5 indicating that employees are highly engaged. The Trust score of 3.83 was above (Better than) average when compared with other similar trusts.

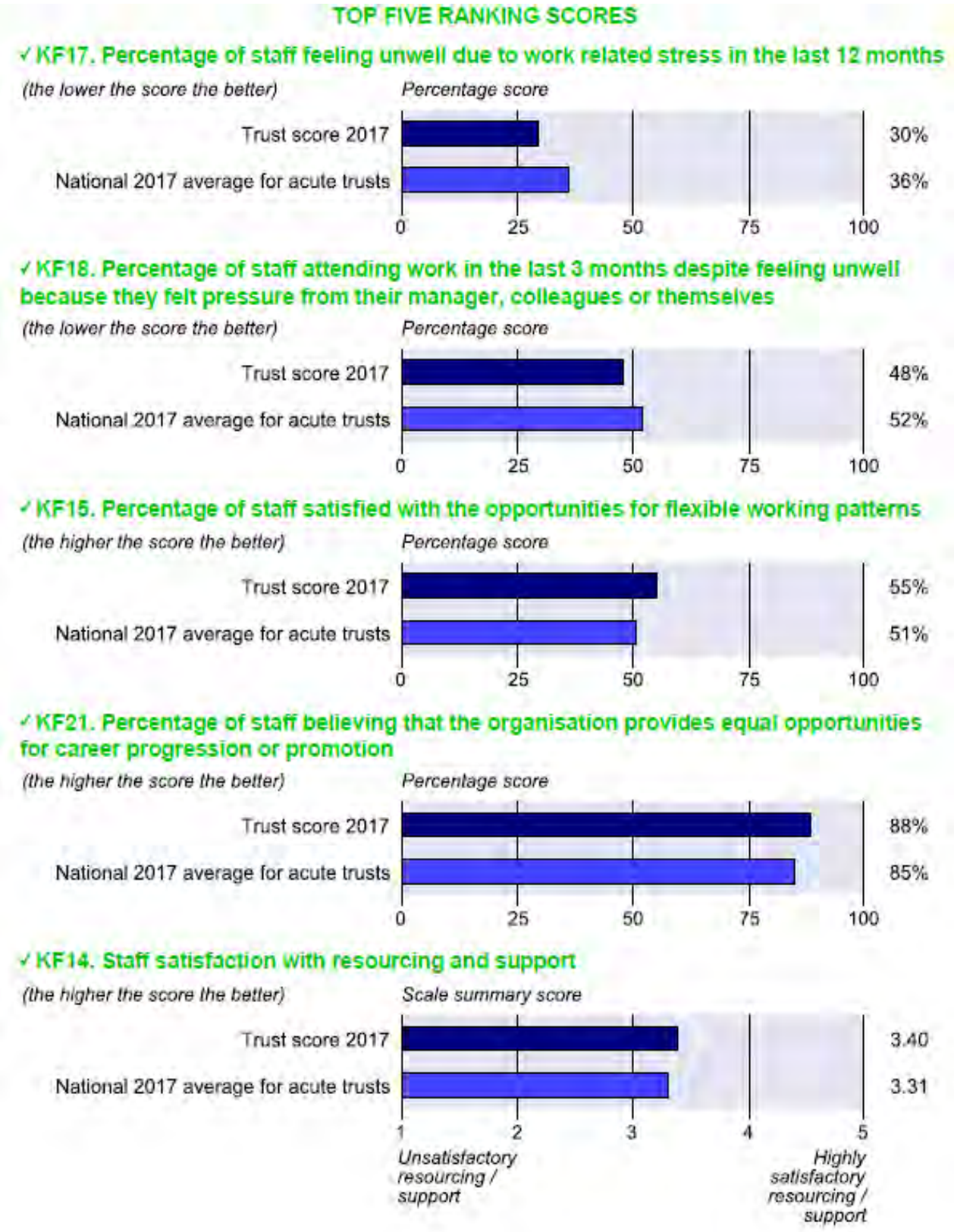


This overall indicator of employee engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to several aspects of employee engagement: employees perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

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

| | Change since 2016 survey | Ranking, compared with all acute trusts |
|---|---|---|
| OVERALL STAFF ENGAGEMENT | • No change | ✓ Above (better than) average |
| **KF1. Staff recommendation of the trust as a place to work or receive treatment** *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)* | • No change | ✓ Above (better than) average |
| **KF4. Staff motivation at work** *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)* | • No change | ! Below (worse than) average |
| **KF7. Staff ability to contribute towards improvements at work** *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)* | • No change | ! Below (worse than) average |

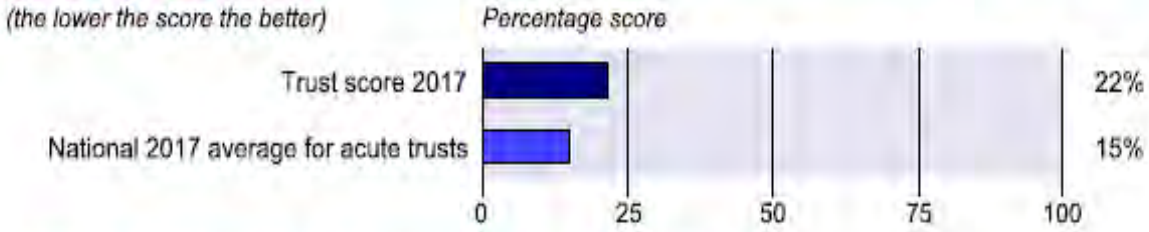
- **Summary of 2017 key findings**



## BOTTOM FIVE RANKING SCORES

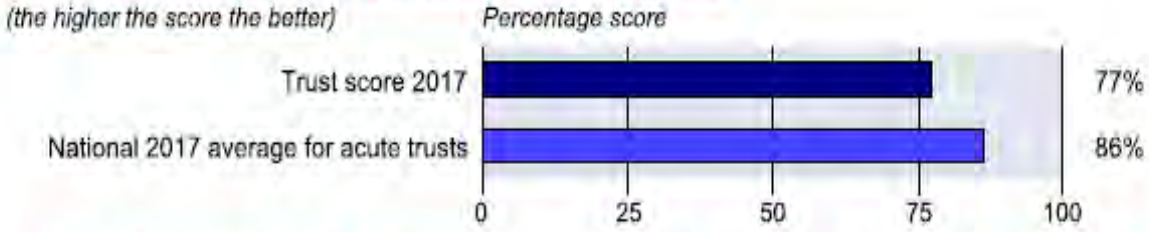
### ! KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

*(the lower the score the better)*



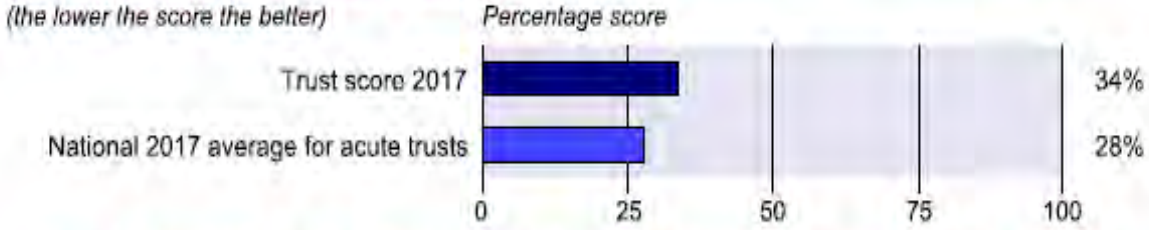

### ! KF11. Percentage of staff appraised in last 12 months

*(the higher the score the better)*



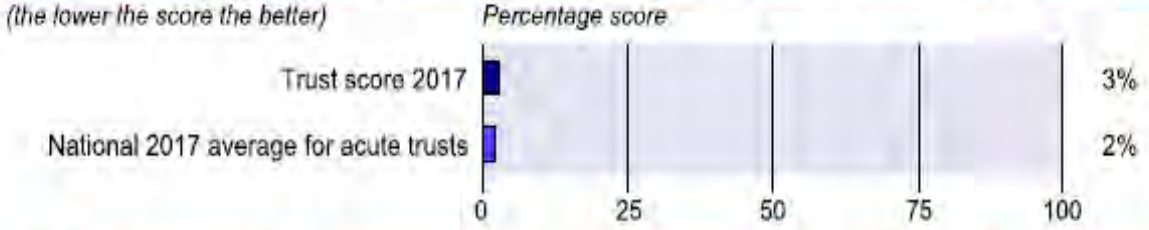

### ! KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

*(the lower the score the better)*



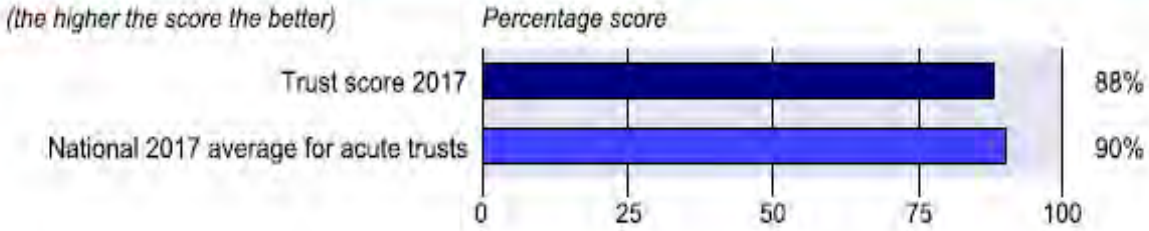

### ! KF23. Percentage of staff experiencing physical violence from staff in last 12 months

*(the lower the score the better)*

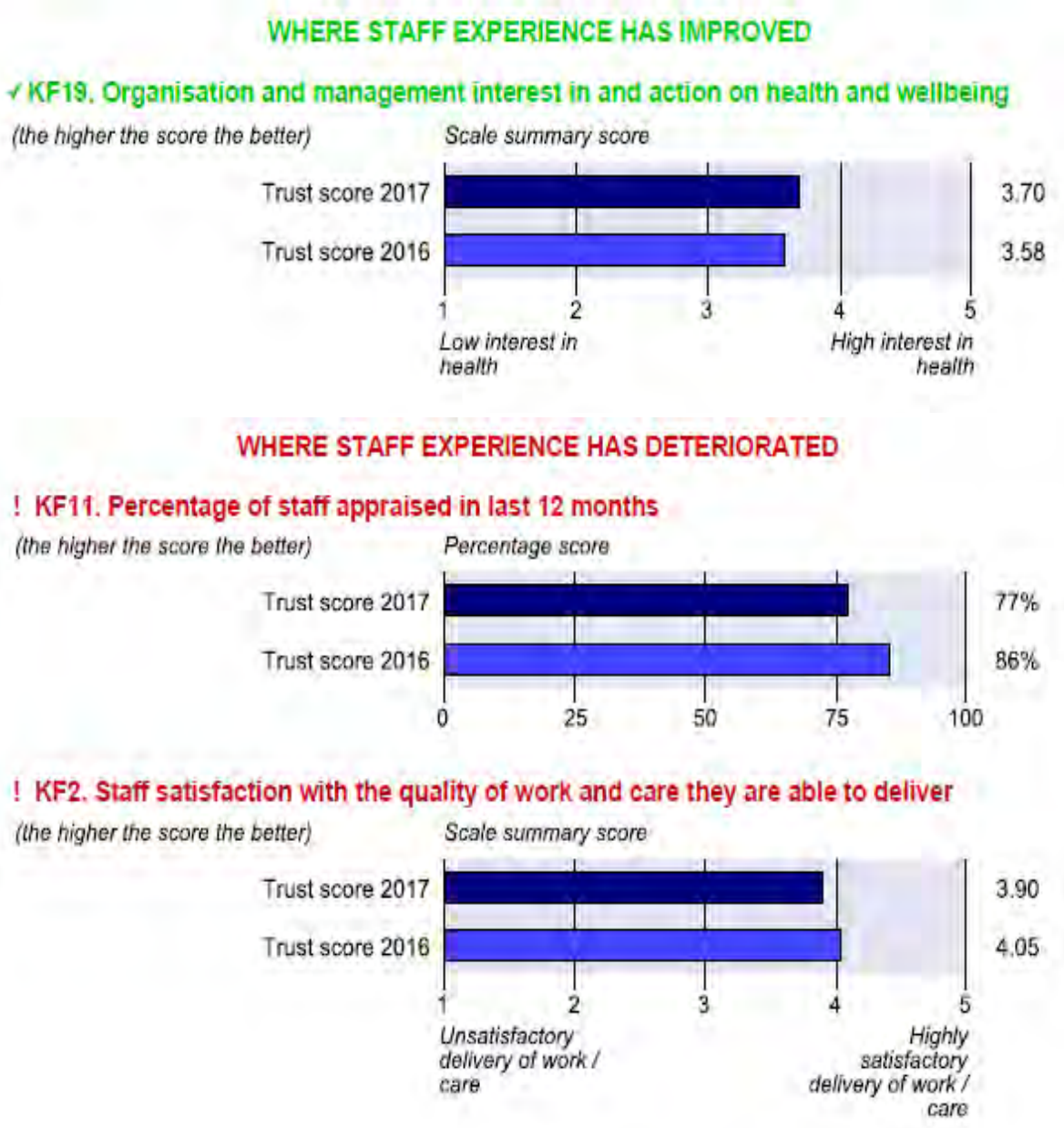



### ! KF3. Percentage of staff agreeing that their role makes a difference to patients / service users

*(the higher the score the better)*



## Largest local changes since 2016 survey




## Current/proposed actions

There were some areas where the Trust did not perform as well as in the previous year and where improvements are needed. This enables us to identify the key actions to be taken forward over the next 12 months.

The Board of Directors, at its meeting in February 2018, received an update on the results. A task and finish group, including a diverse group of staff, is currently working on an action plan. The Health & Wellbeing Group continues to review toolkits/ training to assist both managers and employees in early recognition and management of various absences at work. We will work with our staff to ensure that any ongoing improvements are focused in the areas that will make the most difference. We will also continue to work proactively with our staff to take full account of their views and work preferences as well as any disability or any health related difficulties at all times in order to support them in their work.

## Support for our staff

- **Organisational Development (OD) Strategy**

The objective of the 2016/17 OD plan was to further develop a well led organisation that would continue to deliver the Trust's vision. Whilst the OD plan retained the focus on continued improvement the emphasis was on developing our senior divisional teams and our medical leadership. All 2016/17 NHS staff survey actions were incorporated into the OD strategy.

- **Training and development**

The new registered nurse degree apprenticeship launched in February 2018 gives an "earn while you learn" route to registered nurse status. We have also broadened the apprenticeships offered to employees; this now ranges from Level 2 programmes in clinical and non-clinical apprenticeships up to a Level 7 Senior Leadership Apprenticeship (MBA) offered through the University of East Anglia.

- **Occupational health**

Through an external provider, this offers a confidential employee assistance programme with advice, invaluable information, specialist counselling and support. The service is available 24 hours a day, 365 days per year and employees can readily access this by phone. Face to face counselling support and physio is also offered via the management referral process. We work closely with the provider to ensure that the service continues to meet our needs.

- **Counter fraud processes**

A quarterly counter fraud newsletter, publicising the counter fraud team and details of successful cases prosecuted by NHS Protect, is distributed. The fraud risk assessment for the Trust has been updated, based on our knowledge of fraud in the NHS, nationally emerging trends and global and UK experience from counter fraud networks.

### Off Payroll Engagements

All substantive employees are paid through payroll. Any off payroll engagements are subject to risk based assessment to ensure full compliance with the HMRC requirements relating to such engagements, either by the Trust or external agencies. No members of the Board of Directors were engaged on an interim and off payroll basis during the year.

| For all off payroll engagements as at 31 March 2018 for more than £220 per day and that last for longer than six months | Number of engagements |
|---|---|
| No of existing engagements as of 31 March 2018 | 0 |
| Of which: | |
| Number that have existed for less than one year at the time of reporting | 0 |
| Number that have existed for between one and two years at the time of reporting | 0 |
| Number that have existed for between two and three years at the time of reporting | 0 |
| Number that have existed for between three and four years at the time of reporting | 0 |
| Number that have existed for four or more years at the time of reporting | 0 |

## Employee exit packages

There are processes in place for exit packages which take account of national guidance on how these cases will be dealt with and include compliance and approval through NHSI as required.

There has been one staff exit package during 2017/18.

| Exit package cost band | Number of compulsory redundancies | Number of other departures agreed | Total number of exit packages by cost band |
|---|---|---|---|
| <£10,000 | 0 | 0 | 0 |
| £10,000 - £25,000 | 0 | 0 | 0 |
| £25,001 - £50,000 | 0 | 1 | 1 |
| £50,001 - £100,000 | 0 | 0 | 0 |
| £100,000 - £150,000 | 0 | 0 | 0 |
| £150,001 - £200,000 | 0 | 0 | 0 |
| **Total number of exit packages by type** | **0** | **1** | **1** |
| **Total resources cost** | **0** | **1** | **£48,000** |

## Exit packages: non-compulsory departure payments

| | Agreement Numbers | Total Value of Agreements £000 |
|---|---|---|
| Voluntary redundancies including early retirement contractual costs | 0 | 0 |
| Mutually agreed resignations (MARS) contractual costs | 0 | 0 |
| Early retirements in the efficiency of the service contractual costs | 0 | 0 |
| Contractual payments in lieu of notice | 0 | 0 |
| Exit payments following Employment Tribunals or court orders | 0 | 0 |
| Non-contractual payments requiring HM Treasury (HMT) approval | 1 | 48 |
| **Total** | **1** | **48** |
| Of which:<br>Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary | 0 | 0 |

## Equality and diversity

We embrace the diversity of our staff with our workforce policies ensuring that we eliminate discrimination. The Equality Act 2010 replaced the previous anti-discrimination laws with a single Act. It simplified the law, removing inconsistencies and making it easier for people to understand and comply with it. It also strengthens the law in important ways, to help tackle discrimination and inequality. The majority of the Act came into force on 1 October 2010.

Within the Act, the Equality Duty ensures that all public bodies play their part in making society fairer by tackling discrimination and providing equality of opportunity for all. There are three aims, with the Duty requiring public bodies to have due regard to the need to:

- Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Act

- Advance equality of opportunity between people who share a protected characteristic and people who do not share it, and
- Foster good relations between people who share a protected characteristic and people who do not share it.

We have responded to the provisions within the Act by ensuring consideration of equality issues in strategic and operational decision making. This includes a robust Clinical Quality Risk Assessment (CQRA) process, the agenda of the Safety and Quality Governance Committee and the Workforce, Education and Wellbeing Group. In addition all appointing managers are required to undertake recruitment and selection training which makes specific reference to equality and diversity and the requirement for public bodies to adhere to the Equality Duty.

We continue to incorporate the Workforce Race Equality Standard into our reporting mechanisms. We also seek to make continuous improvement through the use of the Trust staff survey results. All Trust policies are assessed for equality impact and we work in partnership with Staff Side as appropriate to always best support equality and diversity and human rights in our workforce.

### Ethnicity – all employees

| Ethnic Group | FTE | % |
|---|---|---|
| White British | 2,012.60 | 74.45 |
| All 'White' ethnicity other than 'White British' | 299.62 | 11.08 |
| All 'Mixed' ethnicity | 25.46 | 0.94 |
| All 'Asian' groups | 220.69 | 8.16 |
| All 'Black' ethnicity | 37.67 | 1.39 |
| All other ethnic groups | 47.07 | 1.74 |
| Declined to disclose | 60.09 | 2.22 |
| **Grand total** | **2,703.20** | |

Due to the rounding of the percentages this does not equate to 100%.

### Expenditure on consultancy

There were no management consultancy appointments made during 2017/18 which had a contract value greater than £50,000. Total expenditure on management consultancy during the year was £388,000 (2016/17: £116,000) as shown in note 5 on page 31 of the financial statements.

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## Modern Slavery Act 2015

### Our organisation

The James Paget Healthcare NHS Trust became the first Foundation Trust in Norfolk and Suffolk on 1 August 2006 and is known as the James Paget University Hospitals NHS Foundation Trust.

We employ over 3,000 staff. We provide services at the James Paget University Hospital in Gorleston, supported by services at the Newberry Centre Children's Clinic and other outreach clinics.

Our catchment population is 230,000 which is expected to steadily increase.

The Trust is a high performing organisation that prides itself in putting patients first. We continually strive to improve clinical outcomes and patient experience to meet the needs of our patients and local population and our hospital is firmly rooted in the local community. We have a talented and loyal workforce, with a commitment to embrace and deliver improvement and change.

Our budget is around £190m. We procure goods and services from a range of providers. Contracts vary from small one-off purchases to large service contracts.

**Arrangements to prevent slavery and human trafficking**
The James Paget University Hospital supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it, and supporting victims. In particular, we are strongly committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses. Steps taken to date include:

## Our arrangements

**People**
- We confirm the identities of all new employees and their right to work in the United Kingdom, and pay all our employees above the National Living Wage
- Our Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy give a platform for our employees to raise concerns about poor working practices
- We will undertake awareness training where appropriate and possible
- Trust staff will contact and work with the Procurement department when looking to work with new suppliers, so that appropriate checks can be undertaken.

**Safeguarding**
Our commitment to ensure no modern slavery is reflected in a number of our policies and procedures. These include our Adults and Children Safeguarding Policy and the Procurement Strategy.

**Training and Promotion**
Our safeguarding training includes role relevant modern slavery awareness and understanding to reflect the Department of Health's project around provider responses, treatment and care for trafficked people (PROTECT).

**Suppliers/tenders**
The Trust complies with the Public Contracts Regulations 2015 and uses mandatory Crown Commercial Services (CCS) Pre-Qualification Questionnaire on procurement, which exceed the prescribed threshold. Bidders are required to confirm their compliance with the Modern Slavery Act.

Our procurement team and contracting team is qualified and experienced in managing healthcare contracts and have received the appropriate briefing on the requirements of the Modern Slavery Act 2015, which includes:

- Confirming compliance of their plans and arrangements to prevent slavery in their activities and supply chain
- Implementing any relevant clauses contained within the Standard NHS Contract
- We will not award contracts where suppliers do not demonstrate their commitment to ensuring that slavery and human trafficking are not taking place in their own business or supply chains
- We will adopt best practice advice by The Chartered Institute of Procurement and Supply.

**Modern Slavery Act – Section 54**
Section 54 of the modern slavery act details the following:

4) A slavery and human trafficking statement for a financial year is –
   (a) a statement of the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place –
   (i) in any of its supply chains, and
   (ii) in any part of its own business, or
   (b) a statement that the organisation has taken no such steps.

5) An organisation's slavery and human trafficking statement may include information about-
   (a) the organisation's structure, its business and its supply chains
   (b) its policies in relation to slavery and human trafficking
   (c) its due diligence processes in relation to slavery and human trafficking in its business and supply chains
   (d) the parts of its business and supply chains where there is a risk of slavery and human trafficking taking place, and the steps it has taken to assess and manage that risk
   (e) its effectiveness in ensuring that slavery and human trafficking is not taking place in its business or supply chains, measured against such performance indicators as it considers appropriate
   (f) the training about slavery and human trafficking is available to its staff.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the last financial year.

# Council of Governors and our membership

## Structure and responsibilities

The Council consists of 28 Governors, including the Chair: five appointed, 17 elected by the public membership and five elected by our staff. Governors standing for the Staff or Public Constituency are elected by the process set out in the Trust's Constitution, using the single transferable vote system, for a three year term of office. Elections took place in the summer of 2017 in both constituencies, with the new Council in place from 1 August.

Governors are responsible for representing the interests of members and partner organisations in the governance of the Trust and holding the Board of Directors to account for its performance, through the Non Executive Directors. They give their views on strategic issues, but do not manage the hospital. This is the responsibility of the Board of Directors.

The Council of Governors is chaired by the Chair of the Trust supported by the Senior Independent Director. The role of the Council is included within the Trust Constitution, with clear processes in place to ensure information is available to Governors. Formal Council meetings are scheduled at least five times each year. The Annual Members' Meeting/Annual General Meeting is usually held in September. Governor Committees undertake the detailed work and report to Council for decision.

An Interim Lead and Deputy Lead Governor are in place, with elections in June 2018 to appoint for the remaining two years of the Council's term of office. These are important roles in representing the views of the Council with the Deputy Lead supporting the Lead Governor in their absence. The Lead Governor works closely with the Chair and the Trust Secretary to ensure that the Council structure supports Governors to undertake their statutory role and add value.

There were some changes to the Council in year with the current Council members set at below.

## The Council of Governors

**Appointed Governors**

Sue Allen
**Waveney DistrictCouncil**

Councillor Emma Flaxman-Taylor
**Great Yarmouth Borough Council**

Councillor Tony Goldson
**Suffolk County Council**

Haydn Thirtle
**Norfolk County Council**

Dr Neil James
**UEA**

As this report was finalised, we were extremely sorry to learn of the sudden death of Sue Allen, who represented Waveney District Council, and was one of our long standing appointed governors.

Sue had been a member of the Council since the beginning, in 2006, and was heavily involved in our membership efforts over the years. She always ensured that Waveney councillors were kept up to date with issues of Making Waves provided to them. Senior managers were also invited to Waveney District Council meetings to discuss specific issues. Sue will be very much missed on the Council.

**Public Governors**


José Bamonde


Stuart Brooks

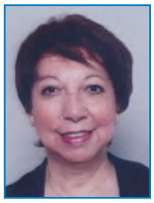

Lesley Bruin


Iain Ferguson


Michael Field


Lyn Gibbs


Andrew Gowen


Jane Harvey


Peter Kirkpatrick


Jean Macheath MBE


Sheena McBain


Jan McCarrick


Terry Rymer


Bryan Watts

**Staff Governors**


Leigh Beuttell


Steven Duffell


Devender Khurana


John Smith


Julie Smith

## Governors gaining assurance

Members of the Board of Directors attend the Council meetings during the year – Executive Directors as required and Non Executive Directors for each meeting. With the new Council we have sought to enhance the assurance available through the Non Executive Directors presenting at each Council meeting. This focusses on their Committee or leadership roles as a Board member. It has been a successful addition to the agenda, with significant time set aside for a wide ranging discussion.

As part of our ongoing review of effectiveness, we have also changed the Council structure over the last year with oversight of membership activity now forming part of the Review & Planning Committee, reporting to Council. Previously the Committee report was presented to the Board of Directors at their next meeting so that all members were aware of any Governor concerns, notwithstanding the Board member attendance at Council meetings. This has not been presented to Board following every Council this year. The report has been further developed and is being reinstated to Board from May 2018.

The Council has never needed to exercise its power to require directors to attend as the agenda setting process ensures attendance when required if more information on specific subject areas is required.

## Supporting continuous improvement

A full review has taken place this year into how Governors are involved in the patient experience. From early 2018 there are a number of opportunities to participate – from Meet the Governor, a long standing mechanism to talk to patients, staff and visitors in the hospital; to undertaking surveys as part of Red2Green and the Friends and Family Test. Two Governors will be part of the new Patient User Group which meets for the first time in June 2018.

At the Council meetings, when necessary, there is a private section to enable strategic debate. Often, this is with some group work to consider a number of elements, such as our transformation programme, ahead of proposals being finalised and more widely communicated. The Council is an important part of our governance processes and we are keen to ensure that Governors can bring their views and those of our members/the public for consideration in the Trust's planning.

This year Governors were involved in revising the strategic ambitions for 2018/19, Trust objectives and quality priorities, as well as discussing issues in relation to the STP.

## Governor training and development

With a new Council of Governors in place from 1 August 2017 we have worked closely with Governors to ensure clarity on their role and to enable them to effectively discharge their responsibilities. How they seek assurance from the Chair and the other Non Executive Directors on the performance of the Board of Directors has been a priority. We will continue to review this in-year as well as undertake an annual review of the structure and its effectiveness.

Our aim is to ensure all Governors have sufficient information and training to undertake their statutory role. Once the new Council was in place, the Chair and Trust Secretary met each Governor individually to brief them on current challenges and to discuss the role. A full induction pack was also provided. This process took account of the previous Council's views. An informal lunch was a new addition to the Council's induction process to enable Governors to start to develop relationships.

A full induction day took place in September and a Governor Development Day in March this year. These are usually planned on a six monthly basis with the Governors' Review, Planning and Membership Committee advising on the requirements having taken account of the feedback received from previous events. This support to Governors enables the Board to undertake the annual self-certification required by our regulator that sufficient training has been provided.

At induction, and on an annual basis, Governors' declared interests are reviewed, in line with the new Trust policy, together with their fitness to continue as Governors. A declarations section is also included on each Council agenda. The register of interests is available on the Trust's website or from the Trust Secretary.

There was a breach of the Governors' Code of Conduct early in 2018. This was investigated by the Senior Independent Director in line with the Code, with Governors required to sign an addendum in late March 2018 to re-confirm their understanding.

Membership of the Council during the year and attendance at meetings is set out opposite.

# Council of Governors' attendance 2017/18

| | | Meeting Date | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Name | Role | 07/04/17 | 05/05/17 | 14/07/17 | 21/07/17 | 10/11/17 | 19/01/18 | 09/03/18 |
| David Wright | Chairman to 30 April 2017 | 1 | | | | | | |
| Anna Davidson | Chair from 1 May 2017 | | 1 | 1 | 1 | 1 | 0 | 1 |
| Appointed Governors | | | | | | | | |
| Sue Allen | Waveney District Council | 0 | 0 | 1 | 1 | 1 | 0 | 1 |
| Julie Brociek-Coulton | Norfolk County Council (to July 2017) | 1 | 0 | | | | | |
| Emma Flaxman-Taylor | Great Yarmouth Borough Council | 1 | 0 | 1 | 1 | 1 | 1 | 1 |
| Tony Goldson | Suffolk County Council | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| Neil James | UEA (from October 2017) | | | | | 1 | 1 | 0 |
| Haydn Thirtle | Norfolk County Council (from July 2017) | | | 1 | 0 | 1 | 1 | 1 |
| Public Governors | | | | | | | | |
| Angela Woodcock | Lead Governor (to July 2017) | 1 | 1 | 1 | 1 | | | |
| Jean Goffin | Deputy Lead Governor (to July 2017) | 1 | 1 | 0 | 1 | | | |
| Martin Arnold | (to July 2017) | 0 | 0 | 0 | 0 | | | |
| Mick Castle | (to July 2017) | 1 | 0 | 1 | 0 | | | |
| Christina Horne | (to July 2017) | 0 | 0 | 0 | 0 | | | |
| Alison Mills | (to July 2017) | 1 | 1 | 1 | 1 | | | |
| José Bamonde | | 1 | 0 | 1 | 0 | 0 | 0 | 1 |
| Stuart Brooks | | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Lesley Bruin | | 1 | 1 | 1 | 1 | 1 | 0 | 1 |
| Jane Harvey | Lead Governor from October 2017 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Lyn Gibbs | Deputy Lead Governor from October 2017 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Jean Macheath | | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Terry Rymer | | 1 | 1 | 0 | 1 | 1 | 1 | 1 |
| Iain Ferguson | (from August 2017) | | | | | 1 | 1 | 1 |
| Mike Cox | (from August 2017 to January 2018) | | | | | 1 | 1 | |
| Michael Field | (from August 2017) | | | | | 1 | 1 | 1 |
| Chris Gates | (from August 2017) | | | | | 1 | 1 | 1 |
| Andrew Gowen | (from August 2017) | | | | | 1 | 1 | 1 |
| Peter Kirkpatrick | (from August 2017) | | | | | 0 | 1 | 1 |
| Bryan Watts | (from August 2017) | | | | | 1 | 1 | 1 |
| Marion Small | (from August 2017) | | | | | 1 | 1 | 1 |
| Jan McCarrick | (from August 2017) | | | | | 1 | 1 | 1 |
| Sheena McBain | (from August 2017) | | | | | 0 | 0 | 1 |
| Staff Governors | | | | | | | | |
| Keith Wilson | Lead Staff Governor (to July 2017) | 1 | 1 | 1 | 1 | | | |
| Sharon Boothby | (to July 2017) | 1 | 1 | 0 | 0 | | | |
| Justine Goodwin | (to July 2017) | 0 | 1 | 0 | 1 | | | |
| Devender Khurana | (from August 2017) | | | | | 0 | 1 | 1 |
| Steven Duffell | (from August 2017) | | | | | 1 | 1 | 0 |
| Julie Smith | (from August 2017) | | | | | 1 | 1 | 1 |
| Leigh Beuttell | (from August 2017) | | | | | 1 | 1 | 1 |
| Nabil Fahimi | (from August 2017 to January 2018) | | | | | 0 | | |
| John Smith | (from January 2018) | | | | | | | 0 |
| In attendance | | | | | | | | |
| Christine Allen | Chief Executive | 0 | 1 | 1 | 0 | 1 | 0 | 1 |
| Ann Filby | Head of Communications and Corporate Affairs | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| David Ellis | Non Executive Director/Senior Independent Director to 30/11/17 | 1 | 1 | 1 | 0 | | | |
| Peter Hargrave | Non Executive Director/Senior Independent Director from 1/12/17 | | 1 | 1 | 0 | 0 | 1 | 0 |
| Paula Kerr | Non Executive Director | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Roger Margand | Non Executive Director | | | | | 0 | 1 | 0 |
| David Scott | Non Executive Director | | | | | 0 | 1 | 0 |
| Nicola Spalding | Non Executive Director | 0 | 1 | 1 | 0 | 0 | 1 | 0 |
| Jon Barber | Deputy Director of Strategy and Transformation/ Director of Strategy from February 2018 | | 1 | 0 | 0 | 1 | 0 | 1 |
| Sharon Boothby | Head of Risk and Safety | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Anna Hills | Director of Governance | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Amanda Hood | Head of Patient Experience and Engagement | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Alan Palmer | Lead Chaplain | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Andrew Palmer | Director of Strategy and Transformation/Director of Transformation from February 2018 | 0 | 1 | 0 | 0 | 0 | 1 | 0 |

1 = Attended 0 = Did not attend

## Our membership

Anyone living in the catchment area covered by the Trust can become a member of the Public Constituency if they are aged 16 or over; our staff are automatically members unless they choose to opt out. There is a section available on the Trust's website and membership information is displayed in the hospital, with clear contact details. A new governors' email address has been implemented as part of the membership strategy

The Council of Governors' work on membership is fully integrated with the wider Trust work on engagement with our patients, carers and the general public. The Head of Patient Experience & Engagement is responsible for considering all feedback and working with the Carer and Patient Experience Committee that reports to the Board's Safety and Quality Governance Committee. CAPE's remit includes agreeing the themes and actions to be taken to enhance the patient experience. These are reported to the Board in public as part of the Quality & Safety report. This enables Governors to see the actions taken from the work they are participating in.

The Council continued with its existing membership strategy until the end of December 2017. The priorities were based on the principle of quality engagement and feedback on Trust services, rather than increasing membership numbers. The highlights are presented, with limited engagement from some Governors in the last few months of the previous Council which impacted on progress, particularly to undertake membership events. Some elements were handed over to the new Council for consideration as part of the next strategy development.

**(a) Public Engagement on key issues to ensure member/public views taken into account in our planning.**
**(i) Site Strategy**
**(ii) Other elements for engagement/discussion in the meantime**

- There was a lack of engagement with members on the longer term site strategy with no specific issues available for discussion/decision which Governors could support. This is largely due to the long term nature of the site strategy
- Whilst Research was agreed as a positive element on which to engage it was not possible to obtain the necessary information from the Trust's team to assist Governors to take this forward. Supporting the Trust's strategic development and engagement with members and the public is a priority for the new strategy
- Governors did not feel it was appropriate to engage with the public on the financial situation and savings. This could be reconsidered for the new strategy bearing in mind the current predicted deficit, using the briefing information provided.

**(b) Membership Events**
**Undertake two to three membership events during the year across the Trust's catchment area, with priority given to Southwold, Hopton, Lowestoft or Somerleyton.**

- Whilst successful events took place in 2016, and there was discussion amongst Governors and events identified in 2017, these did not take place. These events are a good PR opportunity for the Trust and Governors, usually taking place in areas where the membership figures indicate under representation. Targets have previously been set for recruitment of new members, new contacts and completed 'post it' comments, all of which feed into the Trust's patient experience work. Whilst targets weren't met significant discussion with the public, comments on our services and some new Trust members were achieved through the duration of the strategy.

**(c) Maintain current links with GP Surgery Patient Participation Group (PPG) engagement**

- PPG Governor links are mostly well accepted after a number of years, with some working very well, others less so. The Governors' Committee previously agreed that this would become less formal, with no report required. There have been minimal comments, either positive or negative, and attendance of Governors has not been evidenced. However, these links are viewed as a very positive part of our membership strategy which is continuing. New Governors were linked and asked to agree the level of engagement that suits them and their PPG/patient group.

**(d) Continue preparation and circulation of emailed members' newsletter Inside Story**

- The e-newsletter from Governors four times a year continues to be prepared by Lesley Bruin, Public Governor. It is sent to those members for whom we have an email address – a relatively small group of under 900. Unfortunately, despite the request during the summer 2017 Governor elections valid email addresses did not increase significantly.



Your Trust News also continues to be circulated in hard copy to all member households twice a year.

There is minimal response/ engagement from Trust members on either publication and the way we engage with our membership is being re-considered as part of the new strategy.

Membership reports are usually considered at Committee six monthly to ensure that the figures remain largely representative of the local area and there is limited fluctuation. Further work is required to ensure the accuracy of the data. As at 31 March 2017, the staff membership is 3,542, with the public membership at 7830, giving a total of 11,372. This is a slight reduction on last year's figure of 11,917.

## Membership strategy 2018-20

With the new Council there was a detailed discussion on all of the potential options before the new membership strategy was proposed. This took account of best practice and the work that other foundation trusts are doing. Whilst Governors are involved in strategic discussion and bring their views, more focus is being given to ensuring this link with members is stronger. This will more effectively support the development of services and ensure that our member and public views feed into the debate and decision making.

The strategy was approved by the Council of Governors and the Board of Directors in January 2018.

| 1. Enhance engagement with the Trust's membership and the wider public | | |
|---|---|---|
| **Rationale:** Public Members are not currently engaged as evidenced by the 10% turn out in the summer 2017 Governor elections – accepting that this in line with other trust elections rather than the Trust being an outlier. | | |
| **Priority** | **Governor Lead/action** | **Measurement of success** |
| a. Enhance the Governor presence by encouraging feedback and debate through effective use of the Trust's social media accounts, particularly Facebook | Peter Kirkpatrick<br><br>Governor sub group of x5 to be set up to take this forward with monthly support from the Communications team - (Governors to volunteer) | Engagement figures - comments, likes, shares and direct posts from users<br><br>Active participation and responses to strategic questions<br><br>Website page views on linked content – Newsletters Inside Story and Your Trust News |
| b. Maximise effectiveness of existing communication mechanisms by implementing direct e-contact through a Governors' email address governors@jpaget.nhs.uk and reviewing all membership communications and their frequency | Jane Harvey<br><br>Governor sub group to be set up to include Lesley Bruin, Public Governor, as current author of Inside Story (Governors to volunteer)<br><br>Links with 1a. | Increased contacts via new email address/page access figures on Trust website<br><br>Publication of agreed number of communications each year (currently six, bi-monthly)<br><br>Increased engagement identified with members following communication |
| c. Implement a more strategic and consistent approach to engagement with GP Patient Participation Groups and other groups, including Healthwatch | Lyn Gibbs<br><br>Governors to prepare a regular briefing sheet for Trust agreement and all Governors to utilise, to include any strategic question/focus for feedback | Number of meetings attended/ comments received<br><br>Active participation and responses on strategic questions (as 1a) |
| d. Refocus staff governors to ensure effective processes are in place to canvas staff views and support wider staff engagement improvements | Julie Smith<br><br>Plan to be prepared with all staff governors | Measurement against each element of the plan (when prepared)<br><br>Additional comments received from staff<br><br>Responses on strategic questions (as 1a) |

| 2. Ensure that the public and Trust members have the opportunity to engage in strategic discussion | | |
|---|---|---|
| **Rationale:** The member/public voice in strategic debates on the future of services is essential, in addition to views of Governors. This strengthens the Trust's position in moving forward with appropriate, sustainable services for our patients and as part of the Norfolk and Waveney Sustainability and Transformation Plan. | | |
| Priority | Governor Lead/action | Measurement of success |
| a. Agree a process for strategic questioning and gathering of feedback | Jane Harvey<br><br>Head of Communications & Corporate Affairs | Enhanced engagement can be evidenced with response numbers on specific strategic questions (as 1a) |

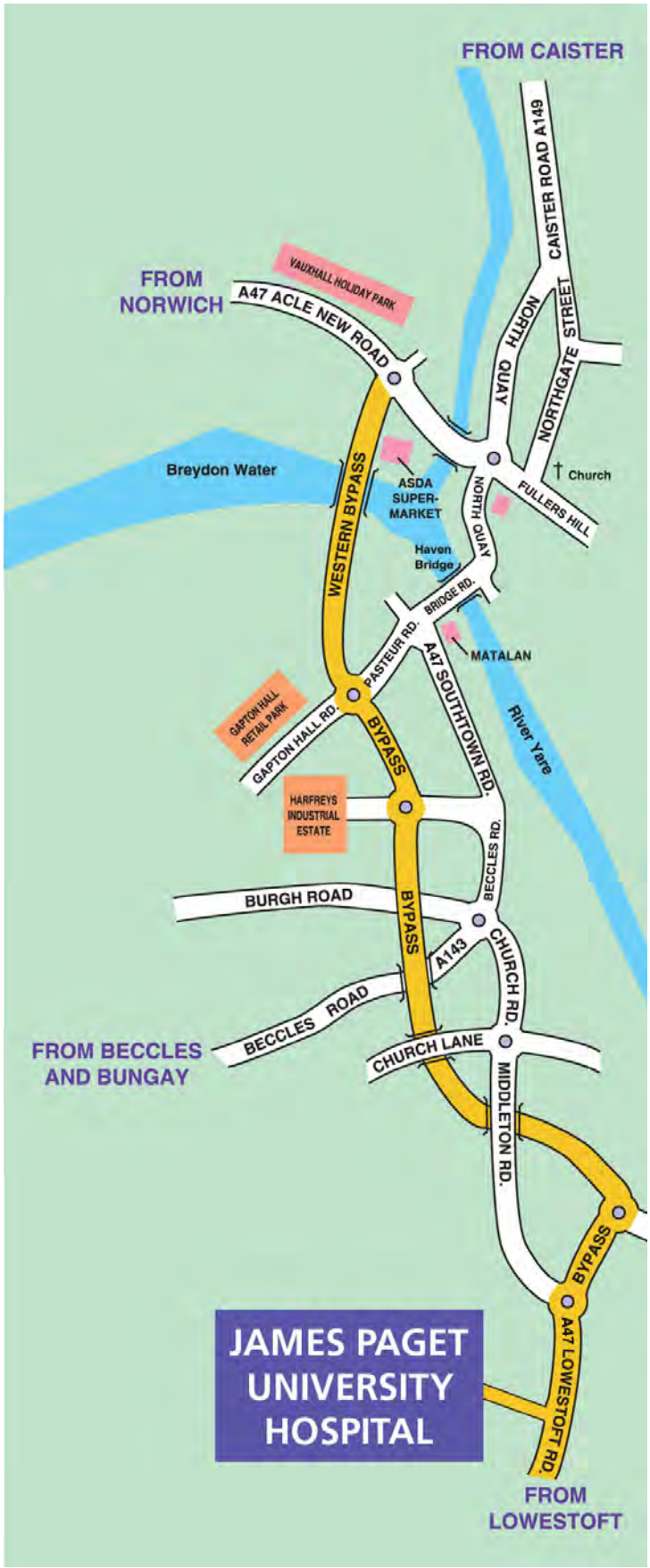
| 3. Monitor the Trust's membership data, focusing on those areas of under-representation | | |
|---|---|---|
| **Rationale:** Monitoring the Trust's membership and how representative it is in comparison with the local population is a regulatory requirement. This detailed information supports priority setting and focus of resource, such as enhanced recruitment, targeted engagement events within the Trust's catchment area. | | |
| Priority | Governor Lead/action | Measurement of success |
| a. Resolve current membership data quality issues | Corporate Affairs Admin Officer | Reduction in data issues<br><br>Accuracy of reporting to Governors' Committee |
| b. Enhance engagement with young people to ensure they have a voice in future service plans | Mike Field<br>Terry Rymer | Increased membership in the 16-35 year group through local colleges and attendance at Trust events including the Trust's Careers Fayre<br><br>An effective process is in place to enable ease of engagement and number of responses can be evidenced |
| c. Hold membership engagement events annually to provide opportunities to engage with Governors and to seek member/public views on strategic questions | Mike Field<br>Terry Rymer | Programme of events confirmed and implemented<br><br>Increase in membership data in target areas<br><br>Active participation and responses on strategic questions (as 1a) |

| 4. Support continuous improvement of the patient experience | | |
|---|---|---|
| **Rationale:** Learning from our patients' experience of the care they receive is a Trust priority, always focusing on the needs of the patient and recognising that whilst in hospital they are vulnerable. We want every contact to count. A new programme of opportunities is in place, the effectiveness and frequency of which will be regularly reviewed to ensure that Governors avoid becoming too operational or undertaking the role of the Patient Advice and Liaison Service and remain working at a strategic level with the Board of Directors. | | |
| Priority | Governor Lead/action | Measurement of success |
| a. Undertake regular surveys under the leadership of the patient experience team | Jane Harvey<br><br>Work with patient experience lead and Head of Communications to ensure feedback/continued effectiveness | Annual dates confirmed and Governors fully commit to the available opportunities<br><br>Increase in FFT completion rate<br><br>Effective roll out of Red2Green patient experience survey |
| b. Bi-monthly Meet the Governor sessions held encouraging engagement and seeking views on agreed strategic questions | Jane Harvey<br><br>Work with patient experience lead and Head of Communications to ensure feedback/continued effectiveness | Increased patient/carer feedback and continuous improvement in patient care/the patient experience<br><br>Active participation and responses on strategic questions (as 1a) |

# Glossary/Abbreviations

| | |
|---|---|
| A&E | Accident and Emergency, part of the Emergency Department |
| Acute | Rapid onset, severe symptoms and brief duration |
| AmbU | Ambulatory Unit |
| AMD | Age-related macular degeneration |
| Audit | A continuous process of assessment, evaluation and adjustment |
| Baseline | The continuous level of funding, year on year, before additional resources are taken into account |
| CAPE | Carer & Patient Experience Committee |
| CCG | Clinical Commissioning Group |
| C Diff | Clostridium difficile |
| CQC | Care Quality Commission |
| CQRA | Clinical quality risk assessment |
| CQUIN | Commissioning for Quality and Innovation |
| Capital | Spending on land and premises and provision, adaptation, renewal, replacement or demolition of buildings, equipment and vehicles |
| Commissioning | Process of acquiring/buying services to meet the health needs of the local population |
| EADU | Emergency Assessment and Discharge Unit |
| ED | Emergency Department |
| ERIC | Estates return information collection |
| ESRBI | The NHS Electronic Staff Record |
| FTE | Full time equivalent (staffing) |
| GPs | General Practitioners |
| HMT | Her Majesty's Treasury |
| Inpatient | A patient admitted to hospital for a period of treatment or to undergo an operation. Patients would stay in hospital for 24 hours or more |
| ICO | Integrated Care Organisation |
| KPIs | Key Performance Indicators |
| ICS | Integrated Care System |
| NAHG | Norfolk Acute Hospitals Group |
| N&R | Nomination and Remuneration |
| NHSI | NHS Improvement, oversees foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care |
| Outpatient | Provided on an appointment basis without the need to be admitted to or stay in hospital, e.g. assess need for further treatment, follow up appointment after a period of treatment |
| PACS | Picture Archiving and Communication System |
| PALS | Patient Advice and Liaison Service |
| PPG | Patient participation group |
| RIDDOR | Reporting of Injuries, Diseases and Dangerous Occurrences Regulations |
| RTT | Referral to Treatment |
| SSMU | Short Stay Medical Unit |
| STP | Sustainability and Transformation Partnership |
| STF | Sustainability and Transformation Fund |
| UoR | Use of Resources |
| UEA | University of East Anglia |
| YTD | Year to date |

# Useful contacts and how to get here

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Website: www.jpaget.nhs.uk

Email: firstname.lastname@jpaget.nhs.uk

Ann Filby
Head of Communications & Corporate Affairs (Trust Secretary)
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For Communications, Board, Governors and membership queries

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governors@jpaget.nhs.uk

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01493 453240
PALS@jpaget.nhs.uk

James Paget
University Hospitals
NHS Foundation Trust


# Quality Report
# 2017/18


Patient Safety

Clinical Effectiveness

Patient Experience

**Contents**

# FOREWORD

## What is a Quality Report

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Report and includes the requirements of the NHS (Quality Accounts) Regulations 2010 as amended by the NHS (Quality Accounts) Amendments Regulations 2011 and the NHS (Quality Accounts) Amendments Regulations 2012. Quality Accounts (and hence this report) aim to increase public accountability and drive quality improvement within NHS organisations. They do this by getting organisations to review their performance over the previous year, identify areas for improvement, and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

Quality consists of three areas which are essential to the delivery of high quality services:

- How safe the care is (patient safety)
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive (patient experience)

Some of the information in this Quality Report is mandatory – this report contains all of NHS Improvement's detailed requirements for quality reports – but most is decided by patients and carers, Foundation Trust Governors, staff, commissioners, regulators, and our partner organisations, collectively known as our stakeholders.

## Scope and structure of the Quality Report

This report summarises how well the James Paget University Hospitals NHS Foundation Trust ('the Trust') did against the quality priorities and goals we set ourselves for 2017/18. It also sets out those we have agreed for 2018/19 and how we intend to achieve them.

This report is divided into three Parts, the first of which includes a statement from the Chief Executive and looks at our performance in 2017/18 against the priorities and goals we set for patient safety, clinical effectiveness and patient experience.

Part 2 sets out the quality priorities and goals for 2018/19 for the same categories and explains how we decided on them, how we intend to meet them, and how we will track our progress.

Part 2 also includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It also includes a description of audits we have undertaken and our research work. We have also looked at how our staff contribute to quality.

Part 3 sets out how we identify our own priorities for improvement and gives examples of how we have improved services for patients. It also includes performance against national priorities and our local indicators.

The annexes at the end of the report include the comments of our external stakeholders including:

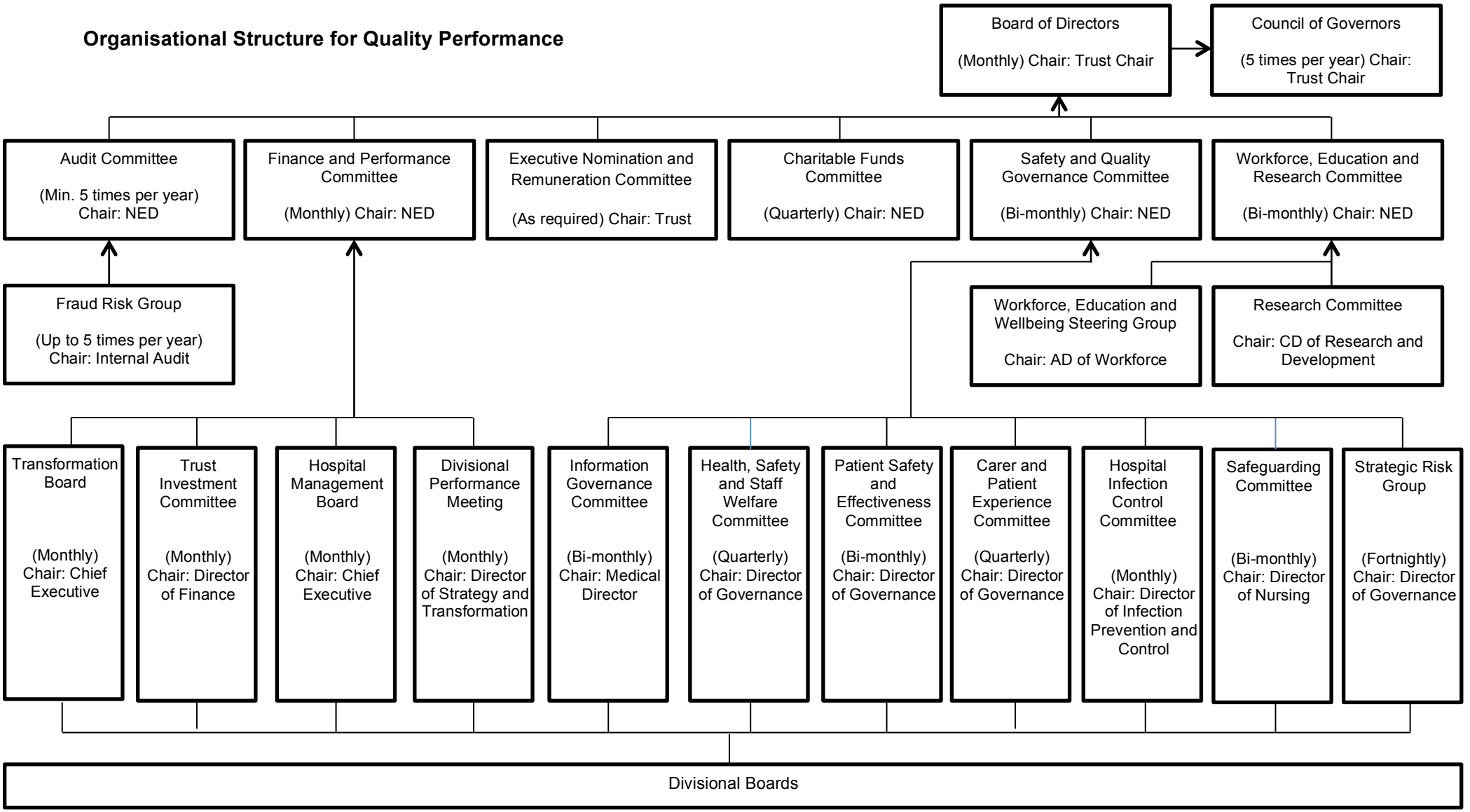
- Great Yarmouth and Waveney Clinical Commissioning Group
- Healthwatch Norfolk
- Healthwatch Suffolk
- Council of Governors
- Health Overview and Scrutiny Committee

The annexes also include a glossary of terms used.

Any text shown in blue boxes is a compulsory requirement to be included in the Quality Report as mandated within NHS Improvement's Annual Quality Accounts Regulations.

If you or someone you know needs help understanding this report, or would like the information in another format, such as large print, easy read, audio or Braille, or in another language, please contact our Director of Governance by calling 01493 452887 or emailing anna.hills@jpaget.nhs.uk.

## Organisational Structure for Quality Performance




NED: Non-Executive Director

# Part 1

## Statement on Quality from the Chief Executive

The James Paget University Hospitals NHS Foundation Trust aims to provide safe and effective care at all times. This means that patient safety and quality are at the heart of everything we do. Our staff are central to delivering the care standards that we expect every patient to receive.

2017/18 has certainly been a year of significant change, with many developments taking place to ensure that our services are fit for the future. I am proud of what we have developed during the last year to further improve the quality and safety of our services. I am delighted to have the opportunity to share with you some of our achievements in this Quality Report and inform you of the plans we have to continue to improve our services.

Our Trust Priorities for 2018/19 have been developed to ensure that we embed quality improvement into our daily practice. We have developed our mortality process in line with national guidance which will support our organisation's learning from deaths.

Over the last year the Trust has won a number of awards including:

- British Journal of Nursing's - Nurse of the Year Award (Joan Pons Laplana);
- Local Authority Building Control East Anglia Building Excellence Awards 2017 - Best Public Service Building (Day care operating theatre complex);
- Nursing Times Award – Learning Disabilities Nursing Category (VIP pathway 'you are important to us');
- Learning Technologies Silver Award in conjunction with Norwich-based Cutting Edge - Medical Education Silver Award (pioneering way of training the surgeons of the future);
- Fab Awards 2017 - Hartley Larkin Award (dementia patients 'blue zimmer frame project').

The biggest challenges in 2017/18 have been the continued, unprecedented increase in the number of emergency patients attending the hospital and the financial challenges facing us (actual outturn deficit £7.3 million, nearly a £3 million improvement on forecast). Despite the challenges we have faced, our staff have all pulled together to do the right thing for our patients.

This year we have seen higher than expected mortality rates, which we have taken extremely seriously. We have been working hard to understand this very complex data. Our Medical Director is leading on significant improvements to Trust processes, with more detail later in this report and within the Quality Report

I would like to take this opportunity to thank our staff, once again, as without their hard work and commitment we would not have achieved the successes we have set out in this Quality Report.

Quality and safety remain our priority and as we move into 2018/19, we look forward to another year of continued focus on improvements in the quality of care and experience for our patients.

To the best of my knowledge, the information in this document is accurate

Signature

**Christine Allen**
**Chief Executive**
**James Paget University Hospitals NHS Foundation Trust**

# Part 2

## Priorities for improvement and statements of assurance from the Board

In this section we describe our priority areas for quality improvement for 2018/19. We explain how we have chosen our priorities, what we set out to do, what we have done in previous years and how we will monitor progress with the priorities throughout the year.



In this section we have included all of the mandatory statements of assurance as required under the NHS (Quality Accounts) Regulations 2010 and associated amendments 2011, 2012, 2017 and 2018.



In this section we have included our performance against a core set of indicators. For each indicator we have included data for the last two reporting periods and, where available and/or applicable, have included the national average for the same and those NHS Trusts with the highest and lowest figures for the same.

### 2.1 Priorities for improvement 2018/19

The Board of Directors has agreed the following key priorities under the three domains of quality for 2018/19. These have been identified from and/or aligned to:

- Trust Quality Improvement Strategy 2018-2023
- The Care Quality Commission (CQC) five Key Lines of Enquiry (KLOE)
  - Safe
  - Effective
  - Caring
  - Responsive
  - Well-led
- Governors/Trust Members/local population feedback via questionnaire
- Quality Report priorities 2017/18
- Issues identified from the CQC Quality Assurance Framework
- Priorities identified by:
  - NHS England
  - NHS Improvement
  - Health Education England
  - Public Health England
  - National Institute for Health and Care Excellence (NICE)

The public and patients are involved in identifying risk and bringing this to the attention of the Foundation Trust in a variety of ways, including:

- Via Healthwatch;
- Via our Council of Governors (involved in setting the priorities within the Quality Report);
- Priorities Questionnaire sent to all members via post, media and Trust website;
- The Trust Board of Directors has continued to include a patient story at each monthly meeting to help identify, manage and mitigate key risks;
- Patients and relatives are involved in addressing issues identified through complaints, claims, Patient Advice and Liaison (PALS) and incidents via involvement in action planning;
- Patient Satisfaction Surveys.

Public Stakeholders are involved in managing risk which impacts on them, for example:

- There are Foundation Trust meetings at all levels with members of the Clinical Commissioning Group at which risk is assessed;
- Health Overview and Scrutiny Committees;
- Partnership working with Social Services; and
- Joint working with other health and social care providers i.e. Norfolk & Norwich University Hospitals NHS Foundation Trust, East of England Ambulance Service NHS Trust, Norfolk and Suffolk NHS Foundation Trust, and East Coast Community Health Community Interest Company.

**Pan-Domain Objective**

a) ***To develop a training programme to equip staff with a Quality Improvement toolkit***

| **What we set out to do (Priority):** |
|---|
| To develop a training programme to equip staff with a Quality Improvement toolkit |
| **Why we chose this (Rationale):** |
| Ambition 1, 2018-23 Quality Improvement Strategy states '*To develop a fully integrated, dynamic Quality Improvement (QI) Team (Hub).* Developing the training plan for identified staff would be Year 1 of this ambition. |
| **What we intend to achieve (Goal):** |
| A pro-active Quality Improvement culture within the Trust; commencing with a robust QI training programme |
| **How we will deliver and monitor progress:** |
| Quarterly updates to Safety and Quality Governance Committee |
| **Responsible Person:** |
| Director of Governance/ Medical Director |

*Baseline data*

This is a new piece of work hence there is no baseline data.

*Actions*

The following actions are to be undertaken:

- Source and connect current staff who have a Quality Improvement (QI) title/aspect within their existing role;
- Identify additional multidisciplinary team staff able to be co-opted to the QI team;
- Identify a Lead for co-ordination of the QI team;
- Develop Quality Improvement training/goals/objectives/work plans for the team to discuss/agree approach/way forward;
- Identify training needs for QI team;
- Source and provide appropriate QI training to upskill staff.

**Patient Safety**

### *a) Establish a Medical Examiner Service.*

| **What we set out to do (Priority):** |
|---|
| Establish a Medical Examiner Service. This means that a Senior Appointed Clinician will screen every death and with the support of an officer, engage with the bereaved, the Coroner and the medical teams to review why the patient died and what the next steps in each case are. |
| **Why we chose this (Rationale):** |
| • Mortality is a high risk area for the Trust and as this forms part of our quality improvement plan for this.<br>• Learning from deaths would be optimised by this service<br>• All Trusts will be required to have a Medical Examiner by May 2019 so it follows that we should implement this early |
| **What we intend to achieve (Goal):** |
| • Not to be above the expected mortality rate as measured against the national baseline<br>• To have no preventable deaths<br>• To improve the quality of learning from deaths and the bereaved experience |
| **How we will deliver and monitor progress:** |
| Reporting through the Patient Safety and Effectiveness Committee (PSEC) |
| **Responsible Person:** |
| Medical Director |

*Baseline data*

This is a new piece of work hence there is no baseline data.

*Actions*

To appoint a Senior Clinician as Medical Examiner to screen every death and with the support of an officer, engage with the bereaved, the Coroner and the medical teams to review why the patient died and what the next steps in each case are.

### *b) To identify services and specialties that have accreditation programmes other than those required for registration or certification*

| **What we set out to do (Priority):** |
|---|
| To identify services and specialties that have accreditation programmes other than those required for registration or certification |
| **Why we chose this (Rationale):** |
| • Voluntary accreditation of services will enhance the care patients receive through the provision of best practice care<br>• There are services provided by the Trust that would benefit from the reputation accreditation would afford them and thus the reputation of the Trust would be positively affected |
| **What we intend to achieve (Goal):** |
| • Knowledge of where accreditation is available to services (where not already required as part of registration etc.)<br>• A list of services that are in a position and willing to work towards accreditation in their field |
| **How we will deliver and monitor progress:** |
| Reporting through the Patient Safety and Effectiveness Committee (PSEC) |
| **Responsible Person:** |
| Medical Director/Director of Nursing |

*Baseline data*

This is a new piece of work hence there is no baseline data.

*Actions*

An initial scoping exercise is to be undertaken to collate details of all accreditation programmes relevant to Trust services.

### c) *Develop a range of options and approaches to maximise recruitment and retention forecasts. To review the current ward-based clinical staffing infrastructure and make recommendations to inform and deliver a five year workforce plan*

| **What we set out to do (Priority):** |
|---|
| Develop a range of options and approaches to maximise recruitment and retention forecasts. To review the current ward-based clinical staffing infrastructure and make recommendations to inform and deliver a five year workforce plan |
| **Why we chose this (Rationale):** |
| • The national and local landscape for recruitment and retention continues to predict significant challenges if traditional methods of workforce planning are used.<br>• We believe that the 'grow your own' approach will support improvements in workforce development and in combination with traditional approaches will both modernise and strengthen the ward-based infrastructure. |
| **What we intend to achieve (Goal):** |
| Year on year cumulative increase in the volume of nursing apprenticeship degree pathways and foundation degree pathways we facilitate |
| **How we will deliver and monitor progress:** |
| • Monitor development and delivery of the workforce plan<br>• Reporting through the Workforce, Education and Research Committee (WERC) |
| **Responsible Person:** |
| Director of Nursing |

*Baseline data*

During 2017/18 there have been 7 staff accepted onto level 6 nursing apprenticeship degrees and 18 staff accepted onto foundation degrees.

As at the period ending March 2018, the Registered Nurse vacancy levels (permanent positions) across all clinical areas (exc. maternity) were as below.

| | **Trust wide – inpatient and outpatients areas** | **Division of Surgery, Women and Children's Services** | **Division of Medicine Diagnostics and Clinical Support** |
|---|---|---|---|
| **Total WTE Vacancies (permanent)** | 51.11 | 17.55 | 33.56 |
| **Total WTE Vacancies (temporary)** | 14.96 | 7.67 | 7.29 |

*Actions*

The Board of Directors agreed a revised establishment for Registered Nurses (RN) in November 2013 of 1:6 in the day and RNs 1:8 at night in general ward areas. Establishment reviews have been undertaken twice a year since November 2013 to identify any need for change to existing staffing templates, the most recent being January 2018. Reviews have also been conducted in specialist areas including Paediatric, Emergency Department and Maternity Services.

The January 2018 establishment review recommended a registered nurse patient ratio of 1:8 during the day and 1:10 at night in the general ward areas. The intention remains for the total staff to patient ratio to be 1:3.8, however, there is some variance to this where professional judgement has informed decision-making.

A significant feature of the review was the formal introduction of the assistant practitioner role into the workforce. This role is a skilled and competent member of the workforce, which contributes to the total safe staffing ratio. Furthermore, this role is instrumental in the Trust's intention to apply the principle of 'grow your own' as a means to achieve medium to long term plans to increase registered nurse recruitment and retention. There will be a period of transition to fully achieve the 2018 workforce plan.

**Clinical Effectiveness**

***a) Learning from clinical audit: develop and apply consistent processes to ensure findings from clinical audits result in action, learning and sustained improvements in practice***

| **What we set out to do (Priority):** |
|---|
| Learning from clinical audit: develop and apply consistent processes to ensure findings from clinical audits result in action, learning and sustained improvements in practice |
| **Why we chose this (Rationale):** |
| Action planning and learning from clinical audit remains the weakest part of the clinical audit cycle |
| **What we intend to achieve (Goal):** |
| • Complete, evidenced audit cycles<br>• Demonstrable learning from clinical audit<br>• Clinical audit outcomes being fed in to Quality work programmes |
| **How we will deliver and monitor progress:** |
| • Monitoring through Clinical Audit and Effectiveness Group (CAEG)<br>• Monthly Clinical Audit reporting at PSEC |
| **Responsible Person:** |
| Director of Governance |

*Baseline data*

Overall implementation rate of clinical audit action plans due in the financial year 2017/18 to date:

| | **High Risk** | **Medium Risk** | **Low Risk** |
|---|---|---|---|
| Number of audit action plans due to be implemented by 19th April 2018 | 9 | 29 | 68 |
| Number of audit action plans implemented by 19th April 2018 | 1 (11%) | 11 (38%) | 20 (29%) |

*Actions*

Completed audits from 2018/19 onwards will be recorded on the Audit module of the Safeguard Integrated Risk Management system and reporting is to be implemented.

From 2018/19 the new Audit module will be used for all new audits, and this will be the foundation of improvements to audit action plan updates, due to automated reminders and direct access for users and managers. Configuration of the system with the provider Ulysses is underway to set up these notifications and reminders.

### *b) To audit compliance with the Trust's Safety Checklists for Invasive Procedures (SCIPs)*

| **What we set out to do (Priority):** |
|---|
| To audit compliance with the Trust's Safety Checklists for Invasive Procedures (SCIPs) |
| **Why we chose this (Rationale):** |
| • National Safety Standards for Invasive Procedures (NatSSIPs) were launched in September 2015 and set out the key steps necessary to deliver safe care for patients undergoing invasive procedures<br>• The Trust has developed SCIPs for use in various locations across the Trust where invasive procedures are carried out. An audit would provide the necessary assurance that the requirements of the original NatSSIPs are being carried out |
| **What we intend to achieve (Goal):** |
| • Good compliance rates with the use and accuracy of SCIPs<br>• Assurance that variations of the SCIPs have only been developed with the NatSSIPs Group's approval |
| **How we will deliver and monitor progress:** |
| • Progress will be monitored through PSEC<br>• Audit results and action plans to be monitored at PSEC |
| **Responsible Person:** |
| Medical Director |

*Baseline data*

In response to the publication of the NHS England National Safety Standards for Invasive Procedures a steering group has been set up to implement the changes required. Safety Checklists for Invasive Procedures have been developed reflecting the requirements of both specialised areas and the general wards and departments within the Trust.

An audit was undertaken in December 2017 with Community Dental, Interventional Radiology, Pain Management and Dermatology participating in the audit. The results were as follows,

| Criterion | Met Standard |
|---|---|
| All fields in the **SIGN IN** section are complete | 67/74 (91%) |
| All fields in the **TIME OUT** section are complete | 72/74 (97%) |
| All fields in the **SIGN OUT** section are complete | 64/74 (86%) |

*Actions*

To ensure that all areas where safety checklists for invasive procedures are required are utilising the forms and to assist the development of new forms for any areas who require bespoke checklists. This will then be followed by a re-audit during 2018/19.

**Patient Experience**

### *a) Improve communication and information to relatives and carers*

| **What we set out to do (Priority):** |
|---|
| Improve communication and information to relatives and carers |
| **Why we chose this (Rationale):** |
| • Ambition 3, 2018-23 Quality Improvement Strategy states '*To achieve within the top 20% of all Trusts for National Survey findings'*<br>• Communication is a consistent theme throughout our patient feedback channels |
| **What we intend to achieve (Goal):** |
| • Develop the Trust Carer Lead role<br>• To develop bespoke local patient surveys aligned to the national surveys to monitor performance and address areas for improvement<br>• To define a key point of contact at each point in the patient's pathway for communications with patients and their families/carers |
| **How we will deliver and monitor progress:** |
| • CQC National Survey publications<br>• All sources of Patient Experience feedback<br>• Monitored through Carer and Patient Experience Committee (CAPE) |
| **Responsible Person:** |
| Director of Governance |

*Baseline data*

Communication and information to relatives and carers has been a theme from the recent patient surveys undertaken. Therefore, the comparative against the previous year's patient survey results will evidence whether there has been an improvement.

*Actions*

- Communication improvement audit integrated into the Making a Difference Framework;
- Red2Green patient experience evaluation survey rolled out Trust wide;
- Liaison with patients/families/carers to have a single point of contact within family to share communications/information and cascade;
- Offering enhanced feedback opportunities – 'you said' 'we did' initiatives;
- Scenario based learning in clinical areas for Accessible Information Standard to raise staff awareness of requirements.
- Enhancing collaborative working arrangements with Suffolk / Norfolk family carers.

### *b) Offer patients/relatives the opportunity to be engaged in investigatory processes following serious incidents*

| **What we set out to do (Priority):** |
|---|
| Offer patients/relatives the opportunity to be engaged in investigatory processes following serious incidents |
| **Why we chose this (Rationale):** |
| Ambition 3, 2018-23 Quality Improvement Strategy states '*Annual number of written complaints to remain within the lowest 20% of all acute trusts'* |
| **What we intend to achieve (Goal):** |
| The process of involving patients in serious incident investigations including Learning from Deaths investigations to become normal practice. |
| **How we will deliver and monitor progress:** |
| Audit of Serious Incident Root Cause Analysis (RCA) reports |
| **Responsible Person:** |
| Director of Governance |

*Baseline data*

This is a new piece of work hence there is no baseline data.

*Actions*

- RCA Terms of Reference to clearly identify that patients and/or relatives should be engaged in the investigation process
- Sign off process by Speciality and Division and to ensure patients and/or relatives have been appropriately involved
- Quarterly report to the Strategic Risk Group on percentage of investigation where patient/relatives have participated.

### c) *Develop opportunities for patient involvement in service improvement/ redesign*

| **What we set out to do (Priority):** |
|---|
| Develop opportunities for patient involvement in service improvement/ redesign |
| **Why we chose this (Rationale):** |
| • To increase the lines of communication with existing internal and external user groups e.g. specialty user groups and Patient Participation Groups (PPGs)<br>• To develop and/or redesign services with the involvement of those who will use the service |
| **What we intend to achieve (Goal):** |
| James Paget Hospitals User Group to be operational |
| **How we will deliver and monitor progress:** |
| Monitored through CAPE |
| **Responsible Person:** |
| Director of Governance |

*Baseline data*

This is a new piece of work hence there is no baseline data.

*Actions*

An inaugural meeting has been arranged for June 2018 and the Patient Engagement Strategy is to be refreshed.

## 2.2 Statements of Assurance from the Board

During 2017/18 the James Paget University Hospitals NHS Foundation Trust provided and/or sub-contracted **58** relevant health services, [listed in the table below].

The James Paget University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in **all** of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents **100%** of the total income generated from the provision of relevant health services by the James Paget University Hospitals NHS Foundation Trust for 2017/18.

| Specialties and services: | |
|---|---|
| Accident and Emergency (A&E) | Gynaecology |
| Anaesthetics | Haematology |
| Antenatal screening | Haematology |
| Audiology | Hyperbaric services |
| Bereavement Services | Intensive Care Services |
| Blood Transfusion | Maternity services |
| Breast Surgery | Medical illustration |
| Cardiology | Neonatology |
| Care of the Elderly | Nephrology and renal dialysis |
| Children's Centre | Obstetrics |
| Clinical Measurement | Oncology |
| Community Dental Services | Ophthalmology |
| Community midwifery | Oral Surgery |
| Community Paediatric Service | Paediatric Surgery |
| Continence and Stoma Care | Paediatrics |
| Coronary Care | Pain Management |
| Dental and Orthodontics | Palliative Care |
| Dermatology | Parentcraft |
| Diabetes | Pharmaceutical services |
| Diabetic Liaison | Rehabilitation |
| Diagnostic Imaging | Respiratory Medicine |
| Ear, Nose and Throat | Rheumatology |
| Endocrinology | Safeguarding children |
| Endoscopy | Sandra Chapman Centre |
| Fertility services | Stroke Services |
| Gastroenterology | Therapies e.g. physiotherapy |
| Gastro-intestinal Surgery | Trauma and Orthopaedics |
| General Medicine | Urology |
| General Surgery | Vascular Surgery |

**Clinical Audits and National Confidential Enquiries**

During 2017/18 **36** national clinical audits and **4** national confidential enquiries covered relevant health services that James Paget University Hospitals NHS Foundation Trust provides.

During that period James Paget University Hospitals NHS Foundation Trust participated in **35** national clinical audits and **4** national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that James Paget University Hospitals NHS Foundation Trust was eligible to participate in during 2017/18 are as follows: [see table below].

The national clinical audits and national confidential enquiries that James Paget University Hospitals NHS Foundation Trust participated in during 2017/18 are as follows: [see table below].

The national clinical audits and national confidential enquiries that James Paget University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry [where available].

| Audit Title | Relevant to JPUH Services? | Trust participation | Case Ascertainment |
|---|---|---|---|
| Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) | Yes | Yes | 100% |
| BAUS Urology Audits: Female Stress Urinary Incontinence | Yes | Yes | 90%+ |
| Bowel Cancer (NBOCAP) | Yes | Yes | 100% |
| ICNARC Case Mix Programme (CMP) | Yes | Yes | 100% |
| Diabetes (Paediatric) (NPDA) | Yes | Yes | 100% of cases will be submitted [at the time of reporting] |
| Elective Surgery (National PROMs Programme) | Yes | Yes | 100% (All eligible patients given PROMs questionnaires) |
| Falls and Fragility Fractures Audit Programme (FFFAP) – Inpatient Falls | Yes | Yes | 100% |
| Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture Database (NHFD) | Yes | Yes | 100% of eligible cases |
| Fractured Neck of Femur – Care in Emergency Departments | Yes | Yes | 100% |
| Inflammatory Bowel Disease (IBD) Registry | Yes | No | A decision was made to take part in the IBD Bioresource project instead, in line with a number of other Trusts. This replicates the majority of data required for the IBD Registry |
| Learning Disability Mortality Review Programme (LeDeR) | Yes | Yes | 100% |
| Major Trauma Audit (TARN) | Yes | Yes | Data awaiting validation due on the 31st May 2018 |

| Audit Title | Relevant to JPUH Services? | Trust participation | Case Ascertainment |
|---|---|---|---|
| National Audit of Breast Cancer in Older Patients (NABCOP) | Yes | Yes | Figures due for publication in June 2018 |
| National Audit of Dementia – Audit on Delirium Screening | Yes | Yes | 100% |
| National Cardiac Arrest Audit (NCAA) | Yes | Yes | 100% |
| National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Pulmonary rehabilitation | Yes | Yes | 100% |
| National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Secondary Care | Yes | Yes | 367 cases have been submitted since February 2017 |
| National Comparative Audit of Blood Transfusion - Transfusion Associated Circulatory Overload (TACO) 2017 | Yes | Yes | 100% |
| National Comparative Audit of Blood Transfusion Programme – Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients | Yes | Yes | 100% |
| National Diabetes Audit - Adults: National Inpatient Audit | Yes | Yes | 100% |
| National Diabetes Audit - Adults: National Core (NDA) | Yes | Yes | 100% |
| National Diabetes Audit - Adults: National Pregnancy in Diabetes Audit | Yes | No | Not available at time of writing |
| National Emergency Laparotomy Audit (NELA) | Yes | Yes | Estimated at 89.23% |
| National Heart Failure Audit | Yes | Yes | 100% |
| National Joint Registry (NJR) | Yes | Yes | 73.8% |
| National Lung Cancer Audit (NLCA) | Yes | Yes | All newly diagnosed lung cancers |
| National Neonatal Audit Programme (Neonatal Intensive and Special Care) (NNAP) | Yes | Yes | 100% |
| National Ophthalmology Audit | Yes | Yes | 100% |
| Oesophago-gastric Cancer (NAOGC) | Yes | Yes | Data collection ongoing |
| Pain in Children – Care in Emergency Departments | Yes | Yes | 100% |
| Paediatric Pneumonia | Yes | Yes | 100% |
| Procedural Sedation in Adults – Care in Emergency Departments | Yes | Yes | 100% |
| National Prostate Cancer Audit | Yes | Yes | 100% |
| Sentinel Stroke National Audit Programme (SSNAP) | Yes | Yes | For the period August – November 2017 the case ascertainment was 90%+ |
| Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme | Yes | Yes | 100% |
| UK Parkinson's Audit | Yes | Yes | 100% |
| Adult Cardiac Surgery | No | N/A | |

| Audit Title | Relevant to JPUH Services? | Trust participation | Case Ascertainment |
|---|---|---|---|
| BAUS Urology Audits: Nephrectomy | No | N/A | |
| BAUS Urology Audits: Cystectomy | No | N/A | |
| BAUS Urology Audits: Radical Prostatectomy | No | N/A | |
| BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL) | No | N/A | |
| BAUS Urology Audits: Urethroplasty | No | N/A | |
| Cardiac Rhythm Management (CRM) | No | N/A | |
| Congenital Heart Disease (CHD) – Adults and Paediatric work streams (cardiac surgery) | No | N/A | |
| Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI) | No | N/A | |
| Endocrine and Thyroid National Audit (UKRETS) | No | N/A | |
| Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service Database | No | N/A | |
| Head and Neck Cancer Audit (HANA) | No | N/A | |
| National Audit of Intermediate Care (NAIC) | No | N/A | |
| National Audit of Psychosis | No | N/A | |
| National Bariatric Surgery Registry | No | N/A | |
| National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI) | No | N/A | |
| National Diabetes Audit - Adults: National Foot care Audit (NDFA) | No | NA | |
| National Maternity and Perinatal Audit (NMPA) | No | N/A | |
| National Vascular Registry | No | N/A | |
| National Neurosurgical Audit Programme | No | N/A | |
| Paediatric Intensive Care (PICANet) | No | N/A | |

The reports of **25** national clinical audits were reviewed by the provider in 2017/18 and James Paget University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

*Some actions from national clinical audits overleaf:*

| |
|---|
| **Royal College of Emergency Medicine (RCEM) Severe Sepsis and Septic Shock in Adults**<br>- Formulate patient information sheet to be given to all patients, and/or relatives, admitted with sepsis. |
| **RCEM Moderate & Acute Severe Asthma (Adult & Paediatric) Care in Emergency Department**<br>- Written patient-held management plan to be developed, to include assessment of inhaler type, technique, steroids and follow-up. |
| **National Audit of Dementia (NAD) - Care in General Hospitals**<br>- Two members of the dementia team to attend NAD workshop in London<br>- Delirium bundle to be utilised<br>- More training and education to be implemented – Collaborative Learning Action Workshops (CLAW) 2 2018 will incorporate delirium training with an information banner pen.<br>- Policy and guidelines to be updated |
| **UK Inflammatory Bowel Disease (IBD) Audit - biological therapy audit (Round 5)**<br>- Laminated scoring sheets to be made available at clinic to reinforce documentation of disease activity index scoring at 3 month and 1 year follow-up. |
| **Oesophago-gastric Cancer National Audit (NOGCA/NAOGC)**<br>- Prospective investigation of all cases diagnosed after emergency admission to identify possible reasons for increased rates of diagnosis after emergency admission. |
| **National Pregnancy in Diabetes Audit (NPID)**<br>- The web site at JPUH to have information for women – information on preconception; how to contact maternity diabetic service. With links to advice and other sites, and have leaflets available. Eastern Academic Health Science Network (EAHSN) have approached the staff responsible for the web site. |
| **National Neonatal Audit Programme (NNAP)**<br>- Teaching of medical staff on induction to improve consistent capturing of data on Badgernet system.<br>- Parental consultation information to be put onto Neonatal handover sheet<br>- Admission pack to be developed to improve consistent giving out of NNAP booklet.<br>- Documentation to be updated regarding describing to patients the need for Retinopathy of Prematurity (ROP) screening using and individualised written resource which sets out the anticipated date of first screening for their baby. |

The reports of **136** local clinical audits were reviewed by the provider in 2017/18 and James Paget University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

*Some actions from local clinical audits overleaf:*

**Diabetic Ketoacidosis (DKA) Audit**

- Creation of a poster for A&E with criteria for HDU (High Dependency Unit)
- Update DKA protocol with following changes:
    - Ensure key areas are emboldened i.e. continue long acting insulin
    - Addition of diabetes team referral proforma
- Monitor effects of relocation of Ward 16 Short Stay on DKA management

**Audit on Door to Needle Time for Stroke Thrombolysis - Current Delays**

- Implementing a new 'flow' box on the form of the thrombolysis forms, to make staff aware of timings at all times

**Trust Compliance of Chest Drain Insertion**

- Produce a sticker for chest drain insertion to be completed and place in notes.
- Chest drain insertion/pleural procedure policy to be written.

**Fractured Neck of Femur Therapy Best Practice Pathway Audit**

- Implementation of the Elderly Mobility Scale (EMS) in Fractured Neck of Femur Patients. Day one physiotherapy assessment, replacing Barthel outcome for physiotherapy staff.

**Audit of discharge planning process to establish compliance with NICE QS117 to record actions to ensure homes are warm enough for people who are vulnerable to the health problems of cold homes**

- To update the discharge checklist used by wards.
- To update the admission booklet discharge checklist to reflect the ward discharge checklist.

**Self-administration of Medicines (SAM) Audit**

- Create a separate document containing the SAM assessment and consent form and the patient information leaflet to enable quick access to these. This will help prompt the issue of the patient information leaflet.
- Pharmacy to perform daily Patients' own drugs (PODs) check on the locker for all patients who are self-administering to ensure a supply of all medicines for SAM are present.

**Paediatric Diabetes Services Re-Audit**

- Implementation of a tracking system to ensure patients are completing the seven key care processes.
- Acquisition of tablets suitable for patients and their parents/carers to use in the waiting room when filling in the PREM (Patient Reported Experience Measure) survey online.

**Safeguarding adults referrals quality**

- To centralise quality control of Safeguarding Adults referral (AA1) forms, with an internal email inbox which is checked daily. This is also to ensure both Norfolk and Suffolk MASH teams only receive appropriate referrals.

**National Neutropenic Sepsis Audit (local audit based on National Guidance)**

- To standardise the use of a stamp and signature regarding time of admission, time of first suspicion of neutropenic sepsis and antibiotic administration, to ensure improved outcome with better data analysis.
- To devise a folder for SOS sheets to ensure proper filing so they can be appropriately traced to all patients presenting with neutropenic sepsis. This will avoid any loss of precious early admission data.

**Audit on management of patients at high risk of Carbapenemase Producing Enterobacteriaceae (CPE). Are we ready?**

- To make CPE screening questions in the admission booklet more prominent to ensure nurses screen all patients. Additionally add CPE screening questions on doctor's clerking section of the booklet.
- An education campaign to improve CPE screening compliance through posters, screen savers, teaching sessions and newsletter for staff.

**National Confidential Enquiries**

NCEPOD – What is it?

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is an independent charitable organisation that reviews medical and surgical clinical practice and makes recommendations to improve the quality of the delivery of care for the benefit of the public. They do this by undertaking confidential surveys and research covering many different aspects of care and making recommendations for clinicians and management to implement.

| Title | Aim | Relevant to JPUH Services | Trust participation | Percentage of Cases Submitted |
|---|---|---|---|---|
| Perioperative diabetes | The aim of this study is to identify and explore remediable factors in the process of care in the peri-operative management of surgical patients with diabetes across the whole patient pathway from referral for surgery (elective) or admission to hospital (emergency) to discharge from hospital. | Yes | Yes | 71% (5 of 7 cases). [1] |
| Heart Failure | To identify and explore avoidable and remediable factors in the process of care for patients admitted to hospital with acute heart failure. | Yes | Yes | 100% (4 of 4 cases) |
| Chronic Neurodisability | To improve the care provided to children and young people aged 0-25 years with a chronic neurodisability. | Yes | Yes | 100% (2 of 2 cases) |
| Young People's Mental Health | To identify the remediable factors in the quality of care provided to young people treated for mental health disorders; with specific reference to:<br>• Depression and anxiety<br>• Eating disorders<br>• Self harm<br>To examine the interface between different care settings.<br>To examine the transition of care. | Yes | Yes | N/A no cases identified. Organisational questionnaires completed. |

[1] Please note the study is still open and the figures have not been finalised

| Title | Aim | Relevant to JPUH Services | Trust participation | Percentage of Cases Submitted |
|---|---|---|---|---|
| Cancer in Children, Teens and Young Adults | The aims of this study are to study the process of care of Children, Teens and Young Adults under the age of 25 years who died/or had an unplanned admission to critical care within 30 days of receiving systemic anti-cancer therapy (SACT) in order to:<br>1.Look at the decision making and consent process around the prescription of SACT in this group of patients.<br>2.Explore remediable factors in the quality of care provided to patients during the final line of therapy.<br>3.Look at preventable causes of treatment-related mortality in young people's cancers.<br>4.Look at the configuration of the service and organisational structures in place for the safe delivery of SACT to children, teenagers and young adults. | No | N/A | N/A |

**Participation in Clinical Research**

Participants were recruited across **55** different studies in 22 specialties as designated by the National Institute for Health Research (NIHR). Studies recruited to in 2017/18 are being undertaken by 28 Good Clinical Practice (GCP) trained Principal Investigators supported by a team of 21 clinical and non-clinical members of the Research & Development Department.

The internationally recognised #WhyWeDoResearch Twitter campaign was nominated and shortlisted for an HSJ award in the Improving Care with Technology category. Four staff members attended the awards ceremony along with the Kissing Goodbye to Sepsis Campaign team who were also nominated in the Patient Safety category.

The department continues to work with the Pharmaceutical industry and has undertaken commercially funded studies in three new specialties this year in Gastroenterology, Paediatrics and Cardiology.

The number of patients receiving relevant health services provided or sub-contracted by James Paget University Hospitals NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee: **830***

* Figures based on projected final recruitment as confirmed figures will not be available until end April.

**Commissioning for Quality and Innovation (CQUIN) Framework**

CQUIN – What is it?

CQUIN means Commissioning for Quality and Innovation. This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. This means that a proportion of our income depends on achieving quality improvement and innovation goals agreed between the Trust and its commissioners.

A proportion of James Paget University Hospitals NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between James Paget University Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017-19 and for the following 12-month period are available electronically at: https://www.england.nhs.uk/wp-content/uploads/2016/11/cquin-2017-19-guidance.pdf

The amount of income in 2017/18 conditional upon achieving quality improvement and innovation goals is: **£3,401,723**

The amount of income received for the associated payment in 2016/17 was: **£3,380,777**

**Care Quality Commission (CQC)[2]**

CQC – What is it?

The CQC are the independent regulator of health and social care in England.

They make sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve.

They monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and publish what they find, including performance ratings to help people choose care.

James Paget University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is with no conditions attached to registration.

The Care Quality Commission **has not** taken enforcement action against James Paget University Hospitals NHS Foundation Trust during 2017/18.

James Paget University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

**Secondary Uses Service**

Secondary Uses Service – What is it?

The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

James Paget University Hospitals NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was:
  - **98.75%** for admitted patient care
  - **99.82%** for outpatient care and
  - **99.10%** for accident and emergency care
- which included the patient's valid General Medical Practice Code was:
  - **100%** for admitted patient care
  - **100%** for outpatient care and
  - **99.28%** for accident and emergency care.

**Information Governance Assessment Report**

Information Governance – What is it?

Information Governance (IG) is the way in which the NHS handles all information and in particular the personal and sensitive information of patients and staff.

Following strict IG guidelines enables the Trust to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care to our patients.

James Paget University Hospitals NHS Foundation Trust's Information Governance Assessment Report overall score for 2017/18 was **94%** and was graded **[GREEN]**.

The table below shows 2017/18 results against previous years:

| Year | 2016 Result (IGT version 13) | 2017 Result (IGT version 14) | 2018 Result (IGT version 14.1) |
|---|---|---|---|
| Overall Result | 77% (Satisfactory) (45 out of 45 answered) | 80% (Satisfactory) (45 out of 45 answered) | **94% (Satisfactory)** (45 out of 45 answered) |

Scoring has increased as a result of auditing level 3 (due to new audits carried out) this will continue on a yearly basis. The first results will be shared at the next Information Governance Committee in May 2018. There continues to be room for improvement and that has been included in the Information Governance improvement plan signed off March 2018.

The Trust has been preparing and raising awareness for the new General Data Protection Regulations that are enforceable from 25th May 2018.

**Payment by Results**

Payment by Results – What is it?

Payment by Results (PbR) is the rules-based payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs.

PbR currently covers the majority of acute healthcare in hospitals, with national tariffs for admitted patient care, outpatient attendances, accident and emergency (A&E), and some outpatient procedures.

James Paget University Hospitals NHS Foundation Trust **was not** subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

**Data Quality**

James Paget University Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

In line with version 14.1 of the IG Toolkit, the Trust monitors its attainment level for the completeness and validity check for data submitted to the Secondary Uses Service (SUS), further detail is available by following this link https://www.igt.hscic.gov.uk/KnowledgeBaseNew/DH_NHS%20IG%20-%20Data%20Output%20Quality%20Standards_0.3.pdf

The areas covered in the assessment are admitted patient care, outpatients and waiting lists. Admitted patient care and outpatients are currently submitted to SUS but waiting lists are not submitted via SUS but are delivered to our Commissioners via email.

Each area is given an Attainment Level and these are scored between 0 (lowest) and 3 (highest).

## 2.3 Reporting against core indicators

### Summary hospital-level mortality indicator (SHMI)

Summary hospital-level – What is it?

The SHMI shows whether the number of deaths linked to a particular hospital is more or less than expected, and whether that difference is statistically significant. It covers all English acute non-specialist providers.

The dataset used to calculate the SHMI includes all deaths in hospital, plus those deaths occurring within 30 days after discharge from hospital. The expected number of deaths is calculated from a risk-adjustment model developed for each diagnosis grouping that accounts for age, gender, admission method and comorbidity (any other illnesses or conditions).

The lower the SHMI figure, the better the outcome for patients

| | JPUH 2015/16 | JPUH 2016/17 | **JPUH 2017/18** | National Average 2017/18 | Highest SHMI for Foundation Trusts | Lowest SHMI for Foundation Trusts |
|---|---|---|---|---|---|---|
| (a) Value and (banding) of the SHMI for the Trust | 107.96 (as expected) | 118.23 (higher than expected) | **120.83 (higher than expected)** | 100 | 120.83 | 73.42 |
| (b) % of patient deaths with palliative care coded at either diagnosis or specialty level | 24.05% | 21.3% | **23.4%** | 31.4% | 59.5% | 11.5% |

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Data is taken from Caspe Healthcare Knowledge Systems (CHKS) iCompare which uses Secondary Users Service (SUS) Hospital Episode Statistics (HES) data which is audited on an annual basis by external auditors.

James Paget University Hospitals NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

✓ A significant improvement programme is in place led by the Trust's Medical Director and overseen by the Mortality Surveillance Group. The following pages detail some of the actions taken and planned.

**Learning from Deaths**

During 2017/18 our governance arrangements for learning from deaths have been continuously reviewed and an internal audit review has provided assurance that we were on track to achieve completion of our system and process changes, including our Learning from Deaths Policy which we published in September 2017. The Learning from Deaths Policy sets out our arrangements for identifying and reviewing mortality cases. Alongside this we have been working through a Mortality Action Plan which is monitored at the Mortality Surveillance Group (MSG) monthly and reported to the Safety and Quality Governance Committee.

Item 1: During 2017/18 **1276** of the James Paget University Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

**306** in the first quarter;
**277** in the second quarter;
**327** in the third quarter;
**366** in the fourth quarter.

Item 2: By 16/04/18, **309** case record reviews and 6 investigations have been carried out in relation to **314** of the deaths included in item 1

In **one** case a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

**88** in the first quarter;
**104** in the second quarter;
**107** in the third quarter;
**15** in the fourth quarter [at the time of reporting].

Item 3: **Four** representing **0.3%** of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

**One** representing **0.3%** for the first quarter;
**Two** representing **0.7%** for the second quarter;
**One** representing **0.3%** for the third quarter;
**Zero** representing **0%** for the fourth quarter [at the time of reporting].

***Item 4 - A summary of what the provider has learnt from case record reviews and investigation is conducted in relation to the deaths identified in item 3***

In line with our policy, we have responded to flags or warning signals from external mortality reports and internal intelligence using a combination of targeted case reviews, investigating data quality issues and impact on coding and performing care pathway reviews as appropriate.

The themes from the analysis of case record reviews and investigations include:

- Insufficient medical assessment;
- Delays in obtaining support from senior decision makers;
- Failure to recognise that it was time to introduce palliation/end of life care;
- Delays in performing tests;
- Incomplete/poor documentation in the medical records;
- Death Certificate inaccuracies;
- Care pathway issues;
- Number of out of hospital falls leading to fracture and subsequent surgery;
- Incidence of people admitted with pressure ulcers from residential settings;
- Depth of coding weaknesses due to incomplete recording of comorbidities.

***Item 5 – A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 4)***

The Trust has published a Learning from Deaths Policy and audited and improved our systems for Mortality Governance. The Trust has shared the learning from case note reviews and investigations with clinical teams and involved clinical staff in designing and delivering improvement actions.

In order to address local system issues the Trust collaborated with local providers and the Clinical Commissioning Group to establish a forum for joint reviews to identify system learning.

With regard to the use of data the Trust has investigated cases in specialty categories where the number of observed deaths exceeded the expected and undertaken coding reviews as appropriate.

Where the data suggested that there could be quality of service issues the Trust has commissioned clinical service reviews of specialties in order to investigate potential flags from data reports.

The Trust plans to bring on stream some developments to help identify and treat known issues including:

- Introduce a structured judgement tool for case note reviews to improve consistency of the process and provide richer detail about what went well and what could have been better;
- Establish a Medical Examiner Service. This means that a Senior Appointed Clinician will screen every death and with the support of an officer, engage with the bereaved, the Coroner and the medical teams to determine why the patient died and what the next steps in each case are. This has been taken forward as a 2018/19 Quality Priority, see page 6;
- Introduce a reporting system to enable us to record staff and relatives' views about each case so that we can identify concerns as close as possible to the event;
- Introduce a process for validation of clinical coding which will bring clinicians and clinical coders together for mutual benefit.

***Item 6 – An assessment of the impact of the actions described in item 5 which were taken by the provider during the reporting period***

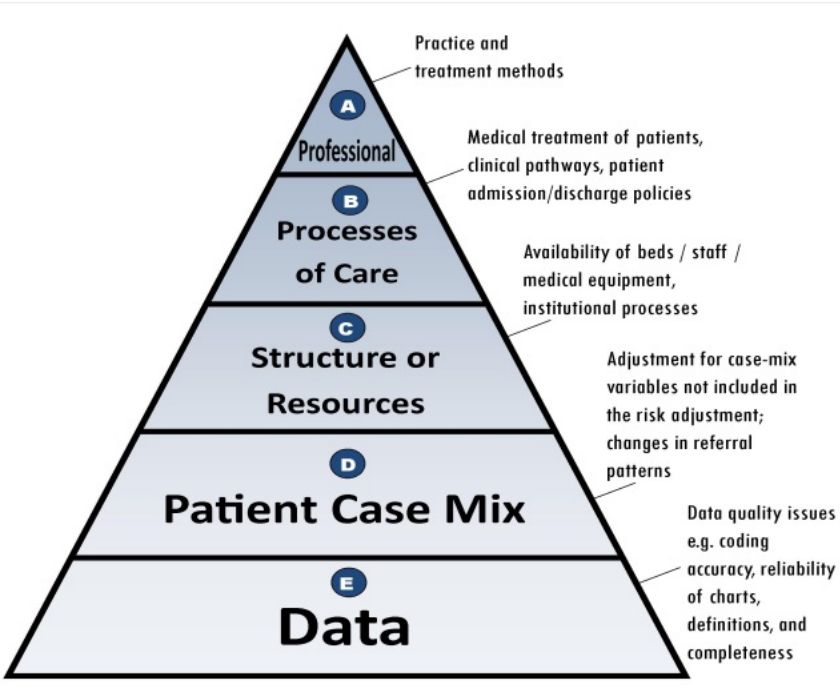
The Trust's mortality governance processes are part of an integrated governance system and the Trust is committed to enabling improvement using data to measure impact. The actions described in item 5 have positively impacted our capacity to learn and respond. Our strategic intent is to equip our staff with quality improvement skills and knowledge which will help them go further, faster in their ability to effect change. Pan domain objective A: To develop a training programme to equip staff with a Quality Improvement toolkit page 4.

Item 7: **22** case record reviews and **3** investigations were completed after 1st April 2017 which related to deaths which took place before the start of the reporting period.

Item 8: **0** representing **0%** of the patient deaths before the reporting period, were reviewed after 1st April 2017 and are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the outcomes of mortality case reviews using a Trust-developed review tool, as well as the outcomes of Root Cause Analyses based on incidents relating to patient deaths.

Item 9: **1** representing **0.1%** of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

The Trust has planned its improvement programme around the 'Pyramid for Improvement' which is an evidence-based multi-faceted approach that simultaneously investigates data, case mix, structure or resources, processes of care and clinical practice and treatment.



**Patient reported outcome measures (PROMs)**

PROMs – What is it?

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

The four procedures are

i. groin hernia surgery
ii. varicose vein surgery
iii. hip replacement surgery
iv. knee replacement surgery

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected from patients through PROMs questionnaires before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

PROMs participation rates

| | JPUH 2015/16 | JPUH 2016/17 | JPUH 2017/18[3] |
|---|---|---|---|
| Groin hernia surgery | 39.3% | 81% | No longer collected |
| Varicose vein surgery | 34.6% | 19% | No longer collected[4] |
| Hip replacement surgery | 63.4% | 49% | 131%[5] |
| Knee replacement surgery | 57.8% | 55% | 148% |
| All procedures | 52.9% | 51% | 139% |

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

• See actions on page 30.

[3] October 2017 - December 2017 data only
[4] Varicose vein and groin hernia PROMS are no longer collected following a consultation undertaken by NHS England.
[5] Please note that in some cases the participation rate figure may be over 100%. If this is the case, it may reflect an increase in clinical activity over and above that recorded by Hospital Episode Statistics (HES). There could be a variety of reasons for this, e.g. an increase in referrals; or bringing activity that was formerly attributed to Independent Hospitals in-house.

James Paget University Hospitals NHS Foundation Trust has taken/intends to take the following actions to improve these percentages, and so the quality of its services, by:

✓ The Division of Surgery undertook a review of the processes that were in place within pre-operative assessment for PROMS to ensure that all patients eligible for participation were being given the opportunity to participate. Staff were asked to then keep a record of how many PROMS were distributed and how many were completed going forward as this information was not available. Reviewing the process has resulted in a significant increase in PROMS participation; evident in the estimated PROMS participation rates received on a monthly basis from the PROMS Manager.

**Hospital re-admissions**

Hospital re-admissions – What is it?

Includes patients readmitted to a hospital within 28 days of discharge from that same hospital or from a hospital which forms part of the same Trust.

| | JPUH 2015/16 | JPUH 2016/17 | **JPUH 2017/18** | National Average 2017/18 | Highest score for Foundation Trusts | Lowest score for Foundation Trusts |
|---|---|---|---|---|---|---|
| Patients aged 0-15 years | 9.24% | 8.33% | **7.73%** | 8.58% | Data not available | Data not available |
| Patients aged 16 or over | 6.54% | 6.64% | **6.72%** | 7.73% | Data not available | Data not available |

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Data is taken from CHKS iCompare which uses Secondary Uses Service/Hospital Episode Statistics data which is audited on an annual basis by external auditors.

James Paget University Hospitals NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

✓ The SAFER (**S**enior review, **A**ll patients, **F**low, **E**arly discharge, **R**eview) campaign is launching on the 5th June 2018 and readmissions are a focus within this. This focus will encompass all readmissions to be reviewed and a report will be put in place to monitor this. A live monitoring of readmissions is to be supported by the newly implemented discharge hub with the creation of a readmission forum to support learning both internally and system wide.

**Responsiveness to the personal needs of patients**

What is the standard?

This indicator is based on data from the National Inpatient Survey and forms part of the NHS Outcomes Framework (Domain 4) 'Ensuring People Have a Positive Experience of Care'

The indicator is based on questions from the inpatient survey under the domains:

- Access and waiting
- Safe, high quality, coordinated care
- Better information, more choice
- Building closer relationships
- Clean, comfortable, friendly place to be

The scores are out of 100. A higher score indicates better performance: if patients reported all aspects of their care as "very good" we would expect a score of about 80, a score around 60 indicates "good" patient experience. The score is the average of the domain scores.

| JPUH 2015/16 | **JPUH 2016/17** | **JPUH 2017/18** | **England score 2016/17** |
|---|---|---|---|
| 70.6 | **67.8** | Data not due to be published until August | 68.1 |

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- This indicator is based on questions from the National Inpatient Survey and patients have scored the Trust highly on the five aspects taken as part of this indicator.
- The Trust score is in line with the national average indicating a 'good' patient experience.

James Paget University Hospitals NHS Foundation Trust intend to take the following actions to improve these percentages, and so the quality of its services, by:

✓ An action plan is in place and bespoke surveys are carried out in response to the national survey.

**Venous thromboembolism (VTE) risk assessment**

Venous thromboembolism – What is it?

A clot within a blood vessel is called a thrombus and the process by which it forms is known as thrombosis. It can be damaging as it might block the flow of blood. Also, part of the clot might break away and block a blood vessel further along, cutting off the blood supply to important organs.

Deep vein thrombosis (DVT) is the formation of a blood clot in one of the deep veins within the body, such as in the leg or pelvis. This kind of thrombosis can occur after surgery and may cause redness, pain and swelling.

Pulmonary embolism (PE) is a serious condition in which the arteries leading from the heart to the lungs become blocked. It can occur when a blood clot breaks away from its original location and travels to the lungs. Symptoms may include sharp chest pain, shortness of breath and coughing up blood.

The process by which blood clots occur and travel through the veins is known as venous thromboembolism (VTE), the collective term for DVT and PE.

What is the standard required?

Percentage of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool. The final indicator value for this is 95%.

| Month | Trust Target | 2017/18 | Variation |
|---|---|---|---|
| April 2017 | 97% | **97.79%** | +0.79% |
| May 2017 | 97% | **97.52%** | +0.52% |
| June 2017 | 97% | **97.61%** | +0.61% |
| July 2017 | 97% | **98.26%** | +1.26% |
| August 2017 | 97% | **97.39%** | +0.39% |
| September 2017 | 97% | **98.36%** | +1.36% |
| October 2017 | 97% | **98.70%** | +1.70% |
| November 2017 | 97% | **98.71%** | +1.71% |
| December 2017 | 97% | **98.03%** | +1.03% |
| January 2018 | 97% | **98.48%** | +1.48% |
| February 2018 | 97% | **97.57%** | +0.57% |
| March 2018 | 97% | **98.07%** | +1.07% |

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- There are robust systems and process in place to ensure patients receive an appropriate VTE risk assessment on admission.

James Paget University Hospitals NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

✓ The Trust is consistently exceeding the national 95% target and the local stretch target of 97%.

**Clostridium difficile *(C.difficile)***

*C.difficile* – What is it?

*C.difficile* is a type of bacteria (germ) that can cause infection of the digestive system resulting in diarrhoea. *C.difficile* infections are usually caused by antibiotics; hence the majority of cases happen in a healthcare environment, such as a hospital or care home. Older people are most at risk from infection - people aged over 65 account for three quarters of all cases. In recent years, the number of *C.difficile* infections has fallen rapidly.

What is the standard?

This measure shows the rate per 100,000 bed days of cases of *C.difficile* infection that have occurred within the Trust amongst patients aged two years or over during the reporting period.

The lower the figure, the lower the number of *C.difficile* cases.

| | JPUH 2015/16 | JPUH 2016/17 | **JPUH 2017/18** | National Average 2016/17 | Highest score for Foundation Trusts | Lowest score for Foundation Trusts |
|---|---|---|---|---|---|---|
| Rate per 100,000 bed days *C.diff* infection | 20.2 | 14.98 | **12.04** | 13.19 | 82.70 | 0 |
| Number of cases of *C.diff* infection | 29 | 19 | **16** | 28 | 110 | 0 |

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Continuing strong focus on prevention as well as control
- Symptomatic carriers are isolated so the Trust is proactive in controlling the risk.

James Paget University Hospitals NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

✓ Encouraging prudent use of antibiotics through:
- Antibiotic policies;
- Encouraging the use of narrow-spectrum antibiotics;
- Limiting the duration of antibiotics usage;
- Encouraging intravenous to oral switch.

The ceiling for *C.difficile* hospital attributable cases for 2017/18 was 17. There have been 16 *C.difficile* cases in total since 1st April 2017. Of these, 10 cases have been successfully appealed; hence six were considered hospital attributable.

The ceiling for 2018/19 is 16 cases, all Trusts have had their numbers reduced by one.

**Patient Safety Incidents**

Patient Safety Incident – What is it?

A Patient Safety Incident (PSI) is any untoward incident that happens involving a patient whilst they are on Trust premises or in Trust care e.g. a patient fall.

Harm definitions

The Trust uses the nationally recognised definitions of harm as described by the National Patient Safety Agency (NPSA)

| | | |
|---|---|---|
| No Harm | – | An incident has occurred but with no harm as a result |
| Minor Harm | – | Minor injury or illness requiring minor intervention (treatment) |
| Moderate Harm | – | Moderate injury requiring professional intervention |
| | – | Increase in length of hospital stay by 4–15 days |
| Major Harm | – | Major injury leading to long-term incapacity or disability |
| | – | Increase in length of hospital stay by more than 15 days |
| | – | Mismanagement of patient care with long term effects |
| Death | – | Incident leading to death |

| | JPUH 2015/16 | JPUH 2016/17 | **JPUH 2017/18** | Highest score for Acute (non-specialist) trusts (Oct 16 to Mar 17)[6] | Lowest score for Acute (non-specialist) trusts (Oct 16 to Mar 17) |
|---|---|---|---|---|---|
| Number of patient safety incidents | 4680 | 4611 | **4930** | 14506 | 1301 |
| | | | | **JPUH (Oct 16 to Mar 17) 2267** | |
| Rate per 1000 bed days | 32 | 35 | **38** | 68.97 | 23.13 |
| | | | | **JPUH (Oct 16 to Mar 17) 32.3** | |
| Percentage of incidents resulting in Major Harm | 0.2% | 0.2% | **0.3%** | 2.1% | 0% |
| | | | | **JPUH (Oct 16 to Mar 17) 0.2%** | |
| Percentage of incidents resulting in Death | 0% | 0.1% | **0.2%** | 0.5% | 0% |
| | | | | **JPUH (Oct 16 to Mar 17) 0.04%** | |

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Incident reporting as a whole has increased by 2% in 2017/18 compared to 2016/17.

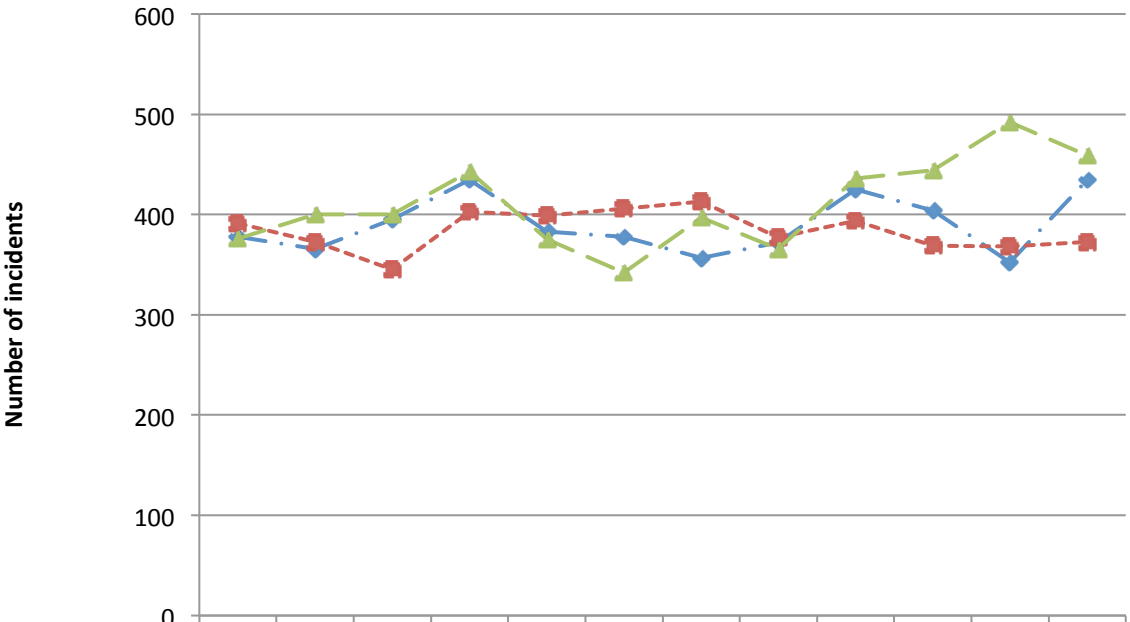
[6] This date range has been selected as this is the most current data available from the National Reporting and Learning Service.

- The Trust has maintained a good position on reporting PSIs to the National Patient Safety Agency within this period. The Trust sits one space below the 'Lowest 25% of reporters' among our peer group (acute (non-specialist) trusts).

The NPSA say: '*We encourage high reporting. Scrupulous reporting and analysis of safety related incidents, particularly incidents resulting in no or low harm, provides an opportunity to reduce the risk of future incidents. Research shows that organisations which report more usually have a stronger learning culture where patient safety is a high priority. Through high reporting the whole of the NHS can learn from the experiences of individual organisations'.*

- Monthly monitoring of what has or, more importantly, has not been submitted as a PSI

*Patient Safety Incidents 2015/16 to 2017/18*




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 378 | 366 | 395 | 435 | 383 | 378 | 357 | 372 | 425 | 404 | 352 | 435 |
| 2016/17 | 391 | 373 | 345 | 403 | 399 | 406 | 413 | 377 | 394 | 369 | 368 | 373 |
| 2017/18 | 376 | 400 | 400 | 443 | 375 | 342 | 397 | 366 | 436 | 444 | 492 | 459 |

James Paget University Hospitals NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- ✓ Incident reporting rates are discussed at Divisional governance meetings and at the Patient Safety and Effectiveness Committee.
- ✓ Incident reporting and learning is discussed at Divisional governance meetings monthly with trends and themes analysed and cascaded to wider teams.
- ✓ Continuing to increase awareness around categorising harm when reporting incidents.

- ✓ Uploads to the National Reporting and Learning Service (NRLS) and quality checking of Patient Safety Incidents will continue. Uploads to the NRLS are carried out at least weekly.

- ✓ All data is provided by bed days/number of contacts for Divisions to provide context when analysing incident data.

**Friends and Family Test - Patient**

Friends and Family Test – What is it?

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

| | Trust Score March 2018 | | Trust response rate March 2018 | NHS England Score February 2018 | | NHS England response rate February 2018 |
|---|---|---|---|---|---|---|
| Area | % recommended | % not recommended | | % recommended | % not recommended | |
| A&E | 91% | 3% | 7.24% | 85% | 8% | 13.4% |
| Inpatients & Daycases | 98% | 1% | 17.84% | 96% | 2% | 24.5% |
| Maternity (combined) | 100% | 0% | 8.18% | 96% | 1% | - |
| Outpatients | 97% | 1% | 14.72% | 94% | 2% | - |
| **Trust Summary** | **97%** | **1%** | **13.94%** | **-** | **-** | **-** |

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- ✓ For all areas our patients are more likely to recommend and less likely to not recommend than the England average evidencing to a better than average patient experience.

James Paget University Hospitals NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- All areas of the Trust review the qualitative comments received via the FFT returns. Actions to address themes are monitored via the Carer and Patient Experience Committee (CAPE).

**Friends and Family Test (FFT) - Staff**

What is the standard?

Staff are asked to respond to two questions. The 'Care' question asks how likely staff are to recommend the NHS services they work in to friends and family who need similar treatment or care. The 'Work' question asks how likely staff would be to recommend the NHS service they work in to friends and family as a place to work. Staff FFT is conducted on a quarterly basis (excluding Quarter 3 when the existing NHS Staff Survey takes place).

| | JPUH 2015/16 | JPUH 2016/17 | **JPUH 2017/18** | England 2017/18[7] | Highest score for Foundation Trusts | Lowest score for Foundation Trusts |
|---|---|---|---|---|---|---|
| Care | 78% | 82% | **88%** | 80% | 100% | 43% |
| Work | 68% | 70% | **73%** | 63% | 100% | 25% |

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- There is a year on year improvement in staff recommending the Trust as a place to receive 'Care' and a place to work.

James Paget University Hospitals NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

✓ The Trust is developing a Staff Engagement Programme to maximise opportunities to gain quantitative and qualitative feedback from staff.

**NHS Staff Survey – Key Finding 21[8]**

| | **2016** | **2017** | | Trust improvement/ deterioration |
|---|---|---|---|---|
| | JPUH | **JPUH** | Benchmarking group (trust type) average | |
| KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion[9] | 88% | **88%** | 85% | 0%<br>No Change |
| | Higher score = better | | | |

[7] Quarter 1 and 2 for 2017/18
[8] For results and actions arising from the NHS Staff Survey, please refer to the Trust Annual Report and Accounts 2017/18
[9] For the Workforce Race Equality Standard https://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard/

**NHS Staff Survey – Key Finding 26**

| | 2016 | 2017 | | Trust improvement/ deterioration |
|---|---|---|---|---|
| | JPUH | **JPUH** | Benchmarking group (trust type) average | |
| KF26 percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months | 26% | **27%** | 25% | 1% Deterioration |
| | Lower score = better | | | |

**Seven Day Services**

What is the standard?

The seven day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.

Patients across England will see a revolution in hospital care with the introduction of seven day consultant-led services that are delivered consistently over the coming years.

The Trust was an early adopter of the 10 standards designed to improve access to high quality services across the seven day week.

1. Patient Experience
2. **Time to First Consultant Review**
3. MDT Handover
4. Shift Handovers
5. **Diagnostics**
6. **Interventions**
7. Mental Health
8. **On-going Consultant review**
9. Transfer to community, Primary or Social Care
10. Quality Improvement

*Standards in bold are the 4 priority areas.*

There is a national requirement that all trusts meet the four priority standards (2,5,6,8) for Seven Day Services (7DS) by March 2020, with a milestone requirement that 50% of patients are receiving access to priority standard compliant services by March 2018. The Trust participated in the national surveys of performance to these standards in March and September 2017 and our benchmark results compare favourably with other trusts with headlines reported below:

- The overall proportion of patients who required twice daily consultant reviews and were reviewed twice by a consultant was 100%;
- The overall proportion of patients who required a daily consultant review and were reviewed by a consultant was 85%;

- The overall proportion of patients seen and assessed by a suitable consultant was 62%.

As with all data, there are areas for further exploration and the Trust does this with the clinical teams. The Trust identified that we could further improve on our results by improving the completeness of clinical record keeping for recording the time an entry is made in the record, and also the consistent recording of the date and time that the patient/or family is aware of the management plan.

During 2018/19 the Trust will be expanding our work to identify measures for all standards in order to meet the requirements of the national contract.

# Part 3

## Review of Quality 2017/18

This section details how we have done against the targets we set for 2017/18 in our 2016/17 Quality Report. Where relevant we have included what we said within the 2016/17 Quality Report as an easy reference for the data included. Where possible we have included historical performance and where available we have included national benchmarks.



This section includes other information relevant to the quality of services we have provided over 2017/18



This section shows how we have done when external inspectors/regulators have visited the Trust. The details include remedial action that has been identified following these visits/inspections.



This section shows our performance against the relevant indicators and thresholds set out in NHS Improvement's Risk Assessment Framework

**Summary of Achievement of Quality Priorities 2017/18**

| 1. | Patient Safety | |
|---|---|---|
| a | To participate in the National Improvement Collaborative programmes for falls, pressure ulcers and end of life care. | Achieved |
| b | To develop and embed the Trust mortality process in line with national guidance. | Achieved |
| c | CQC inspection 2016: Plan and prioritise the actions required to address the findings in relation to areas identified by CQC where the Trust 'should' take action. | Achieved |
| d | Themed review of learning from medicines management incidents and Never Event | Achieved |

| 2. | Clinical Effectiveness | |
|---|---|---|
| a | Learning from clinical audit: develop and apply consistent processes to ensure findings from clinical audits result in action, learning and sustained improvements in practice | Achieved |
| b | Develop clinical audits with our health and social care partners aligned to our strategic objectives e.g. service developments with the Sustainability and Transformation Plan (STP) | Achieved |

| 3. | Patient Experience | |
|---|---|---|
| a | Address the areas where performance has deteriorated as measured by the patient experience National Surveys e.g. Inpatient, Maternity, A&E, etc. | Achieved |
| b | Develop and implement clear, action-oriented Trust-wide Always Events | Achieved |
| c | Develop a patient experience survey tool aligned to aims of Red to Green programme | Achieved |
| d | Co-design a staff/patient experience education and training DVD | Achieved |

| 4. | Pan-Domain Objective | |
|---|---|---|
| a | Improve patient flow throughout the hospital so that patients are provided with safe care in the right place at the right time | Achieved |

## Patient Safety

### *a) To participate in the National Improvement Collaborative programmes for falls, pressure ulcers and end of life care.*

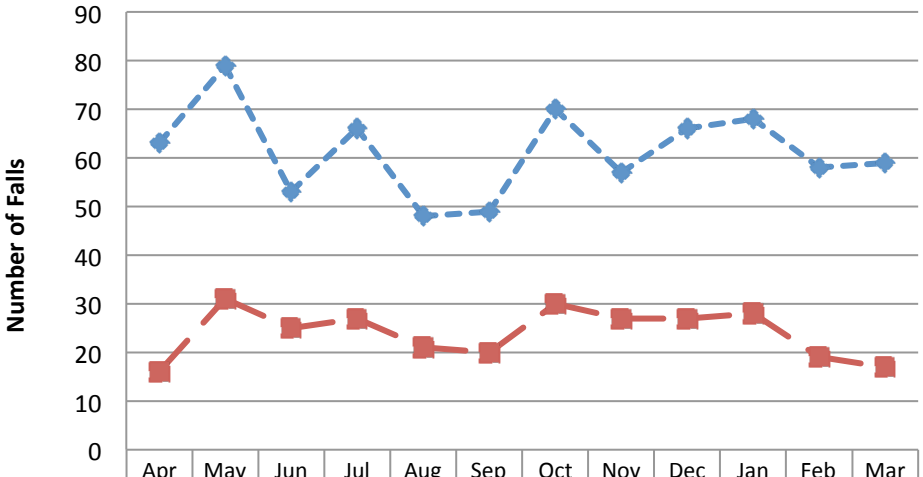
This Quality Priority has been **achieved** due to the Trust not being accepted onto the pressure ulcer collaborative due to the pressure ulcer incident rates being low.

Progress has been made throughout the year and the following actions are well embedded:

- Internal Operational and Strategic groups for falls are well established;
- Pressure Ulcer Strategic group has a work plan based on scoping exercise action plan;
- End of Life Strategy presented to Safety and Quality Governance Committee (SQG) in September 2017;
- Clinical audits planned:
  - 'Making a Difference' Trust wide nursing care audit programme covers falls and pressure ulcers as part of a rotating programme;
  - Preferred Place of Death audit (NICE NG31 and QS13);
- The Trust was not accepted onto the 2017 pressure ulcer collaborative.

The graph below shows the number of patient falls and falls with harm for 2017/18. There has been an overall decrease in the number of patient falls and falls with harm.

Patient Falls and Falls with Harm 2017/18




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Falls | 63 | 79 | 53 | 66 | 48 | 49 | 70 | 57 | 66 | 68 | 58 | 59 |
| Falls with Harm | 16 | 31 | 25 | 27 | 21 | 20 | 30 | 27 | 27 | 28 | 19 | 17 |

### *b) To develop and embed the Trust mortality process in line with national guidance.*

This Quality Priority has been **achieved**. The Trust Lead for mortality has developed processes and reported on progress through the monthly Quality and Safety report to the Board of Directors. The following progress has been made during 2017/18:

- Learning From Deaths Policy approved and published on the Trust website;
- Mortality Group Terms of Reference have been reviewed and revised;
- Mortality Register revised;
- Trust Mortality Lead has attended train-the-trainer training for use of the national mortality review tool;
- Support, guidance and best practice shared by NHS Improvement with a Board of Directors workshop in November 2017;
- Discussions under way with other trusts to collaborate and share best practice;
- Divisional Boards include Mortality as a standing agenda item;
- Reporting on learning from mortality reviews/meetings to Patient Safety and Effectiveness Committee (PSEC);
- Review in line with Health and Social Care Information Centre (HSCIC) Summary Hospital-level Mortality Indicator (SHMI) guidance commenced with data/coding review in October 2017.

### *c) Care Quality Commission (CQC) Actions*

This Quality Priority has been **achieved**. Core Service action plans are monitored through Divisional Governance and the Patient Safety & Effectiveness Committee. A Quality Assurance Framework has been developed to test the effectiveness of the action plans and ensure standards are maintained in all areas. A Trust wide action plan is in place to address areas the CQC recommended the Trust 'should' look at.

Safety issues relating to staffing are monitored monthly at the Board of Directors with a bi-annual review of nursing establishment. The below table has been updated following review of the divisional action plans.

| Issue Raised in Final Report: The Trust Should: | Outcomes |
|---|---|
| **Division of Medicine**<br>Review its registered nurse staffing across the emergency and medical divisions to ensure sufficient numbers of nurses are on duty to ensure safe delivery care. | The January 2018 establishment review recommended a registered nurse patient ratio of 1:8 during the day and 1:10 at night in the general ward areas. The intention remains for the total staff to patient ratio to be 1:3.8, however, there is some variance to this where professional judgement has informed decision-making.<br><br>A significant feature of the review was the formal introduction of the assistant practitioner role into the workforce. This role is a skilled and competent member of the workforce, which contributes to the total safe staffing ratio. Furthermore, this role is instrumental in the Trust's intention to apply the principle of 'grow your own' as a means to achieve medium to long term plans to increase registered nurse recruitment and retention. There |

| | |
|---|---|
| | will be a period of transition to fully achieve the 2018 workforce plan.<br><br>Further details can be found within section 2.1 of this report as this is a quality priority for 2018/19. |
| **Division of Medicine**<br>Review medical staff participation in mandatory training and increase compliance with required training<br><br>**Division of Surgery**<br>Review dental staff participation in mandatory training and increase compliance with required training. | Medical and Dental staff mandatory training compliance is currently at 87% within the Division of Medicine and 82% within the Division of Surgery. |
| **Division of Surgery - Children and Young Persons (CYP)**<br>Ensure all staff have the appropriate up to date paediatric and/or neonatal life support training | Currently we do not provide European Paediatric Advanced Life Support (EPLS) at the James Paget Hospital as we do not have a faculty team. However, paediatric staff undertake the required training. |
| **Division of Medicine – Ward 16 and 17**<br><br>**Division of Surgery– Charnwood and CYP, Maternity**<br>Consider reviewing medicines management practice to ensure medications are appropriately stock checked so that out of date medicines are disposed of and action taken when fridge temperatures are recorded outside of range. | All medicines and controlled drugs have processes in place to check and dispose of out of date medicines. Pharmacy technicians check areas which they cover on a weekly basis and twice weekly CD checks are undertaken Trust wide. |
| **Division of Surgery – Maternity**<br>Consider reviewing prescription recording to ensure that signatures on prescription charts are legible. | Electronic Prescribing & Medicines Administration (EPMA) was introduced in Maternity in December 2016. |
| **Division of Surgery – CYP**<br>Consider improving the recording of staff sharing across ward 10 and the neonatal wards to prove safe staffing standards. | Safer staffing tool currently not enabled to deploy staff for part shift which is what is required for supporting the paediatric rotation. A manual process is now in place neonatal unit capture daily paper staffing detail and Ward 10 are using an adapted tasks adapted to the dependencies tool. |
| **Division of Surgery – CYP**<br>Consider reviewing infection control arrangements within the children and young people's service to ensure effective hand hygiene and equipment cleaning. | Paediatric Services have established self and peer hand wash audits. These are as additional to the organisational infection prevention audit. |

### *d) Themed review of learning from medicines management incidents and Never Event*

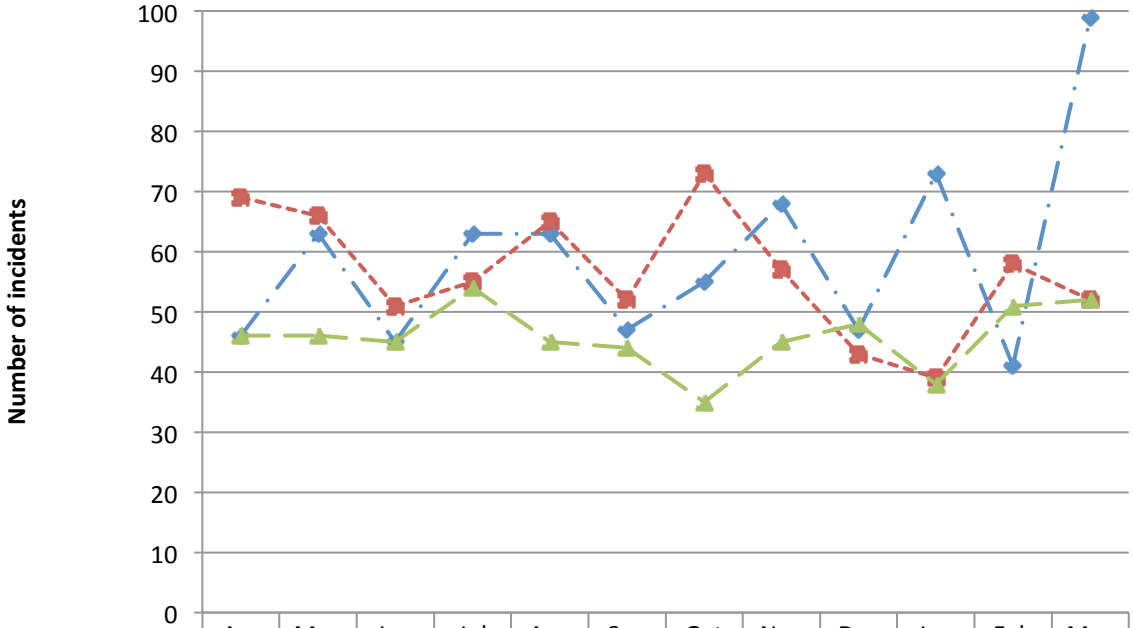
This Quality Priority has been **achieved**.

Medicines management
To develop task and finish groups aligned to the Medicines Management Committee to take forward required improvement actions following analysis of the themed review.

A Medicines Management Improvement Programme commenced in June 2017. The governance structure has been revised to give the Safety & Quality Governance Committee oversight of medicines management through Patient Safety & Effectiveness Committee (PSEC).

Internal audit follow up review showed gaps in control related to administration and storage of controlled drugs at ward level showed significant improvement.

Medicines Management Incidents 2015/16 to 2017/18




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 46 | 63 | 45 | 63 | 63 | 47 | 55 | 68 | 47 | 73 | 41 | 99 |
| 2016/17 | 69 | 66 | 51 | 55 | 65 | 52 | 73 | 57 | 43 | 39 | 58 | 52 |
| 2017/18 | 46 | 46 | 45 | 54 | 45 | 44 | 35 | 45 | 48 | 38 | 51 | 52 |

Details of the medicines management Never Event that occurred during 2016/17 have been included in the Never Events section on page 58.

**Clinical Effectiveness**

***a) Learning from clinical audit: develop and apply consistent processes to ensure findings from clinical audits result in action, learning and sustained improvements in practice***

This Quality Priority has been **achieved** and has also been agreed to be included in next years priorities. There is a well-established process in place for ensuring audit findings are reviewed and action plans developed. Processes have been developed to ensure that actions identified following audits are completed to timescale and a timeline is set for re-audit.

During 2017/18 a bid for funds was agreed for the installation of a clinical audit module add-on to the Ulysses Safeguard Integrated Risk Management System. From April 2018 the new clinical audit module will be used for all new audits. This will be the foundation of improvements to audit action plan updates, due to automated reminders and direct access for users and managers.

***b) Develop clinical audits with our health and social care partners aligned to our strategic objectives e.g. service developments with the Sustainability and Transformation Plan (STP)***

This Quality Priority has been **achieved**. The 2018/19 forward plan has been approved and there are not any clinical audits that can be aligned to the new STP pathways until they are developed during 2018/19.

**Patient Experience**

***a) Address the areas where performance has deteriorated as measured by the patient experience National Surveys e.g. Inpatient, Maternity, A&E, etc.***

This Quality Priority has been **achieved**. Following the publication of 2016 Emergency Department Survey and Inpatient Survey; an action plan was developed to address the themes for the 'requires improvement' aspects; monitored via the Carer and Patient Experience (CAPE) committee. Action plan progress is a standing agenda item at the CAPE committee.

All actions developed as a result of the findings from the 2016 National Cancer Patient Experience Survey are now complete.

An action plan was developed and is being progressed in response to the National Maternity Survey 2017 findings.

***b) Develop and implement clear, action-oriented Trust-wide Always Events***

Four Always Events were launched during April 2017, three Trust wide and one piloted on Ward 16 (short stay) and Ward 4. An executive lead has been assigned to each always event as detailed below:

| Always Event | Aligned Value and Behaviour | Executive Lead |
|---|---|---|
| 1. We will always greet patients/visitors to the Trust using 'hello my name is…' | Courtesy and Respect | Director of Finance |
| 2. We will always promote a lights out at 11pm/ noise-reduction philosophy | Responsive Communication | Director of Nursing |
| 3. We will always offer discussions with service users who post negative feedback on social media | Attentively Kind and Helpful | Chief Operating Officer |
| 4. We will always explain medication on patients discharge (pilot) | Effective and Professional | Medical Director |

Always Event 1

Following the introduction of the always events as a quality priority for 2017/18, this report provides a year end summary of achievements/updates. The 'Hello my name is' ethos has been adopted as a Trust wide expectation. Whilst matrons have been monitoring via spot check audits in the clinical setting and will report on progress via divisional reports, general feedback from patients via the Friends and Family Test (FFT) and social media evidence that this always event is being achieved in the main.

Always Event 2

Noise at night has continued to present as an ongoing feedback theme across the Trust, evident specifically as a theme within the Friends and Family test (FFT) feedback data. Themes from the FFT feedback are shared with the Divisions so that Divisional staff can explore comments and implement improvement actions where applicable. Hospital at night audit findings updates are presented within the Divisional reports to CAPE; which specifically monitor compliance to the 'lights out/noise reduction' philosophy.

Always Event 3
The Patient Experience Team has alerted the Divisional teams to any negative feedback posts on Facebook, maintaining a spreadsheet for recording divisional action when negative feedback discussions have taken place (where feedback is not anonymous) and recording via the PALS module of Safeguard.

Always Event 4
Daily audit of the discharge checklists within the two piloted areas continued to evidence inconsistency in completion of using the checklist itself but also inconsistency in the completion of the 'medications explained' section where discharge checklists are present in the records. Regular discussions with the senior staff within both areas regarding results and partial compliance are carried out to explore ways in which results may be improved. Two further areas are now being audited to ascertain compliance with patients being given explanations of medication on discharge in those areas as a comparison.

***c) Develop a patient experience survey tool aligned to aims of Red to Green programme***

Whilst this Quality Priority has been **achieved** in terms of developing the survey, evidence from patients in relation to Red2Green remains inconsistent. The survey was initially piloted on ward 16 and has since been extended to other inpatient areas across the Trust; each survey running for a two week period; following which, analysis takes place. Roll out to all areas is scheduled to be completed by the end of June 2018. Ward 16 will be included again within the roll out programme to evidence whether there has been improvement in the patients' experiences/understanding of their management plans when compared to the findings of the initial survey carried out within this area.

***d) Co-design a staff/patient experience education and training DVD***

This Quality Priority has been **achieved**. The patient experience DVD has been filmed and the initial edit has been received and reviewed. Subsequent edits are currently in progress to ensure the finished result reflects the overall objectives before the film is shared more widely.

**Pan-Domain Objective**

***a) Improve patient flow throughout the hospital so that patients are provided with safe care in the right place at the right time***

This Quality Priority has been **achieved**. The agreed Key Performance Indicators (KPIs) for patient flow related to patient experience are detailed below:

| **Indicator** |
|---|
| There will be a ≥ 2% annual reduction in the number of multiple-ward moves |
| A year on year reduction in patient flow related negative patient experience feedback will be evidenced |

The multiple moves data is detailed below, year to date, with the previous year included as the benchmark from which to measure improvement percentages. Data is produced based on monthly discharged patients who had more than one ward movement during their admission spell.

It is clear, from the information in the tables below that the volume of multiple moves has increased when compared to the previous year reflecting the ongoing operational pressures and the unprecedented demand that the Trust has witnessed, resulting in overall non-achievement of the KPI and a 7.37% increase in the number of patients experiencing multiple moves.

**Number of patients with multiple moves**

| | **2016/17** | **2016/17 per 1000 bed days** | **2017/18** | **2017/18 per 1000 bed days** |
|---|---|---|---|---|
| **Total** | 505 | 46.1 | **542** | **43.5** |

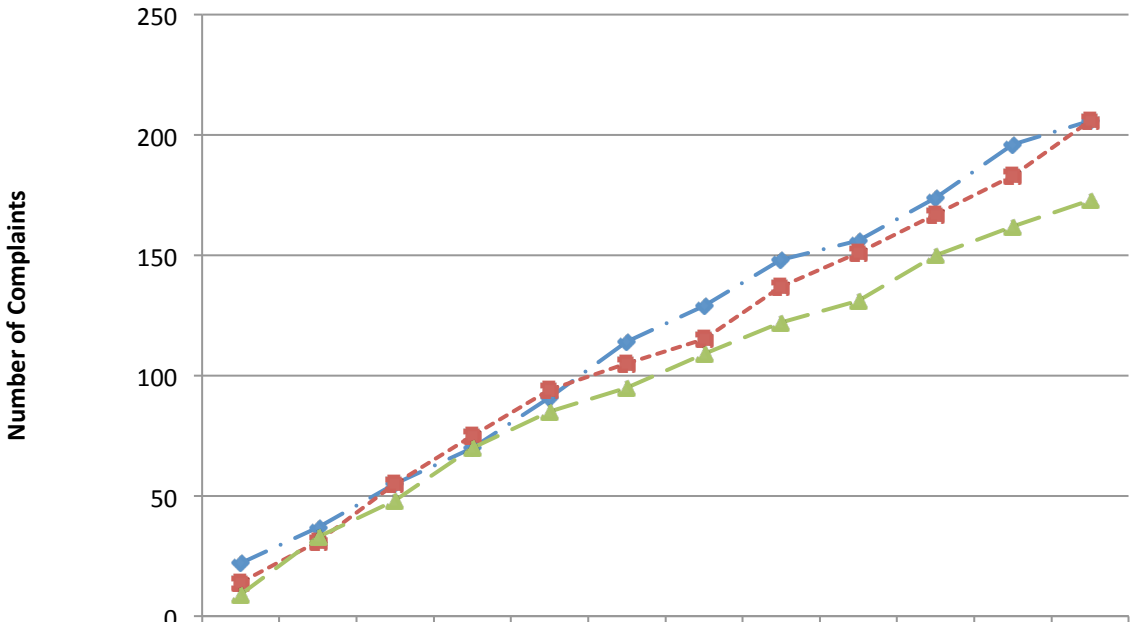
The patient experience negative feedback comments are extracted from the FFT data and are detailed below. Performance evidences the continued challenges the Trust has experienced with operational pressures caused by unprecedented demand, which have impacted on patient experience resulting in increased negative patient flow feedback. A 14.6% increase in patient flow related negative comments have been received in total during 2017/18.

| | **2016/17** | **2016/17 Per 1000 bed days** | **2017/18** | **2017/18 Per 1000 bed days** |
|---|---|---|---|---|
| **Inpatients** | 36 | 0.3 | 45 | **0.3** |
| **Outpatients** | 26 | 1.2 | 37 | **0.2** |
| **A&E** | 11 | 0.1 | 18 | **0.1** |
| **Maternity** | 16 | 0.1 | 2 | **0.01** |
| **Total** | 89 | 1.7 | 102 | **0.61** |

# A Listening Organisation

## Learning from Complaints

Cumulative Complaints 2015/16 to 2017/18




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 22 | 37 | 55 | 70 | 91 | 114 | 129 | 148 | 156 | 174 | 196 | 206 |
| 2016/17 | 14 | 31 | 55 | 75 | 94 | 105 | 115 | 137 | 151 | 167 | 183 | 206 |
| 2017/18 | 9 | 33 | 48 | 70 | 85 | 95 | 109 | 122 | 131 | 150 | 162 | 173 |

Complaints handling is carried out as per the NHS Complaints procedure. Written acknowledgement is sent to the complainant within three working days. Telephone contact with the complainant is made by the Complaints Investigator wherever possible to discuss the issues and assess response timescale parameters. Wherever possible the Trust tries to adhere to a 60 day response timeframe, however, response time is agreed with the complainant at the start of the process. At initial contact and at closure, complainants are offered the opportunity to meet with senior staff to discuss the complaint in detail to support early and final resolution respectively.

The number of formal complaints received has reduced during the last year when compared to the previous two years. This should be considered extremely positive for the Trust; given the unprecedented operational challenges the Trust has faced, which one would expect to associate with an increase in the number of complaints. Equally, the reduction may also be indicative of our continued commitment to support early resolution of issues, evidenced in the continued rise in Patient Advice and Liaison Service (PALS) enquiries.

Acknowledgement times to complaints 2015/16-2017/18

| Days to Acknowledge | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|
| **0** | 9 | 81 | **59** |
| **1** | 188 | 118 | **101** |
| **2** | 8 | 6 | **9** |
| **3** | 0 | 1 | **4** |
| **4** | 1 | 0 | **0** |
| ***Total*** | ***206*** | ***206*** | ***173*** |

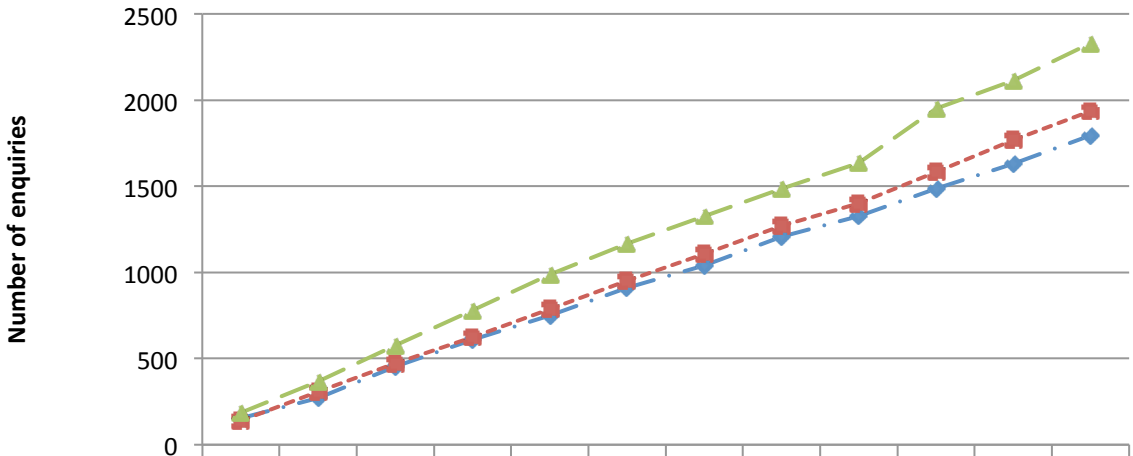
The complaints team work in collaboration with the Divisional teams to ensure that there is an agreed, informative response provided which covers all the issues raised. Complaints are reviewed by members of the Executive Team before Chief Executive sign-off.

As a Trust, we have introduced complaints handling Key Performance Indicators[10] to monitor performance. Numbers of complaints, themes and those areas attributable are covered in detail within governance meetings to ensure that learning takes place and actions are implemented when complaints are upheld/partially upheld. Monthly Trust communications to staff now also detail complaint numbers, themes and trends.

**Patient Advice and Liaison Service (PALS)**

The Patient Advice and Liaison Service is available to support local resolution of queries or concerns which not only improves the experiences of service users by helping to resolve any issues as soon as possible, but also contributes to the reduction in the number of formal complaints the organisation receives.

Cumulative PALS enquiries 2015/16 to 2017/18




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 154 | 273 | 454 | 611 | 752 | 912 | 1041 | 1206 | 1328 | 1488 | 1633 | 1796 |
| 2016/17 | 139 | 309 | 472 | 626 | 787 | 950 | 1107 | 1269 | 1400 | 1581 | 1767 | 1934 |
| 2017/18 | 185 | 368 | 575 | 781 | 988 | 1168 | 1328 | 1485 | 1635 | 1950 | 2115 | 2329 |

[10] A Key Performance Indicator is a measurable value that demonstrates how effectively a Trust is achieving key business objectives.

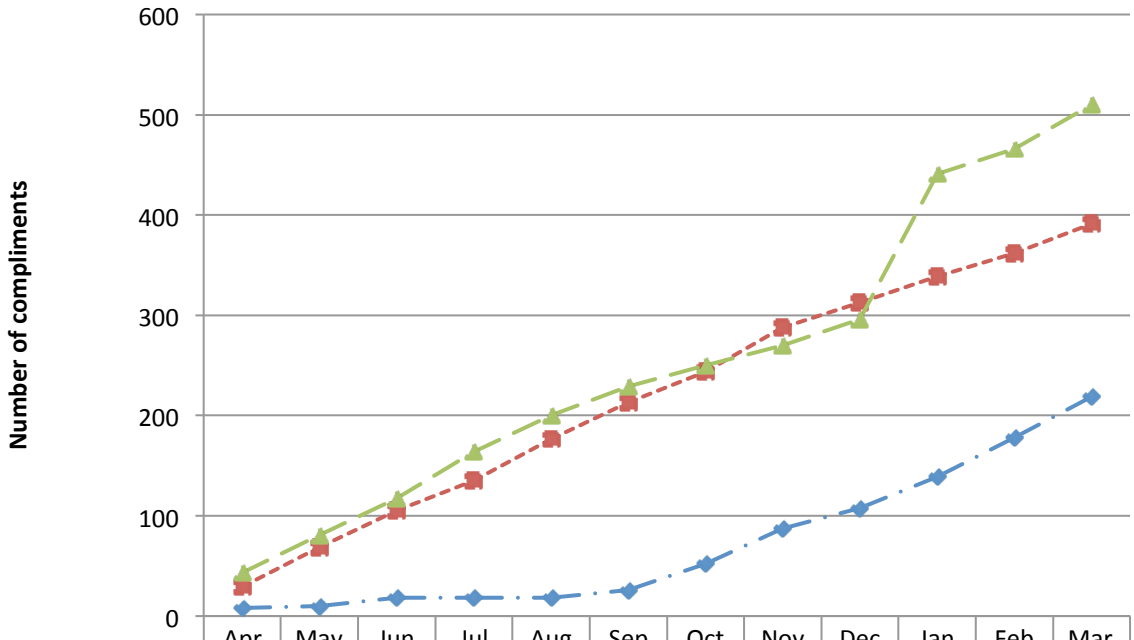
**Compliments**

Compliments are received into the Trust via many sources. The Chief Executive receives written compliments which are recorded on our risk management system via our PALS team. In addition compliments are received direct to our PALS team or via the compliments email address, compliments@jpaget.nhs.uk. The email address can be used by members of the public, staff and other organisations to share information about what works well.

Compliments data is shared Trust wide in monthly Leadership Brief communications to ensure staff receive the positive feedback

In addition the patient experience team support data capture of compliments at Divisional and departmental level by producing a data capture template which is populated by the operational/clinical staff as compliments are received.

Cumulative Compliments 2015/16 to 2017/18




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 8 | 10 | 18 | 18 | 18 | 26 | 52 | 87 | 108 | 139 | 178 | 219 |
| 2016/17 | 29 | 69 | 105 | 135 | 177 | 213 | 244 | 288 | 313 | 339 | 362 | 391 |
| 2017/18 | 43 | 81 | 117 | 164 | 200 | 229 | 250 | 270 | 296 | 441 | 466 | 510 |

The sudden increase in compliments / overall PALS in January is due to thank you cards that are now being logged corporately (as thank you cards do not generally have a date on they have been logged as the date they were added onto Safeguard hence the high volume in January).

Examples of compliments received

I was deeply impressed with the professionalism and dedication of the staff, doctors, nurses and support staff in both A&E and the children's ward who kept us feeling safe, warm and happy.

**Patient experience measurement tools**

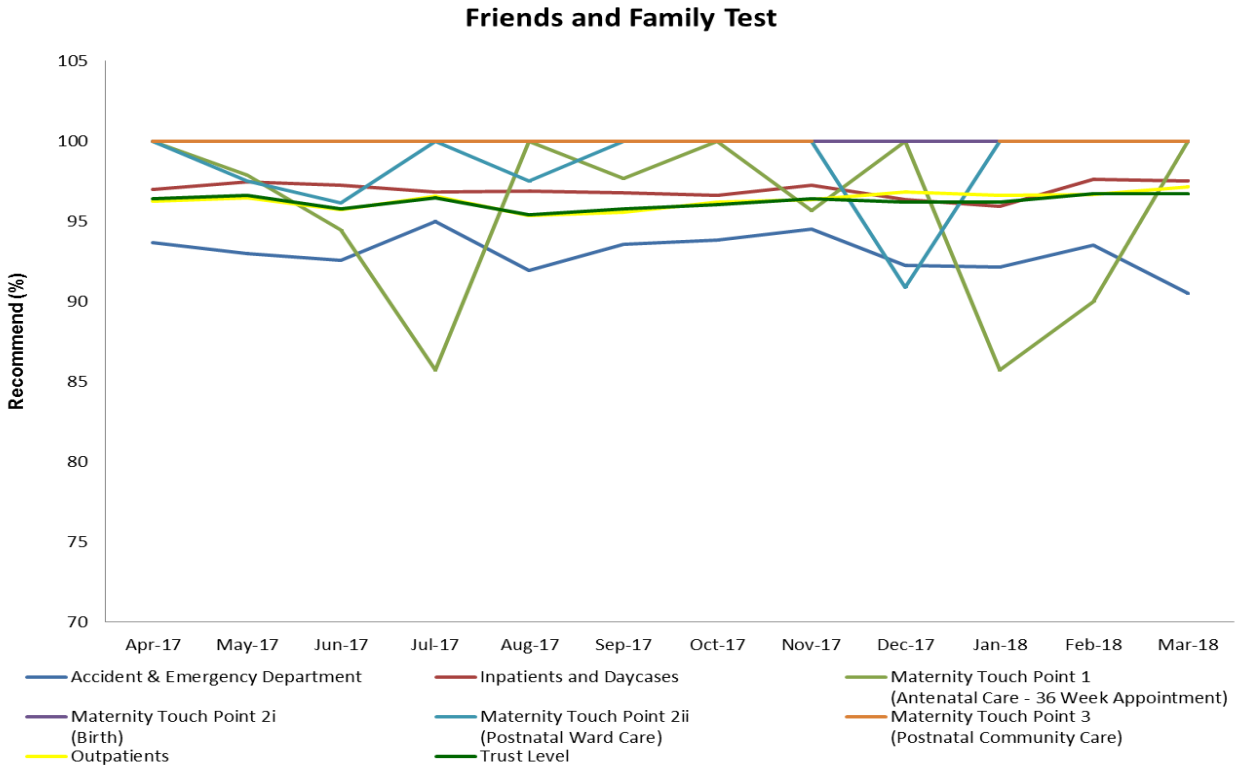
Friends and Family Test – What is it?

The NHS Friends and Family Test (FFT), launched in 2013, was created to help providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous for patients to give their views after receiving care or treatment across the NHS.

Patients are asked how likely they are to 'recommend our ward/department to a friend or family member should they require similar care or treatment' and their experience is scored based on a six-point scale. The categories are: 'Extremely likely', 'Likely', 'Neither likely nor unlikely', 'Unlikely', 'Extremely unlikely' and 'Don't Know'.

Patients also have the opportunity to explain their ranking by adding comments, and may be asked some follow-up questions. This is important, because service providers can only make changes if they know exactly what is or isn't working.

Friends and Family Test Score 2017/18




Whilst FFT feedback predominantly evidences that patients would recommend services to family and friends, the Trust continues to explore where improvements can be made in relation to those that would not recommend our services based on any narrative detail provided in the FFT responses.

**Family carers**

The Trust has a Family Carer Support and Information Worker based at the Trust, three days each week. Her role is to ensure family carers are identified and supported whilst in hospital and during the discharge process. A family carer is someone who provides unpaid care to a family member, friend or neighbour who could not manage without their help.

**Patient Surveys**

Feedback from National Surveys is reported to the Carer and Patient Experience Committee (CAPE) and the themes identified are looked at alongside other feedback data received into the Trust. During 2017/18 the National Surveys which were published are detailed below. Divisions are required to look at the findings and formulate action plans to address key issues identified. The National Inpatient Survey 2017 is due for publication in May/June 2018 (date yet to be confirmed).

**National Inpatient Survey 2016**

The results of the survey were published on 31st May 2017 and detailed the experiences of 77,850 people who responded nationally; having received care at an NHS hospital during July 2016. All patients aged 16 or over who had at least one overnight stay were eligible to participate.

The total number of respondents for the Trust was 616 out of a total of 1250 (49%).

*Overall findings*

The Trust scored within the expected range in 52 out of the 59 questions asked within the survey; six areas scored negatively out of the expected range and one positively out of the expected range.

*Actions*

Where we have deteriorated against our own performance an action plan has been developed to address the themes.

**National Cancer Patient Experience Survey 2016**

The National Cancer Patient Survey is commissioned by NHS England and runs annually. This is the sixth iteration of the survey, first undertaken in 2010. The full report illustrates the Trust scores for each question and compares these against national performance to help Trusts understand their own performance; identifying areas for local improvement. Service users are asked to rate their care on a scale of 0 (very poor) – 10 (very good). The response rate for the Trust was 73% out of a sample size of 469.

The annual survey provides valuable patient feedback on services and enables the Trust to further develop quality services for patients who access cancer services. Based on patient responses, the survey identifies issues highlighted by patients where perception of services needs improvement whilst also identifying significant areas of very good practice.

*Overall findings*

Overall the Trust was flagged as a negative outlier in six areas and a positive outlier in one area.

*Actions*

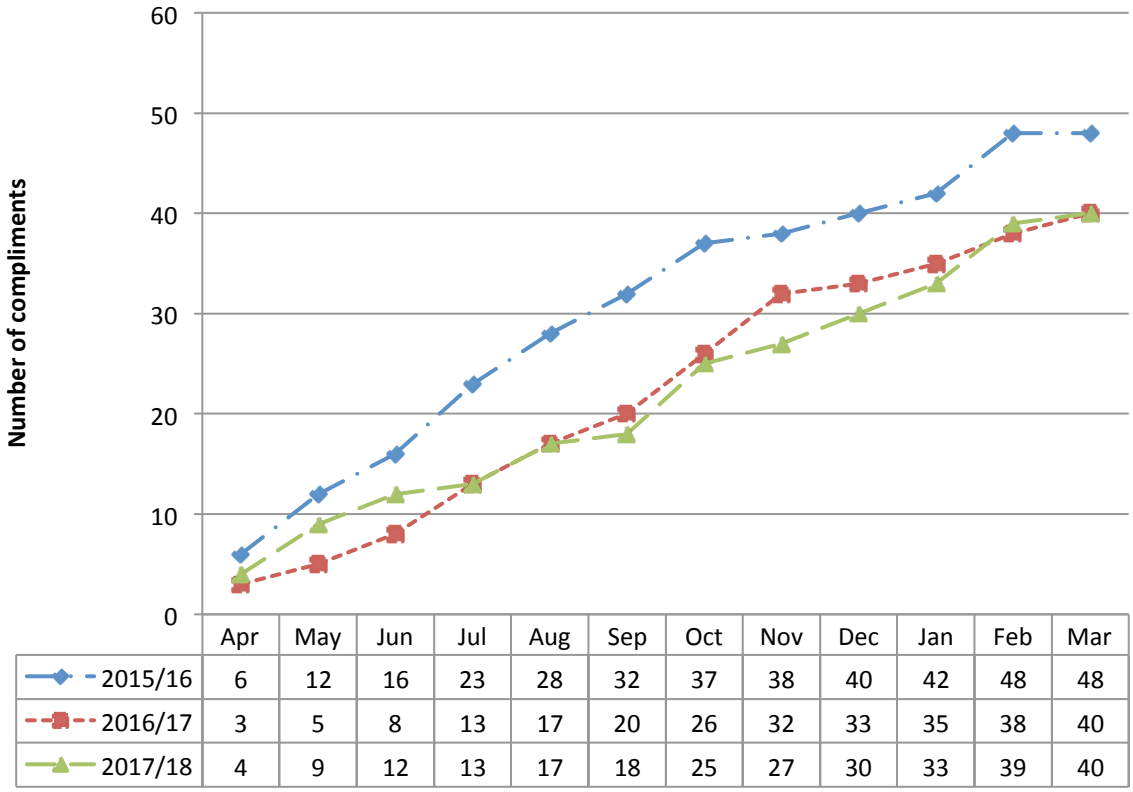
Key actions included:

- Clinic template letters updated to ensure patients are routinely told that they can bring a family member of friend with them when first informed of cancer;
- Haematology oncology survey underway;
- Local survey conducted within theatre speciality to monitor improved explanations of operation outcome.

# A Learning Organisation

### Serious Incidents

The Serious Incidents (SI) Register contains formal SIs, which must follow the agreed reporting process to our Commissioners. The SI process has been followed in terms of providing three-day updates and root cause analysis investigation reports within the required timescales to the Commissioners (or via prior agreement), throughout 2017/18.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 6 | 12 | 16 | 23 | 28 | 32 | 37 | 38 | 40 | 42 | 48 | 48 |
| 2016/17 | 3 | 5 | 8 | 13 | 17 | 20 | 26 | 32 | 33 | 35 | 38 | 40 |
| 2017/18 | 4 | 9 | 12 | 13 | 17 | 18 | 25 | 27 | 30 | 33 | 39 | 40 |

**Never Events**

The Trust has reported **three** Never Events as having occurred in 2017/18. These incidents were as follows:

| Summary | Actions taken |
|---|---|
| Removable screw head left in situ when should have been removed. Identified at post-op x-ray. | – Confirm education and training delivered prior to the introduction / use of the Integra Snap off Screw.<br>– Confirm number of procedures undertaken since introduction by operating surgeon.<br>– Review and Update The Swab, Instrument, Disposable Device and Sharp Count Procedure<br>– Ensure all local Ward / Department policy / procedure documents are identified within the Division with review dates.<br>– Ensure Divisional Governance has oversight of all local Ward / Department policy / procedure documents and that review date(s) are known and tabled through Divisional Governance meetings for ratification. |
| Retained surgical tampon following perineal repair after childbirth. | – Preceptorship and induction packs to be reviewed and include reference to policy and expectations on individual midwives<br>– Induction pack for locum doctors to be reviewed to ensure it contains reference to swab/instrument/sharp count policy expectations<br>– To amend Perineal and Assessment repair guideline to highlight the use of an instrument when using a tampon and reinforce use of whiteboard<br>– Audit to be designed to test compliance to policy and completed in real-time with eyes on the actual count procedure |
| Regional block given on wrong side. | – Spot audit of all Anaesthetists and Anaesthetic Assistants on awareness of “Stop Before You Block”<br>– Ensure ‘Stop Before You Block’ process is part of Local Safety Standards for Invasive Procedures(LocSSIPs)<br>– Posters of “Stop Before you Block” by the Safe Anaesthesia Liaison Group to be posted in theatres/block trolley<br>– Human Factors Training for safe & effective team to all staffs in the department of anaesthesia and theatres |

During 2016/17 a never event occurred relating to medicines management. A summary of this incident and the actions taken following this are detailed overleaf:

| Summary | Actions taken |
|---|---|
| Dispersible aspirin given via a Hickman Line (central venous catheter) | – All Nursing and Medical Staff in ICU to be reminded of the JPUH Local Central Venous Catheter and Enteral Line Guidelines (includes use of purple syringes)<br>– All Medical Staff need to be reminded to review radiological imaging that is available to assist in identification of lines and their position on admission to ICU/HDU<br>– Reinforce the use of the aspiration technique to ascertain if line/tube/catheters are in the correct place<br>– To correctly identify the content of any attached fluid/medication that are attached to lines/tubes/catheters on admission to ICU/HDU<br>– Training on NG Tube feeding/medication for ICU Nursing Staff<br>– Review guidelines for enteral feeding<br>– Present the finding of the RCA at various forums<br>– To re-issue NPSA alert reference NPSA/2011/RRR003 for syringes |

**Duty of Candour**

Duty of Candour – What is it?

The Trust is obligated to comply with the Duty of Candour when a patient under the Trust's care suffers Moderate Harm, Major Harm or dies as a result of an adverse incident under.

- the Health and Social Care Act 2008 (Regulated Activities) Regulations: Regulation 20
- Service Condition 35 of the NHS Standard Contract

Essentially this means patients must be informed when an adverse event happens whilst they are in our care.

The initial Duty of Candour (DoC) conversation with the patient/their family/carer must take place within 10 working days of the incident occurring (or the Trust becoming aware of the incident).

Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. It involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment. It ensures communication is open, honest and occurs as soon as possible following an incident. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers.

Francis said*: "Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it".*

The Trust remains fully committed to delivering the 'Being Open' policy and has developed a process for identifying incidents which are required to be communicated to patients in a different way under the Duty of Candour definitions. Below is a summary of compliance with this process for 2017/18:

| Month | N° of notifiable incidents | Number of Patients informed | | Number of patients not informed[11] |
|---|---|---|---|---|
| | | Within timescale | Outside timescale (breach) | |
| April 2017 | 5 | 2 | 2 | 1 |
| May 2017 | 3 | 2 | 1 | 0 |
| June 2017 | 4 | 4 | 0 | 0 |
| July 2017 | 2 | 0 | 1 | 1 |
| August 2017 | 4 | 1 | 2 | 1 |
| September 2017 | 3 | 1 | 0 | 2 |
| October 2017 | 7 | 4 | 3 | 0 |
| November 2017 | 3 | 0 | 1 | 2 |
| December 2017 | 8 | 2 | 3 | 3 |
| January 2018 | 5 | 0 | 2 | 3 |
| February 2018 | 1 | 0 | 0 | 1 |
| March 2018 | 3 | 1 | 1 | 1 |
| **Total** | **48** | **17** | **16** | **15** |

## An Effective Organisation

### Ulysses

Installation of a clinical audit module add-on to the Ulysses Safeguard Integrated Risk Management System has occurred and from April 2018 the new clinical audit module will be used for all new audits. This will be the foundation of improvements to audit action plan updates, due to automated reminders and direct access for users and managers.

## A Responsive Organisation

### Fire Inspection following Grenfell Tower Fire

An inspection was undertaken by the Norfolk Fire and Rescue service on the 30th June 2017. This national fire safety inspection was commissioned following the Grenfell Tower Fire.

*Findings*

Following the Grenfell Tower Fire, the Director of NHS Estates and Facilities and Head of Profession - NHS Improvement, sent an email to all Trusts to obtain information regarding the construction materials used in any buildings. The email and the Trust also asked that an urgent review of Fire Risk Assessments (FRA) takes place.

[11] Cases where a decision has been taken not to inform a patient or their family/carers or the patient is unable to partake in the conversation, are made on compassionate grounds

*What we have done about it:*

- All Fire Risk Assessments are reviewed on a regular basis unless there are significant changes which require review;
- The Head of Estates and the Fire Officer completed the pro-forma sent from the Director of NHS Estates and Facilities;
- Samples of the cladding were sent to the Building Research Establishment (BRE) for official testing and no concerns were identified;
- Inpatient areas were inspected by Norfolk Fire and Rescue Fire Safety department on 30th June 2017 as requested by Government. An Officer from Norfolk Fire & Rescue countersigned a letter along with the Chief Executive to confirm to NHS Improvement that an extraordinary fire safety inspection had taken place.

## External Inspections

**Patient-Led Assessments of the Care Environment (PLACE)**

The 2017 Patient-Led Assessments of the Care Environment (PLACE) programme commenced at the James Paget University Hospital on 7th March 2017.

In the accordance with the Prime Minister's commitment in 2012 to give patients a real voice in assessing the quality of healthcare, including the environment for care, at least 50% of those involved in undertaking assessments must meet the definition of a patient.

Members of the Trust Council of Governors and members of Trusts are eligible to act as 'patient representatives' within their own Trust.

The assessment covers 10 ward areas, 6 outpatient departments and A&E and assess against the following criteria awarding the following scores:

| Domain | Score 2015 | Score 2016 | Score 2017 | National Average 2017 |
|---|---|---|---|---|
| Cleanliness | 98.47% | 99.13% | 98.38% | 95.50% |
| Food/Ward | 89.49 | 93.40% | 90.16% | 87.65% |
| Organisation Food | New category 2016 | 80.55% | 88.80% | 76.35% |
| Privacy, Dignity and Wellbeing | 76.36 | 73.63% | 83.68% | 71.65% |
| Condition, Appearance and Maintenance | 88.03 | 93.41% | 94.02% | 91.05% |
| Dementia | 67.92 | 74.01% | 76.71% | 68.64% |
| Disability | New category 2016 | 81.94% | 82.56% | 77.43% |

*Privacy, Dignity and Wellbeing*

This section covers:
- Whether the wards have single rooms with ensuite bathrooms
- Whether patients are dressed to protect dignity
- Television access
- Radio access

We will:
- ✓ Incorporate the need for ensuite facilities within ward and side room refurbishment as part of the site strategy
- ✓ Consider access to television and radio

*Dementia*

This section covers the perspective of a dementia patient on floor coverings, lighting, signage, colours used for doors, toilet furniture colour, and removal of mirrors

We will:
- ✓ Meet the dementia criteria in particular flooring, wall and door colours within the upgrade of the wards

*Disability*

This section assesses the needs of those with disabilities and how well hospital environments meet them.

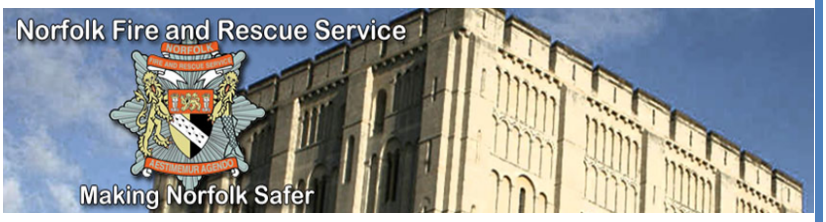
We will:
- ✓ Incorporate the need for increased numbers of handrails, which are in a colour that contrasts with the walls, within ward and side room refurbishment as part of the site strategy

**Environmental Health**

2000 meals are provided to patients, visitors and staff each day. All are home-cooked, on site using local ingredients and suppliers wherever possible.

In November 2017 the Trust underwent an inspection and was awarded four stars for our food hygiene rating. This was a reduction from our previous five star award, which was due to limescale on Ward taps. These taps have since been replaced.

**Norfolk Fire and Rescue Service**




The annual fire inspection by Norfolk Fire and Rescue Service took place on 12th April 2018. The external Fire Officer was satisfied with all areas inspected and this will be confirmed in writing to the Deputy Chief Executive and the Trust Fire Officer.

**Getting it Right First Time (GIRFT)**

In 2012, Professor Tim Briggs published a report entitled 'Getting it right first time' (GIRFT) which considered the current state of England's orthopaedic surgery provision and suggested that changes could be made to improve pathways of care, patient experience, and outcomes with significant cost savings. The report took the view that this approach has the potential to deliver a timely and cost effective improvement in the standard of orthopaedic care across England.

The programme has been extended to include other disciplines. The ambition of the programme is to identify areas of unwarranted variation in clinical practice and/or divergence from the best evidence. The work will culminate in a report and set of national recommendations aimed at improving quality of care and also reducing expenditure on complications, litigation, procurement and unproven treatment.

*Surgery*

The Surgery GIRFT visits took place in November 2017. The following is a summary of the findings:

- FFT response rate is low but positive recommendation rate;
- RTT 18 week pathway is exceptionally good;
- Coding accuracy to be improved;
- Emergency service not as busy as other sites;
- Colorectal cancer, rectal resection rate higher than average but again issues with data accuracy;
- Suggestion to review bowel prep and implement Enhanced Recovery Nurse;
- Readmission rate – to inform all patients of 10% readmission rate;
- In process of changing anti-reflux surgery to day case procedure;
- Cholecystectomy length of stay is low and day case rate is high;
- Expedited cholecystectomy for emergency cases is low;
- Litigation is very low.

It should be noted that this GIRFT report is based on old data and there have already been improvements in some areas. The findings have been discussed at the Surgical Speciality Meetings so that further actions can be agreed.

*Ear, Nose and Throat (ENT)*

The ENT GIRFT visit took place on the 27th March 2018. The Trust is yet to receive the full report, however, the key themes that were identified included coding issues and sustainability of the ENT service. Overall a good response was received regarding the service that the Trust delivers.

*Obstetrics and Gynaecology*

An obstetrics and gynaecology GIRFT visit took place on the 9th August 2017. An action plan was developed following this inspection with four actions to be addressed:

- Move benign gynae procedures onto outpatient pathway;
- Run data off of NHSLA and discuss litigation in an education morning;
- Discussion with theatre teams about what kit needs to be used in theatre;

- Annual review of data (in an away-day setting).

*Paediatric General Surgery*

A paediatric general surgery GIRFT visit led by Mr Simon Kenny took place in September 2017. An action plan was completed and submitted and the Children's surgical working group are currently working through the report to consider all recommendations.

Main points:

- Consider working with commissioners to support a children's surgical network;
- Develop children's surgical standard operating procedure that is in line with national guidance;
- Ensure day cases are correctly coded;
- Review variance of procedure coding;
- Review the children's appendectomy pathway;
- Consider staggered admissions;
- Review nil by mouth policy.

**Joint Advisory Group on Gastrointestinal Endoscopy (JAG)**

The JAG accreditation assessment was due on the 1st March 2018, however, was postponed due to bad weather and has been rearranged for the 31st May 2018.

**Human Tissue Authority (HTA)**

An inspection was undertaken by the Human Tissue Authority on the 29th June 2017. No serious concerns were raised and an action plan has been developed to address the recommendations.

**Neonatal Critical Care Peer Review**

An inspection was undertaken on the 5th February 2018. The final report from this review is awaited following final review.

**Intensive Care Unit Peer Review**

An inspection was undertaken on the 19th June 2017. This review was based on areas for improvement identified during the initial peer review visits that took place in 2015. All areas for improvement were addressed with the exception of:

- Discharge from Critical Care to a ward should be within 4 hours of the decision to discharge – National Threshold 57.1%;
- A minimum of 50% of registered nursing staff will have a post registration award in critical care nursing;
- Patients on discharge from critical care receive a rehabilitation prescription;
- Physiotherapy staffing available to provide rehabilitation components of care. Should be available 24/7 if required;
- All eligible patients on discharge from critical care must receive a rehabilitation prescription;
- A Consultant in Intensive Care Medicine must be immediately available for contact 24/7, be able to attend within 30 minutes and undertake twice daily ward rounds.

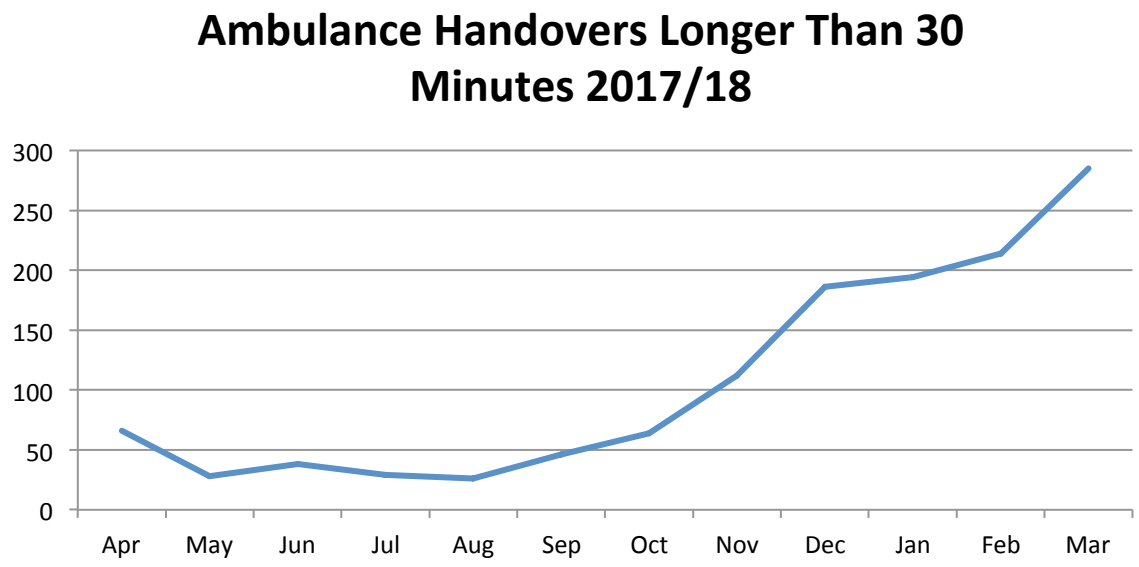
## Ambulance Handover - Governors' indicator

What is the indicator?

This indicator measures the number of handovers of care between the ambulance service and the Trust which take longer than 30 minutes.

*Background*

This indicator measures the number of handovers of care between the ambulance service and the Trust which take longer than 30 minutes. The formal target only applies to contracted activity. This indicator displays both contracted and non-contracted activity.




*What we are doing about it*

On the 4th December 2017 a new handover process was implemented in Accident & Emergency. A senior clinical co-ordinator is situated at the ambulance entrance from 07:00-19:30 each day to receive and triage patients. This allows a clinical assessment and potential triage to minors, ambulatory care and GP streaming if appropriate.

From late December 2017 through to March 2018 an East of England Ambulance Service NHS Trust (EEAST) Hospital Ambulance Liaison Officer (HALO) is onsite in A&E which has enabled further improvements in managing demand on peak days.

A Standard Operating Procedure (SOP) is in place for staff and caring for patients in the corridor to enable paramedic crews to handover.

Early Intervention Vehicle (EIV) is service is now in place running Friday 7am – 7pm to Monday 7am-7pm. This team attend patients who have fallen in the community and early feedback suggests the number of conveyances to A&E from a fall has reduced

Improving flow out of the Emergency Admission and Discharge Unit (EADU) is one of the foundations to ensuring handover delays are minimised and this is part of the SAFER patient flow bundle (**S**enior review, **A**ll patients, **F**low, **E**arly discharge, **R**eview) and Red2Green work that is ongoing. It should be noted though that Short Stay now triage A&E patients directly to the ward which has also improved flow.

A new process for managing GP urgent admissions is being explored which would enable booked slots for patients to attend and a reduction in those patients arriving by ambulance.

Monthly audit meetings with EEAST are in place to discuss conveyance (being brought to hospital by ambulance) numbers, inappropriate conveyances and actions to improve.

The plan to reconfigure the majors area in A&E to increase cubicle numbers is currently underway. It is unlikely this work will be completed until 2019.

Internally the Emergency Team continue to address the handover period by reviewing their internal decision making processes.

**NHS Improvement's Governance Indicators**

Performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement. For 2017/18 these are:

| Indicator | | Threshold 2017/18 | JPUH 2017/18 |
|---|---|---|---|
| Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway | | 92% | 85.58%[12] |
| A&E: maximum waiting time of four hours from arrival to admission/ transfer/discharge[13] | | 95% | 90.49% |
| All cancers: 62 day wait for first treatment from: | urgent GP referral for suspected cancer | 85% | 88.40%[14] |
| | NHS Cancer Screening Service referral | 90% | 95.31% |
| Maximum 6-week wait for diagnostic procedures | | 1% | 0.11% |
| C difficile: variance from plan | | 0 | -1 |
| Summary Hospital-level Mortality Indicator (also included in quality accounts regulations)[15] | | 100 | 120.83[16] |
| Venous thromboembolism (VTE) risk assessment | | 97% | 98.04% |

For definitions for all Indicators, please see Appendix 1 of the *Single Oversight Framework: appendices (Updated November 2017)* or via the link: https://improvement.nhs.uk/documents/1933/SOF_Appendices_November_2017_FINAL_edv0.4_updatedlinks_310118.pdf

[12] position as at the end of March 2018
[13] The full definition for this mandated indicator can be found on page 82
[14] position as at the end of February 2018
[15] The full definition for this mandated indicator can be found on page 82
[16] latest published statistics, rolling 12 month period to the end of September 2017

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# Annex 1

## Statements from Stakeholders

**Great Yarmouth and Waveney Clinical Commissioning Group[17]**

Great Yarmouth & Waveney Clinical Commissioning Group as a commissioning organisation of JPUH supports the organisation in its publication of a Quality Account for 2017/18. We are satisfied that the Quality Account incorporates the mandated elements required based on available data. The information contained within the Quality Account is reflective of the Trust over the previous 12 month period.

In our review, we have taken account of the clinical quality improvement priorities identified for 2018/19 and support the identified improvement objectives in the quality and safety of care provided to Great Yarmouth & Waveney residents. The Trust will do this by:

- **Pan-Domain Objective;**

To develop a training programme to equip staff with a Quality Improvement toolkit. This will develop a pro-active Quality Improvement culture within the organisation including training, goals, objectives and work plans for multi-disciplinary teams.

- **Improving Patient Safety;**

To identify services and specialties that have accreditation programs other than those required for registration or certification. This will ensure that services provided to patients will enhance their care by the provision of best practice.
Develop a range of options and approaches to maximize recruitment and retention by reviewing the current ward-based clinical staffing infrastructure and make recommendations to inform and deliver a five year workforce plan. This will address the significant challenges by ensuring a 'grow your own' approach to support improvements in workforce development and aim to modernise and strengthen the ward-based infrastructure.

- **Improving Clinical Effectiveness;**

Learning from clinical audit: to develop and apply consistent processes to ensure findings result in action, learning and sustained improvements in practice.
To audit compliance with Safety Checklists for Invasive Procedures to ensure compliance by staff with the key steps necessary to deliver safe care for patients undergoing invasive procedures.

- **Improving Patient Experience;**

Improving communication and information to relatives and carers by ensuring a key point of contact is identified at each point in the patient's care for communication with patients and their families and carers.

Offering patients / relatives the opportunity to be engaged in investigatory processes following serious incidents and to ensure that Learning from Deaths investigations become normal practice within the organisation.

Developing opportunities for patient involvement in service improvement / redesign. This will increase communication between user groups and Patient Participation Groups and ensure that patients who use services are involved in the development or redesign of services.

[17] Feedback from Great Yarmouth and Waveney CCG was received after the deadline had passed for final draft production. All suggestions for improvement, received with thanks, will be considered in the Quality Report 2018/19.

**2017/18 Quality Priorities**

Great Yarmouth and Waveney CCG also notes the quality priorities identified within the previous Quality Account for 2017/18.
We commend the Trust on their achievement against ten out of the eleven quality priorities with a partial achievement noted for Participation in the National Improvement Collaborative Programmes for falls, pressure ulcers and end of life care. This was due to the Trust not being accepted onto the 2017 Pressure Ulcer Collaborative.

The CCG recognises the cross-organisational collaborative work to improve Learning from Deaths in line with national guidance and acknowledge that there is ongoing work in relation to this.

The Great Yarmouth & Waveney Clinical Commissioning Group looks forward to working with the JPUH during 2018/19.
Yours sincerely

Rebecca Hulme
Chief Nurse
Director of Children, Young People and Maternity
Director of Infection Prevention and Control

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**Council of Governors**

The Council of Governors are grateful for the opportunity to add our comments to the 2017/18 Quality Report. A well written document which demonstrates how well the Trust has been and is currently performing.

The NHS is undergoing great change, and to help make services fit for the future, Sustainability and Transformation Partnerships were set up across England. Their focus is on three National challenges:

- Addressing health equalities
- Ensuring the Quality and Performance.
- Making sure the Health and Social care is efficient and financially sustainable.

The James Paget is working in partnership with the Queen Elizabeth Hospital, Norfolk and Norwich University Hospital, Norfolk & Suffolk Mental Health Trust, Community Health Trusts, Norfolk County Council, and Community, Voluntary and Social Enterprise Sector Colleagues. By all working together on making changes it will make a real difference to people's lives. Providing the support needed to keep the population healthy and well, providing quality services that support people in their own home. This will lessen the strain on our A/E departments, emergency services and bed occupancy.

Each month, A/E attendances have been consistently been above 6000 since March 2017 which is a great challenge. Ambulance conveyances also remain high so the A & E Department continues to experience difficulties regarding handover due to this high number. On average sixty eight ambulances arrive each day with large numbers arriving at the same

time. It is worth noting that 49.6% of patients are handed over within 15 minutes, however, on some days the JPUH has the best handover statistics in the region.

Development in the Emergency Department is essential and work has begun in two phases. £2 million (£1 million from central funding) is needed to carry out this work.

Phase 1. Two new Consulting Rooms for GP streaming.

Phase 2. Expansion of Ambulatory Care
Moving of the Operational centre to be shared with Discharge Hub.
Moving of Switch board which will free up space for 10 -12 new cubicles for A/E Majors.
Ambulatory unit to be extended.

All of these changes are designed to speed up patient flow through the hospital.

Mortality - In 2017 The National Quality Board introduced new guidance for the NHS providers on how they should learn from the deaths of people in their care. NHS Improvement are leading this agenda in supporting Trusts to meet the requirements. In 2017 a Learning from Deaths Policy was published, which sets out how we will investigate and learn from Mortality data. A Non-Executive Director has been identified to Lead on Mortality who will give Governors regular reports at Council meetings. The Trust has also set up a Mortality Surveillance Group which is led by the Medical Director.

NHS Improvement continues to scrutinise this work and support has been provided by them. The Trust has made significant progress over the last year to standardise its systems and processes for mortality reviews in line with national guidance.

The Council of Governors now has a closer working relationship with the Non-Executive Directors (NEDs). At each council meeting all of the NEDs give individual reports on their own areas of expertise. This provides the Council with additional assurance that they have their “Finger on the pulse” of the organisation, which also provides Governors with an opportunity to question and clarify if we have any concerns.

Governor engagement with patients, Trust members, and members of the public has been further enhanced by being involved with The Friends and Family survey, the Red to Green initiative, and also “Meet the Governor”. The Council is grateful for the all the hard work that goes into facilitating our involvement by the Patient Experience Team. We have two Governor Representatives on the new Patient User Group which is in the process of being set up.

Despite working under extreme pressure staff continue to provide excellent care for all patients. The Council of Governors would like to take this opportunity to thank all of the staff for their continuing hard work in whatever discipline, in providing such a high level of service.

I would encourage all to read the Quality Report as it is essential reading to reassure you that good quality care and delivery of services is being maintained and constantly improved upon.

**Jane Harvey**
**Interim Lead Governor**

**Healthwatch Norfolk & Healthwatch Suffolk Joint Response**

Healthwatch Norfolk appreciates the opportunity to make comments on the JPUH Quality Account for 2017/18.

The document is well laid out with the contents page identifying different sub-sections, which is very helpful. There is a glossary, which would be very useful to the lay reader. Contact details are given for people to request the document in different formats e.g. braille or other languages.

The document presents information in detail – which may not be easy for members of the public to understand. This could perhaps be addressed through adding an Executive Summary in plain English.

Currently there is no Executive Summary - there is a blank headed page and we have assumed it will be included in the final report. There are also a significant number of incomplete sections at the time of responding to the Quality Account.

2016/17 priorities are clearly identified and the majority achieved with one partially achieved - which is acknowledged and being addressed. The priorities for the coming year have been clearly identified with statements as to what is intended to achieve them.

Part 3 of the report is still without significant amounts of data making evaluation of this section difficult. We hope that when completed it will be easy for the public to read and understand.

Actions are shown to be clearly set to improve quality when required, however, the report does not always adequately describe how the necessary actions will be implemented and monitored.

We note that the Duty of Candour reporting has been included but this is disappointing at only at only 50% compliance – a figure that is not spelt out in the presentation. (16 patients informed within timescale and 16 breached the timescale of 10 working days.)

It is pleasing to see a 10% increase in the percentage of staff likely to recommend the NHS Services they work in to friends and family: from 78% in 2015-6 to 88% in 2017-18. However it is disappointing to see the percentage of staff experiencing bullying/harassment or abuse from staff has increased a further 1% percent to 27% against a benchmarking group of 25%.

We remain totally committed 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**

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**Health Scrutiny Committee**

As has been the case in previous years, the Suffolk Health Scrutiny Committee does not intend to comment individually on NHS Quality Accounts for 2018. This should in no way be taken as a negative response. The Committee has, in the main, been content with the engagement of local healthcare providers in its work over the past year. The Committee has taken the view that it would be appropriate for Healthwatch Suffolk to consider the content of the Quality Accounts for this year, and comment accordingly.

**County Councillor Michael Ladd**
**Chairman of the Suffolk Health Scrutiny Committee**

# Annex 2

## Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

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 2017/18 and supporting guidance

- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2017 to 31/03/2018
  - papers relating to quality reported to the board over the period April 2017 to 31/03/2018
  - feedback from commissioners dated 21/05/2018
  - feedback from governors dated 11/05/2018
  - feedback from local Healthwatch organisations dated 11/05/2018 (Norfolk) and 03/05/2018 (Suffolk)
  - feedback from Overview and Scrutiny Committee dated 23/04/2017
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 11/05/2018
  - the 2016 national patient survey 31/05/2018
  - the 2017 national staff survey 06/03/2018
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 21/05/2018
  - CQC inspection report dated 20/12/2016

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements on preparing the Quality Report.

By order of the Board

21/5/18 Date _____ Chair

21.5.18 Date _____ Chief Executive

21/5/18 Date _____ Director of Finance

21/5/18 Date _____ Chief Operating Officer

21/5/18 Date _____ Medical Director

21/5/18 Date _____ Director of Nursing

21/5/18 Date _____ Director of Governance

21/5/18 Date _____ Director of Strategy

21/5/18 Date _____ Director of Transformation

21/5/18 Date _____ Associate Director of Workforce

# Glossary of terms and abbreviations

| Term | Meaning |
|---|---|
| A&E | Accident and Emergency Department |
| ACU | Acute Cardiac Unit |
| BPT | Best Practice Tariff |
| *C.difficile* or *C.diff* | *Clostridium difficile* |
| CAM | Confusion Assessment Method |
| CAPE | Carer and Patient Experience Committee |
| CDI | *Clostridium difficile* infection |
| CG | NICE Clinical Guideline |
| CHD | Congenital Heart Disease |
| CHKS | Caspe Healthcare Knowledge Systems |
| CLAW | Collaborative Learning Action Workshops |
| CMP | Case Mix Programme |
| CMT | Core Medical Trainee |
| CQC | Care Quality Commission |
| CQUIN | Commissioning for Quality Improvement and Innovation |
| CRM | Cardiac Rhythm Management |
| CT | Computerised Tomography |
| CYP | Children and Young Persons |
| DNACPR | Do not attempt Cardiopulmonary Resuscitation |
| DVD | Digital Versatile Disc |
| DVT | Deep Vein Thrombosis |
| EADU | Emergency Admission and Discharge Unit |
| EAHSN | Eastern Academic Health Science Network |
| ECG | Electrocardiogram |
| EEAST | East of England Ambulance Service NHS Trust |
| ENT | Ear, nose and throat |
| EPLS | European Paediatric Advanced Life Support |
| EPMA | E-Prescribing and Medicines Administration |
| FFFAP | Falls and Fragility Fractures Audit Programme |
| FFT | Friends and Family Test |
| FY | Foundation Year |
| GCP | Good Clinical Practice |
| GIRFT | Getting it right first time |
| HALO | Hospital Ambulance Liaison Officer |
| HANA | Head and Neck Cancer Audit |
| HAT | Hospital Acquired Thrombosis |
| HES | Hospital Episode Statistics |
| HMCI | Her Majesty's Chief Inspector of Education, Children's Services and Skills |
| HSCIC | Health and Social Care Information Centre |
| HTA | Human Tissue Authority |
| IBD | Inflammatory Bowel Disease |
| IG | Information Governance |
| IGT | Information Governance Toolkit |
| IT | Information Technology |
| JAG | Joint Advisory Group |
| JPUH | James Paget University Hospitals NHS Foundation Trust |
| KF | Key Finding |
| KLOE | Key Lines of Enquiry |
| MASH | Multi-Agency Safeguarding Hub |
| MINAP | Myocardial Ischaemia National Audit Project |

| Term | Meaning |
|---|---|
| MRI | Magnetic Resonance Imaging |
| MTPJ | Metatarsophalangeal Joint |
| N/A | Not applicable |
| NAD | National Audit of Dementia |
| NAOGC | National Oesophago-Gastric Cancer Audit |
| NBOCAP | National Bowel Cancer Audit |
| NCA | National Comparative Audit |
| NCEPOD | National Confidential Enquiry into Patient Outcome and Death |
| NDA | National Diabetes Audit |
| NDFA | National Diabetes Footcare Audit |
| NED | National Endoscopy Database |
| NELA | National Emergency Laparotomy Audit |
| NG | NICE Guidance |
| NHFD | National Hip Fracture Database |
| NHS | National Health Service |
| NHSLA | National Health Service Litigation Authority |
| NICE | National Institute for Health and Care Excellence |
| NIHR | National Institute for Health Research |
| NJR | National Joint Registry |
| NLCA | National Lung Cancer Audit |
| NNAP | National Neonatal Audit Programme |
| NNUH | Norfolk and Norwich University Hospital NHS Foundation Trust |
| NOFERP | Neck of Femur Enhanced Recovery Programme |
| NPDA | National Paediatric Diabetes Audit |
| NPSA | National Patient Safety Agency |
| NRLS | National Reporting and Learning Service |
| PALS | Patient Advice and Liaison Service |
| PbR | Payment by Results |
| PCNL | Percutaneous nephrolithotomy |
| PE | Pulmonary Embolism |
| PICANet | Paediatric Intensive Care Audit Network |
| PLACE | Patient-Led Assessments of the Care Environment |
| PODs | Patients' own drugs |
| PROMs | Patient Reported Outcome Measures |
| PSEC | Patient Safety and Effectiveness Committee |
| PSI | Patient Safety Incident |
| QI | Quality Improvement |
| QS | NICE Quality Standard |
| RAG | Red/Amber/Green |
| RCA | Root Cause Analysis |
| ROP | Retinopathy of prematurity |
| SACT | Systemic Anti-Cancer Therapy |
| SAFER | Senior review, All patients, Flow, Early discharge, Review |
| SEND | Special Educational Needs and Disability |
| SHMI | Summary hospital level mortality indicator |
| SHOT | Serious Hazards of Transfusion |
| SI | Serious Incident |
| SSNAP | Sentinel Stroke National Audit Programme |
| STP | Sustainability and Transformation Plan |
| StR | Specialty Registrar |

| Term | Meaning |
|---|---|
| T&O | Trauma and Orthopaedic |
| TACO | Transfusion Associated Circulatory Overload |
| TARN | Trauma Audit and Research Network |
| UK | United Kingdom |
| UKRETS | UK Registry of Endocrine and Thyroid Surgery |
| VC | Virtual Clinic |
| VTE | Venous Thromboembolism |
| WTE | Whole Time Equivalent |

# NHS Improvement mandated indicator definitions

### *Summary Hospital-level Mortality Indicator*

*Detailed descriptor*

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number who would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.

SHMI values for each trust are published along with bandings indicating whether a trust's SHMI is 'higher than expected', 'as expected' or 'lower than expected'.

More details are available at www.digital.nhs.uk/SHMI

*Indicator format*

As the indicator is not computed by the trust, details of the calculation are not reproduced here, but can be found in the frequently asked questions document available at the link above.

Auditors should refer to the main body of this document for guidance on the scope of assurance work.

### *Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge*

*Source of indicator definition and detailed guidance*

The indicator is defined within the technical definitions that accompany *Everyone counts: planning for patients 2014/15 - 2018/19* and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf

Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found at https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf

*Additional information*

This indicator is as required to be reported by the *Risk Assessment Framework*:

> A&E four-hour wait: waiting time is assessed on a provider basis, aggregated across all sites: no activity from off-site partner organisations should be included. The four-hour waiting time indicator applies to minor injury units/walk-in centres.

Paragraph 6.8 of the NHS England guidance referred to above gives further guidance on inclusion of a type 3 unit in reported performance:

> *We are an acute trust. Can we record attendances at a nearby type 3 unit in our return?*
>
> *Such attendances can be recorded by the trust in the following circumstances.*

*a) The trust is clinically responsible for the service. This will typically mean that the service is operated and managed by the trust, with the majority of staff being employees of the trust. A trust should not assume responsibility for reporting activity for an operation if the trust's involvement is limited to clinical governance.*

*b) The service is run by an IS provider on the same site as a type 1 unit run by the trust. This would need to be agreed by the parties involved, and only one organisation should report the activity.*

Where an NHS foundation trust has applied criterion (b) and is including type 3 activity run by another provider on the trust site as part of its reported performance, this will therefore be part of the population of data subject to assurance work.

In rare circumstances there may be challenges in arranging for the auditor to have access to the third party data in these cases. In this scenario the NHS foundation trust may present an additional indicator in the quality report which only relates to its own activity and have this reported indicator be subject to the limited assurance opinion.

*Numerator*

The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge. Calculated as:
(Total number of unplanned A&E attendances) – (Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge)

*Denominator*
The total number of unplanned A&E attendances

*Accountability*

Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution Measures).

*Indicator format*

Reported as a percentage

# Independent auditor's report to the Council of Governors of James Paget University Hospitals NHS Foundation Trust

We have been engaged by the council of governors of James Paget University Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of James Paget University Hospitals NHS Foundation Trust's quality report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

**Scope and subject matter**
The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

1. Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period, see page 66;
2. A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge, see page 66

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 2017/18* ('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 supporting guidance and the six dimensions of data quality set out in the *Detailed requirements for external assurance on quality reports for foundation trusts 2017/18*.

We read the quality report and consider whether it addresses the content requirements of the *NHS foundation trust annual reporting manual* and supporting guidance, 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 for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018
- feedback from commissioners, dated 21/05/2018
- feedback from governors, dated 11/05/2018

- feedback from local Healthwatch organisations, dated 11/05/2018 (Norfolk) and 03/05/2018 (Suffolk)
- feedback from the Overview and Scrutiny Committee dated 23/04/18
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 11/05/2018
- the 2016 national patient survey, dated 31/05/2018
- the 2017 national staff survey, dated 06/03/2018
- Care Quality Commission inspection, dated 20/12/2016
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated 21 May 2018; 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 James Paget University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and James Paget University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

**Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by James Paget University Hospitals NHS Foundation Trust.

**Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

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

23 May 2018

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#Proud of the Paget

NHS
James Paget University Hospitals
NHS Foundation Trust

# Financial Statements

for the year ended 31 March 2018

# Contents

# Statement of Accounting Officer's Responsibilities

## Statement of the Chief Executive's responsibilities as the Accounting Officer of the James Paget University Hospitals NHS Foundation Trust

The National Health Service Act 2006 (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 James Paget University Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of James Paget University Hospitals NHS Foundation Trust and of its income and expenditure, items of other comprehensive income 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 the NHS Foundation Trust Annual Reporting 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;
- • assess the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of its services to another public sector entity.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error and for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The accounting officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

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

Chief Executive
21 May 2018

# Annual Governance Statement

## Scope of responsibility

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

## The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the James Paget University Hospitals 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 James Paget University Hospitals NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

## Capacity to handle risk

The Trust has in place a Risk Management Strategy which makes it clear that overall leadership and responsibility for risk management is placed with the Chief Executive. The Audit Committee receives reports and assurance from the directors and managers as appropriate, concentrating on the over arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. In addition, responsibility for specific risk management areas has been assigned to the following key Committees and Groups;

- Audit Committee;
- Safety and Quality Governance Committee;
- Finance and Performance Committee;
- Workforce, Education and Research Committee;
- Transformation Board;
- Patient Safety and Effectiveness Committee;
- Health & Safety and Staff Welfare Committee;
- Fraud Risk Group;
- Information Governance Committee;
- Hospital Infection Control Committee;
- Carer and Patient Experience Committee;
- Divisional Boards; and
- Divisional Governance Groups.

The Trust has a Clinical Quality Risk Assessment (CQRA) process in place to ensure that any new change project, whether arising from cost saving initiatives or otherwise, has been rigorously assessed for the impact on the quality of patient services. All CQRAs are signed off by the Director of Nursing and Medical Director before changes are implemented.

The Strategy also identifies individual Executive Directors, Deputy Directors, Divisional Directors, all managers and all employees and clearly defines their role and responsibilities within the risk management framework. The Board of Directors has clearly articulated that it has no appetite to tolerate any extreme risks on the risk register and worked under the following Risk Appetite statement during 2017/18: The Trust will not accept risks that materially impact on patient safety. However, the Trust has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust has greatest appetite to pursue innovation and challenge current working practices and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment. Monthly reporting to the Board focusses on any extreme risks and the actions being taken to mitigate them. The Trust's Board Assurance Framework sets out the principal risks to delivery of its strategic objectives. Regular review of the Board Assurance Framework is undertaken which includes an analysis of whether achievement of the strategic objectives is on track and if not, whether the Board has the appetite to re-focus priorities in order to ensure compliance.

A range of risk management training is provided to staff and there are policies in place to describe their roles and responsibilities in relation to the identification and management of risk. The Trust also records and manages risks using a computer software package called Safeguard, specifically designed to record and track progress of risks electronically in real time and nominated key staff are responsible for ensuring this system is kept up to date. An introduction to the Safeguard incident reporting system is provided for staff at induction together with information on what should be reported and when. This is supplemented by bespoke training sessions for individuals, departments and staff groups upon request or if deemed necessary following incidents. Periodically awareness raising is also undertaken in relation to incident reporting including when new national guidance is issued, such as for Never Events. All incidents are fully investigated and ways to cascade the learning are included in action plans signed off and monitored at Divisional level. During the year, the Trust continued to provide bespoke training sessions on Root Cause Analysis investigation for staff.

All relevant policies are available on the Trust's intranet. Written guidelines are also disseminated, covering all components of risk management.

## The risk and control framework

The James Paget University Hospitals NHS Foundation Trust has an integrated Risk Management and Assurance Strategy in place which is reviewed by the Audit Committee and the Safety and Quality Governance Committee. The Risk Management and Assurance Strategy and associated policies set out the key responsibilities for managing risk within the organisation, including the ways in which the risk is identified, evaluated, updated and controlled.

All staff are responsible for responding to incidents, hazards, complaints and near misses in accordance with the appropriate policies. Local Clinical Governance and Risk Groups are responsible for identifying and managing local risks and overseeing the management of adverse incidents. Management teams are responsible for reviewing risk action plans and ensuring they are implemented through business planning and other established routes.

The Board of Directors has delegated responsibility to the Audit Committee for monitoring and reviewing risk processes. Other key features include:

- There is an integrated reporting system, including the identification within all terms of reference of all committees, action groups and other working groups which require every type of risk and adverse event to be reported;
- The Audit Committee and all other Board Committees receive reports and instigate action to deal with risks which have been identified; and
- There is a comprehensive corporate Risk Register which is presented at each meeting of the Board of Directors and all high and extreme risks and any changes to the risks within the register over the previous month are highlighted.

The Trust's Board Assurance Framework sets out the principal risks to delivery of its strategic objectives. The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified. The Board Assurance Framework identifies the assurances available to the Board of Directors in relation to the achievement of the Trust's key priorities and objectives. The principal risks to the delivery of these objectives are mapped to key controls. The Board of Directors requires both the assurance that the Board Assurance Framework identifies those actions required to address gaps in control and assurance, and the development and implementation of action plans.

Risk appetite and tolerance of risk is determined via a risk estimation matrix which has been developed for use throughout the Trust for identifying risks, maintaining progress and monitoring the risk register and plans. The Trust's risk management approach establishes the appetite for risk, and also determines whether risks are to be accepted or not. Where it is determined that risks are to be managed, priorities are assigned with resources and timescales for remedial action. The full risk register is available to the Board of Directors at each meeting. The Safety and Quality Governance Committee reviews all high and extreme risks at each meeting and approves all additions, closures and amendments to the corporate risk register. The Audit Committee reviews and receives assurance at each meeting from the relevant Executive Director in relation to their key risks to their portfolio annually on a rolling basis.

Issues related to data security are monitored by the Information Governance Committee which also reports to the Safety and Quality Governance Committee, and reviews both risks and adverse incidents at every meeting. Following the national cyber attack on the NHS in May 2017 the Trust has convened an Executive led information security committee. As a result of this, there are now enhanced systems for ensuring patching takes place, penetration testing takes place, and there is generally greater visibility of risks and monitoring of mitigating actions.

The following are the extreme risks identified by the Foundation Trust together with the key mitigations in place.

| Risk | Mitigation |
|---|---|
| Failure to deliver incomplete RTT target.<br><br>Regulatory and patient experience risk | Daily PTLs for consultant.<br>Waiting list management policy.<br>Additional capacity being provided internally and considered externally.<br>Theatre list sign off by management to be initiated. Generic working to be extended.<br>Executive focus weekly with orthopaedics.<br>Extra sessions up and running for ophthalmology.<br>Daily performance reporting to Divisions.<br>Weekly PTL meetings with management.<br>Transformation program to improve theatre utilisation. |
| Mortality indicators (HSMR/SHMI) are above expected with a resulting reputational risk and a subsequent requirement to provide assurance that any safety issues are mitigated. | Detailed review of co-morbidities for April 2017 to assess impact (in line with HSCIC SHMI mortality review process)<br>Care quality assessment using risk and safety frameworks as per normal business.<br>Learning from deaths Policy.<br>Case note reviews.<br>SI investigations.<br>Data Quality Checks Audits.<br>Engagement with other local and regional providers.<br>Engagement with NHSI regarding best practice.<br>Group convened with the CCG and Community Providers in order to identify a system-wide solution.<br>Plans to put in place a medical examiner service.<br>Clinical coders aligned with clinical specialties. |
| Risk of going into Financial Special Measures (FSM) with NHSI. | Internal financial turnaround plan developed and approved, and subjected to independent review.<br>F&P and Board oversight.<br>Regular contact with regulator, NHSI<br>Pay and Non-Pay Cost Control executive panels in place each weekday morning. |

A&E urgent care is under review at the time of writing, but is likely to be an extreme risk once ratified as a result of performance against the 4 hour waiting time target.

Risk management is embedded throughout the organisation at every level. The Trust also records and manages incidents using the computer software package Safeguard, specifically designed to record and track progress of incidents electronically in real time and nominated key staff are responsible for ensuring this system is kept up to date. As described above, there is an extensive training and awareness programme in place which has fostered a culture where incident reporting is encouraged. The Trust reported 40 Serious Incidents during 2017/18 (2016/17 - 37), all of which were subject to full root cause analysis investigation and actions have been taken to prevent recurrence. Further detail can be found in the Trust's Quality Report. The most recent report from the NRLS shows that for incidents reported between 1st October 2016 and 31st March 2017 the Trust sits in the lower 50% of reporters for all acute (non-specialist) trusts.

Public Stakeholders are involved in managing risk which impacts on them, for example:

- There are Foundation Trust meetings at all levels with members of the Trust's lead Clinical Commissioning Group at which risk is assessed;
- Health Overview and Scrutiny Committees;
- Partnership working with Social Services; and
- Joint working with other Trusts i.e. Norfolk & Norwich University Hospitals NHS Foundation Trust, East of England Ambulance Service NHS Trust, Norfolk and Suffolk NHS Foundation Trust, Queen Elizabeth Hospital King's Lynn NHS Trust and East Coast Community Health Community Interest Company.

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

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.

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

The internal audit work methodology highlights areas as advisory where inefficiencies or good practice have been identified.

The Trust has in place a Local Counter Fraud Specialist whose work plan includes providing information to and engaging with staff, prevention through the work of the Fraud Risk Group, including fraud specific risk assessments, and holding to account through investigations. The Counter Fraud Standards Self Review Toolkit has been reviewed and an overall return was scored as green with no standards being assessed as red and four as amber out of a total of twenty four.

The Trust's transformation methodology and approach identifies and highlights any potential for the furtherance of economy, efficiency and effectiveness and is balanced and further assured through the clinical quality risk assessment process.

The Board of Directors has also received assurances on the use of resources from agencies outside the Trust including NHSI. NHSI requires the Board of Directors to self-assess, and scores the Trust in accordance with the Single Oversight Framework. Other assurances sought during the year have included reviews conducted by Royal Colleges, the Getting it Right First Time (GIRFT), and the British Orthopaedic Association.

The Trust further obtains assurance of its systems and processes and tests efficiency through benchmarking by membership of NHS Providers where other NHS Foundation Trusts share good practice. Also, the Trust continues to participate in the nationally mandated reference cost collection exercise which, amongst other purposes, provides information on the relative efficiency and assessment of productivity. 2016/17 reference cost data was published during the year in which the Trust achieved a reference cost score of 101.

NHSI's drive to implement the recommendations from Lord Carter of Coles report on unwarranted variation provides another source of benchmarking assurance. The Trust has in place governance arrangements to oversee internal projects to implement recommendations as and when new information is released to the Model Hospital portal.

The Board of Directors receives a monthly report of Care Hours per Patient Day (CHPPD) actual versus required, which reflects nursing hours only. This is one of many tools utilised by the Board to monitor safe staffing levels across all areas of the Trust.

## Information Governance

During the year 2017/18 the Trust had no serious incident relating to information governance, data loss or confidentiality breach and this is a great improvement since 2016/17 and highlights the work the Trust has been doing in over the year.

The Trust has been preparing for the introduction of the General Data Protection Regulations (GDPR) which will apply from 25 May 2018. A detailed review was performed by the Trusts internal auditors and they identified areas of good practice and areas for improvement, the Trust continues to further embed the good practice and will be fully compliant with the regulations.

## Annual Quality Report

The directors are required under the Health Act 2009, the National Health Service (Quality Accounts) Regulations 2010 (as amended) and the Health and Social Care Act 2012 to prepare Quality Accounts for each financial year. NHSI (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.

In preparing these accounts, directors are required to take steps to satisfy themselves that:

- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with relevant requirements and guidance issued by NHS Improvement.

To satisfy these requirements the Safety and Quality Governance Committee reviews a draft Quality Report where there is the opportunity to shape the content and detail. The Trust's external auditors are also involved in reviewing each formal draft and their comments are acted upon. The content and style is adapted each year based upon feedback from users and other stakeholders including Governors and commissioners to ensure a balanced view is presented.

The systems in place to collect and report on quality metrics culminate in a detailed performance, quality and safety report which is presented at each public Board meeting. Each key performance indicator (KPI) that the Board monitor is assigned to a committee of the Board whose work plan is shaped around the key risks and these KPIs. There are monthly performance meetings between the Executive and Divisional Management focussing on quality and performance metrics. Reporting by clinical divisions on a bi-monthly basis to Patient Safety and Effectiveness Committee, Health & Safety and Staff Welfare Committee, and the Carer and Patient Experience Committee also maintains oversight of the key priorities for Quality as per the Quality Report.

The Trust has developed a Quality Improvement Strategy for 2018 – 23 which is aligned to the Trust's over-arching 5 year strategy. The key priorities for quality each year are designed to deliver the aims of the Quality Improvement Strategy and divisional reporting to the executive committees is designed to demonstrate progress with achievement of these aims and objectives. A suite of policy documents are in place and available to staff via the Trust intranet to support delivery of the Trust's Quality Strategy.

The Board receives monthly performance reports on quality as well as patient access targets. There is a data quality framework associated with each key performance indicator, and the Board also receives detailed quality and safety reports monthly.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Trust's Quality Report.

## 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, Safety and Quality Governance Committee and Finance and Performance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed through confirmation by NHS Improvement via monthly monitoring on the Trust's compliance with its Single Oversight Framework. Throughout the year the Trust has been classified as being within segment 2.

The Board of Directors reviewed the 2017/18 Board Assurance Framework throughout the year. The Board of Directors has received regular reports on risk management, performance management and clinical governance. There was one strategic objective on the 2017/18 Board Assurance Framework which has not been achieved, which was to deliver the Trust's financial regulatory and use of resource requirements as set out in the regulatory framework. This was not achieved because of the partial achievement of the 6.8% savings plan. This was identified by the Board of Directors as an extreme risk before and during 2017/18, and mitigating actions were taken where possible to minimise the financial deficit. The outturn was reforecast during the year, with full oversight of the regulator, NHSI, and the reforecast deficit has been delivered at the financial year end.

The Audit Committee has provided the Board of Directors with an independent and objective review of financial and corporate governance and internal financial control within the Trust. The Committee has received reports from external and internal audit. Internal audit has reviewed and reported upon control, governance and risk management processes, based on an audit plan approved by the Committee. The work included identifying and evaluating controls and testing their effectiveness, in accordance with Public Sector Internal Audit Standards. When scope for improvement was found, recommendations were made and appropriate action plans were agreed with management.

The internal audit programme was developed by the Trust's internal auditors on a risk based approach in consultation with the Trust's Executive Team and Audit Committee. The internal audit programme involved reviews in areas considered by the Trust to be higher risk, including operational areas which had not previously been audited and from which the Trust would gain the most value from the audit work. As well as approving this plan, the Audit Committee has also received a report detailing the alternative sources of assurance on the risks not covered by the internal audit programme.

An internal audit review of Pharmacy and Medicine's Management resulted in high risk overall. Trust management acknowledged these audit findings and during the year implemented remedial actions, which led to the follow up risk reducing to low. An internal audit review into mortality which resulted in a high risk classification in 2016/17 was followed up in 2017/18 and reduced to medium risk overall. An internal audit review of the readiness for GDPR was carried out as a piece of work which did not produce an risk rating, and similarly the internal auditors carried out a review of the Trust's financial improvement plan without providing a risk rating. Two other internal audit reviews into IG Toolkit and key financial controls including procurement were rated as medium and low risk respectively. All action plans are monitored by the Trust's Audit Committee to ensure actions are taken within the agreed timescales.

An internal audit review into Consultant job planning also received an overall report classification of high risk during 2016/17. The follow up review carried out in 2017/18 again produced a high risk overall. In response to this, the Trust requested a further follow up review towards the end of the financial year, and whilst some progress had been made to reduce the score, this follow up review again produced a high risk overall. The Trust acknowledges the findings and continues with the process of implementing the associated recommendations.

The Trust has a well developed Clinical Audit Forward Plan which is based upon prioritised audits to ensure national recommendations are embedded as well as the learning from significant events. The Clinical Audit Forward Plan has been monitored by the Board of Directors and has remained on track throughout the year.

The Trust commissioned an external Well-Led review in the Autumn of 2016. The review, whilst resource intensive, was a very useful process enabling reflection on current practice and discussion with external governance experts. It involved one to one interviews, focus groups with staff, Governors and patients, and observation of Board and Committee meetings. The outcome was largely very positive, with some areas for improvement for consideration focused on the two main areas of Divisional governance and stakeholder engagement. Throughout 2017/18 the Trust has implemented the recommendations from the well-led review and prepared for a CQC inspection of the well-led domain. Two executive directors are CQC well-led reviewers, who are supporting the Trust's well-led inspection preparations.

Internal Audit have completed their program of internal audit work for the year ended 31 March 2018. Their work identified low, moderate and high rated findings. Based on the work they have completed, the main opinion of Internal Audit is "Generally satisfactory with some improvements required". Governance arrangements, risk management processes and internal controls in relation to business critical areas are generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control. In relation to the mortality review and Consultant job planning there are weaknesses which could put the achievement of organisational objectives at risk.

## Conclusion

As described throughout the governance statement above, the Trust is aware of its significant internal control issues and the Board has responded to all the final reports issued and has developed action plans with clear ownership of the issues together with its regular review of governance. An action plan to address the Consultant job planning issues continues to be implemented, whilst an action plan to address the mortality issues is already in place and will continue to be implemented during 2018.

I believe this to be a balanced statement of the governance arrangements within the Trust during 2017/18.

Chief Executive
21 May 2018

# Independent Auditor's Report to the Council of Governors of James Paget University Hospitals NHS Foundation Trust

## . REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

### 1. Our opinion is unmodified

We have audited the financial statements of James Paget University Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Group and the Trust's Consolidated Statement of Comprehensive Income, Consolidated Statement of Financial Position, Consolidated Statement of Changes in Taxpayers' Equity, Consolidated Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Group and the Trust's affairs as at 31 March 2018 and of the Group and Trust's income and expenditure for the year then ended; and

— the Group and the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

| Overview | |
|---|---|
| **Materiality:** Group financial statements as a whole | £3.65m (2016/17:£2.7m)<br>1.9% (2016/17: 1.5%) of Income from operations |

| Risks of material misstatement | | vs 2016/17 |
|---|---|---|
| **Recurring risks** | Valuation of land and buildings | ◄► |
| | Recognition of NHS and non-NHS income | ◄► |

# Independent Auditor's Report to the Council of Governors of James Paget University Hospitals NHS Foundation Trust

## 2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows (unchanged from 2016/17):

All of these key audit matters relate to the Group and the parent Trust.

| | The risk | Our response |
|---|---|---|
| **Land and buildings**<br><br>£41.2 million (2016/17: £42.3 million).<br><br>*Refer to pages 22 to 24 (accounting policy) and pages 38 to 40 (financial disclosures).* | **Valuation of land and buildings:**<br><br>The appropriate basis for valuing the Trust's land and buildings depends on whether it is a specialised or non-specialised operational asset.<br><br>Specialised assets are valued at depreciated replacement cost of a modern equivalent asset that has the same service potential of the existing property. Non-specialised operational assets are valued at current value in existing use.<br><br>The Group's main hospital site at Lowestoft Road, Gorleston, has both specialised and non-specialised operational assets. In 2016/17 the hospital was valued by an external valuer. In 2017/18, the same external valuer, has provided an opinion of materiality in respect of the valuation of the hospital in the 12 months to 1 March 2018.<br><br>The appropriate valuation of land and buildings therefore relies on: the expertise of the valuer and the accuracy of the records provided to the valuer to prepare the valuation. | Our procedures included:<br><br>— **Assessing valuer's credentials:** critically assessing the scope, qualifications, experience and independence of the Trust's external valuer;<br><br>— **Methodology choice:** critically assessing the valuation basis of the Lowestoft Road land and buildings by comparing to our own expectations based on our knowledge of the client and experience of the industry in which it operates to ensure they were appropriate;<br><br>— **Indicators of impairment:** reviewing Board meeting minutes to identify any changes in use or indicators of impairment of the Trust's land and/or buildings, which could lead to a change in the valuation; and<br><br>— **Benchmarking indices:** comparing the indices used in the indexation by the external valuer to externally derived data in relation to the Lowestoft Road site. |
| **NHS and non-NHS Income**<br><br>Income: £190.2 million; 2016/17: £192.0 million.<br><br>*Refer to page 22 (accounting policy) and pages 29 to 31 (financial disclosures).* | **Completeness, existence and accuracy of NHS and non-NHS income**<br><br>£166.7 million (87%) of the Trust's income came from commissioners (Clinical Commissioning Groups (CCGs) and NHS England). The majority of this income is contracted on an annual basis, however actual achievement is based on completing the planned level of activity and achieving key performance indicators (KPIs).<br><br>In 2017/18, the Trust received transformation funding from NHS Improvement. This is received subject to achieving defined financial and operational targets on a quarterly basis. The Trust was allocated £4.4 million of transformation funding.<br><br>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<br><br>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 £300k are required to be reported to the National Audit Office to inform the audit of the Department of Health consolidated accounts.<br><br>The Trust reported income of £17.7 million from other activities, primarily education and training, research and development, or other activities. | Our procedures included:<br><br>— **Test of detail:** confirming that signed contracts were in place for the four largest commissioners of the Trust;<br><br>— **Test of detail:** obtaining the outcome of the agreement of balances exercise with other NHS bodies. Where there were mismatches over £300k we sought explanations and supporting evidence to verify the Trust's entitlement to the income;<br><br>— **Test of detail:** testing transformation funding to cash receipt; and<br><br>— **Test of detail:** testing a sample of other operating income to supporting documentation and, where available, cash receipts; |

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# Independent Auditor's Report to the Council of Governors of James Paget University Hospitals NHS Foundation Trust

continued

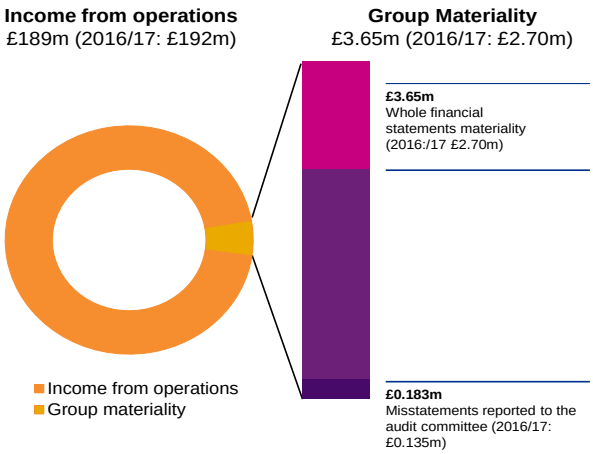
## 3. Our application of materiality and an overview of the scope of our audit

Materiality for the Group financial statements as a whole was set at £3.65 million (2016/17: £2.70 million), determined with reference to a benchmark of income from operations (of which it represents approximately 1.9%). We consider income from operations to be more stable than a surplus- or deficit-related benchmark.

Materiality for the parent Trust's financial statements as a whole was set at £3.65 million (2016/17: £2.70 million), determined with reference to a benchmark of income from operations (of which it represents approximately 1.9%).

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.183 million (2016/17: £0.135 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

The Group comprises the Trust and it's charity (James Paget University Hospitals Charitable Fund). In auditing the Group financial statements materiality has been set for the Trust and Charity based on Group materiality.




## 4. We have nothing to report on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

## 5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

### Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

### Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Group's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

## 6. Respective responsibilities

### Accounting Officer's responsibilities

As explained more fully in the statement set out on page 2, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of its services to another public sector entity.

### Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

# Independent Auditor's Report to the Council of Governors of James Paget University Hospitals NHS Foundation Trust

continued

## REPORT ON OTHER LEGAL AND REGULATORY MATTERS

### We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

### We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources..

We have nothing to report in this respect.

### Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources..

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

### Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out below together with the findings from the work we carried out on each area.

| Significant Risk | Description | Work carried out and judgements |
|---|---|---|
| **Financial sustainability** | When forming our value for money conclusion we consider the in-year performance of the Trust and it's future financial sustainability. The Trust reported a deficit for 2017/18 and is forecasting a deficit for 2018/19.<br><br>In forming our value for money opinion in 2017/18 we considered the following areas:<br><br>— The results of regulators work;<br><br>— The cash position of the Trust and any exceptional measures undertaken to manage this position;<br><br>— The Trusts financial performance against the agreed control total and against internal budgets; and<br><br>— The Trusts 2018/19 plan and longer term forecasts. | Our work included:<br><br>• Reviewing 2017/18 financial outturn against budget and achievement of cost improvement schemes against plan;<br><br>• Reviewing the cash position of the Trust and any exceptional measures undertaken to manage this position;<br><br>• Review of the Financial Improvement Review report;<br><br>• Review of the five year financial strategy; and<br><br>• Review of correspondence with the NHS Improvement.<br><br>**Our findings on this risk area:**<br><br>• The Trust has incurred a deficit of £7.3m against an initial budget surplus of £2.1m. However actual outturn was ahead of the unmitigated Q2 expected forecast outturn deficit of £10.2m;<br><br>• The variance against the initial budget was driven by under delivery of STF in the second half of the year, an increase in non-elective admissions and a shortfall in planned elective activity;<br><br>• The Trust managed its cash position throughout the year, with cash and cash equivalents of £9.6m as at 31 March 2018;<br><br>• The Trust has prepared a five year financial strategy setting out its plans and initiatives to improve its financial position. This strategy includes pursuing opportunities identified in the Financial Improvement Review and cost savings plans supported by reformation of a Finance PMO. |

# Independent Auditor's Report to the Council of Governors of James Paget University Hospitals NHS Foundation Trust

continued

## THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

## CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of James Paget University Hospitals NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

SBeavis

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

*Chartered Accountants*
Dragonfly House
2 Gilders Way
Norwich
NR3 1UB

23 May 2018

# Foreword to the Accounts

## James Paget University Hospitals NHS Foundation Trust

These accounts for the year ended 31 March 2018 have been prepared by the James Paget University Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Chief Executive
21 May 2018

# Statement of Comprehensive Income

| | Note | Group Year Ended 31 March 2018 £ 000 | Group Year Ended 31 March 2017 £ 000 | Trust Year Ended 31 March 2018 £ 000 | Trust Year Ended 31 March 2017 £ 000 |
|---|---|---|---|---|---|
| Operating income from continuing operations | 4.2 | **190,200** | 192,044 | **189,703** | 191,917 |
| Operating expenses of continuing operations | 5 | **(196,190)** | (194,593) | **(195,877)** | (194,316) |
| **Operating (deficit)** | | **(5,990)** | (2,549) | **(6,174)** | (2,399) |
| **Finance costs** | | | | | |
| Finance income | 8 | **143** | 121 | **36** | 27 |
| Finance expense - financial liabilities | 9 | **(39)** | (29) | **(39)** | (29) |
| Finance expense - unwinding of discount on provisions | 21.1 | **(4)** | (27) | **(4)** | (27) |
| Public Dividend Capital - dividends payable | | **(1,365)** | (1,680) | **(1,365)** | (1,680) |
| **Net finance costs** | | **(1,265)** | (1,615) | **(1,372)** | (1,709) |
| Gains/(losses) of disposal of assets | | **290** | 95 | **290** | 95 |
| **(Deficit) for the year** | | **(6,965)** | (4,069) | **(7,256)** | (4,013) |
| **Other comprehensive income** | | | | | |
| Impairments | | **-** | (59) | **-** | (59) |
| Revaluations | | **-** | 213 | **-** | 213 |
| Fair Value gains/(losses) on Available-for-sale financial investments | | **(36)** | 363 | **-** | - |
| **Total comprehensive income/(expense) for the year** | | **(7,001)** | (3,552) | **(7,256)** | (3,859) |

All income and expenditure is derived from continuing operations, and all surplus and comprehensive income / expense is attributable to the owners of the parent.

**Note to statement of comprehensive income/(expense)**

| | | | | | |
|---|---|---|---|---|---|
| Total comprehensive income/(expense) as above | | **(7,001)** | (3,552) | **(7,256)** | (3,859) |
| Less reserve movements in other comprehensive income/(expense) | a | **36** | (517) | **-** | (154) |
| **Total comprehensive income/(expense) before reserve movements** | | **(6,965)** | (4,069) | **(7,256)** | (4,013) |
| Add back in year impairments and reversals of impairments included in deficit above (note 10) | b | **-** | 6,590 | **-** | 6,590 |
| Surplus/(deficit) excluding impairments | | **(6,965)** | 2,521 | **(7,256)** | 2,577 |
| Less other non-operating income | c | **(4,364)** | (6,532) | **(4,364)** | (6,532) |
| **Net underlying Surplus/(Deficit)** | d | **(11,329)** | (4,011) | **(11,620)** | (3,955) |

a This is the total of the three items shown in other comprehensive income.
b This is the total of impairments and impairment reversals charged to expenditure (note 10).
c This is the non recurrent sustainability and transformation fund income received by the Trust in 2017/18 and 2016/17.
d The net underlying deficit for the organisation excluding adjustments for non-recurrent impairment charges and STF income.

The notes on pages 20 to 49 form part of these accounts.

# Statement of Financial Position

| | Note | Group As at 31 March 2018 £ 000 | Group As at 31 March 2017 £ 000 | Trust As at 31 March 2018 £ 000 | Trust As at 31 March 2017 £ 000 |
|---|---|---|---|---|---|
| **Non-current assets** | | | | | |
| Intangible assets | 12 | **2,773** | 3,003 | **2,773** | 3,003 |
| Property, plant and equipment | 13 | **55,407** | 53,896 | **55,407** | 53,896 |
| Other investments | 13.5 | **3,200** | 3,151 | **-** | - |
| Trade and other receivables | 15.2 | **205** | 220 | **205** | 220 |
| **Total non-current assets** | | **61,585** | 60,270 | **58,385** | 57,119 |
| **Current assets** | | | | | |
| Inventories | 14.1 | **2,814** | 2,632 | **2,814** | 2,632 |
| Trade and other receivables | 15.1 | **9,565** | 12,849 | **9,852** | 12,903 |
| Non-current assets held for sale and assets in disposal groups | 13 | **78** | - | **78** | - |
| Cash and cash equivalents | 16 | **10,473** | 12,718 | **9,583** | 11,617 |
| **Total current assets** | | **22,930** | 28,199 | **22,327** | 27,152 |
| **Current liabilities** | | | | | |
| Trade and other payables | 17.1 | **(16,565)** | (15,200) | **(16,463)** | (14,912) |
| Borrowings | 19.1 | **(459)** | (322) | **(459)** | (322) |
| Provisions | 21.1 | **(939)** | (1,414) | **(939)** | (1,414) |
| Other liabilities | 18.1 | **(1,496)** | (772) | **(1,496)** | (772) |
| **Total current liabilities** | | **(19,459)** | (17,708) | **(19,357)** | (17,420) |
| **Total assets less current liabilities** | | **65,056** | 70,761 | **61,355** | 66,851 |
| **Non-current liabilities** | | | | | |
| Trade and other payables | 17.2 | **(27)** | (6) | **(27)** | (6) |
| Borrowings | 19.2 | **(2,431)** | (1,925) | **(2,431)** | (1,925) |
| Provisions | 21.3 | **(1,342)** | (1,608) | **(1,342)** | (1,608) |
| **Total non-current liabilities** | | **(3,800)** | (3,539) | **(3,800)** | (3,539) |
| **Total assets employed** | | **61,256** | 67,222 | **57,555** | 63,312 |
| **Financed by taxpayers' and others' equity** | | | | | |
| Charitable funds reserves | | **3,701** | 3,910 | **-** | - |
| Public dividend capital | | **49,332** | 47,829 | **49,332** | 47,829 |
| Revaluation reserve | 22 | **2,843** | 2,843 | **2,843** | 2,843 |
| Income and expenditure reserve | | **5,380** | 12,640 | **5,380** | 12,640 |
| **Total taxpayers' and others' equity** | | **61,256** | 67,222 | **57,555** | 63,312 |

The financial statements on pages 15 to 48 were approved by the Board on 21 May 2018 and signed on its behalf by:

Chief Executive

Director of Finance

# Consolidated Statement of Changes in Taxpayers' Equity

| | Public Dividend Capital £ 000 | Revaluation Reserve £ 000 | Income and Expenditure Reserve £ 000 | Trust Total £ 000 | Charitable Funds Reserves £ 000 | Group Total £ 000 |
|---|---|---|---|---|---|---|
| **Taxpayers' equity at 1 April 2017** | 47,829 | 2,843 | 12,640 | **63,312** | 3,910 | **67,222** |
| Surplus/(Deficit) for the year | - | - | (8,104) | **(8,104)** | 675 | **(7,429)** |
| Fair Value gains/(losses) on Available-for-sale financial investments | - | - | - | **-** | (36) | **(36)** |
| Other - charitable funds consolidation | - | - | 848 | **848** | (848) | **-** |
| Public Dividend Capital received | 1,503 | - | - | **1,503** | - | **1,503** |
| Other reserve movements | - | - | (3) | **(3)** | - | **(3)** |
| **Taxpayers' equity at 31 March 2018** | **49,332** | **2,843** | **5,380** | **57,555** | **3,701** | **61,256** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Taxpayers' equity at 1 April 2016 as previously stated** | 47,829 | 2,689 | 16,653 | **67,172** | 3,603 | **70,775** |
| Surplus/(Deficit) for the year | - | - | (5,211) | **(5,211)** | 1,142 | **(4,069)** |
| Impairments | - | (59) | - | **(59)** | - | **(59)** |
| Revaluations - property, plant and equipment | - | 213 | - | **213** | - | **213** |
| Fair Value gains/(losses) on Available-for-sale financial investments | - | - | - | **-** | 363 | **363** |
| Other - charitable funds consolidation | - | - | 1,198 | **1,198** | (1,198) | **-** |
| **Taxpayers' equity at 31 March 2017** | **47,829** | **2,843** | **12,640** | **63,312** | **3,910** | **67,222** |

# Consolidated Statement of Cash Flows

| | Group Year Ended 31 March 2018 £ 000 | Group Year Ended 31 March 2017 £ 000 | Trust Year Ended 31 March 2018 £ 000 | Trust Year Ended 31 March 2017 £ 000 |
|---|---|---|---|---|
| **Cash flows from operating activities** | | | | |
| Operating (deficit) from continuing operations | **(5,990)** | (2,549) | **(6,174)** | (2,399) |
| **Operating surplus** | **(5,990)** | (2,549) | **(6,174)** | (2,399) |
| **Non-cash income and expense:** | | | | |
| Depreciation and amortisation | **4,758** | 4,884 | **4,758** | 4,884 |
| Impairments | **-** | 6,590 | **-** | 6,590 |
| Sales of property, plant and equipment | **350** | 186 | **350** | 186 |
| (Increase)/decrease in trade and other receivables | **3,207** | 2,679 | **2,979** | 3,128 |
| (Increase)/decrease in Inventories | **(182)** | 139 | **(182)** | 139 |
| Increase/(decrease) in trade and other payables | **1,648** | (1,091) | **1,648** | (1,091) |
| Increase/(decrease) in other liabilities | **724** | (2,992) | **724** | (2,992) |
| Increase/(decrease) in provisions | **(746)** | (1,801) | **(746)** | (1,801) |
| NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows | **(623)** | 257 | **-** | - |
| **Net cash generated from operating activities** | **3,146** | 6,302 | **3,357** | 6,644 |
| **Cash flows from investing activities:** | | | | |
| Interest received | **36** | 30 | **36** | 30 |
| Purchase of intangible assets | **(470)** | (389) | **(470)** | (389) |
| Purchase of property, plant and equipment | **(4,806)** | (3,921) | **(4,806)** | (3,920) |
| **Net cash (used in) investing activities** | **(5,239)** | (4,280) | **(5,239)** | (4,279) |
| **Cash flows from financing activities:** | | | | |
| Public dividend capital received | **1,503** | - | **1,503** | - |
| Loans repaid | **-** | (11) | **-** | (11) |
| Capital element of finance lease rental payments | **(340)** | (116) | **(340)** | (116) |
| Interest element of finance lease | **(39)** | (29) | **(39)** | (29) |
| PDC Dividend paid | **(1,276)** | (1,466) | **(1,276)** | (1,466) |
| **Net cash (used in) financing activities** | **(152)** | (1,622) | **(152)** | (1,622) |
| **Increase/(decrease) in cash and cash equivalents** | **(2,245)** | 400 | **(2,034)** | 743 |
| **Cash and cash equivalents at 1 April** | **12,718** | 12,318 | **11,617** | 10,874 |
| **Cash and cash equivalents at 31 March** | **10,473** | 12,718 | **9,583** | 11,617 |

# Notes to the Accounts

## 1 Significant Accounting policies and other information

### 1.1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

The Trust has prepared the Financial Statements on a going concern basis. The Trust has realistic expectations that continuing services will be required into 2018/19 and beyond. The Trust plan for 2018/19 includes deficit support loan funding from the Department of Health and there has been no indication that this funding would not be provided. Long term planning and realistic plans for future transformation savings delivery provide the necessary assurance that the Trust is a going concern.

### 1.1.2 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.

### 1.1.3 New and revised IFRSs applied in the current year

There are no new or revised IFRSs applied in the current period that have affected amounts reported or disclosed in these financial statements.

### 1.1.4 New and revised IFRSs in issue but not yet effective

The following list of new or revised IFRSs have been issued but are not yet effective and have not been early adopted by the Trust in the current period. These new or revised IFRSs are either not relevant to the organisation or are not expected to have a material impact on the amounts reported or disclosed in future financial statements.

- IFRS 9 Financial Instruments
- IFRS 14 Regulatory Deferral Accounts
- IFRS 15 Revenue from Contracts with Customers
- IFRS 16 Leases

### 1.1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

### 1.1.6 Critical judgements in applying accounting policies

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- The Trust does not have any contractual arrangements that contain material embedded leases that are required to be capitalised under IFRIC 4.
- The Trust has used component lives based on historic data provided by the District Valuer to depreciate building and dwellings on a component basis.
- The Trust has estimated the provisions for pensions relating to former staff using estimates provided by the NHS Pensions Agency provided at the time of the member's early retirement. These are updated if the member dies or if it becomes apparent that the provision is not sufficient to meet the liability.
- The Trust has estimated the provisions for pensions relating to former staff using estimates provided by the NHS Pensions Agency provided at the time of the member's early retirement. These are updated if the member dies or if it becomes apparent that the provision is not sufficient to meet the liability.

- The last full market valuation of land and building assets was carried out by Montagu Evans LLP, and was applied on 1st March 2016 based on an alternate site, modern equivalent asset basis. An assumptions review was conducted by Montagu Evans LLP on 1st March 2018.

### 1.1.7 Key sources of estimation uncertainty

In accordance with IAS 1, the Trust has assessed the key areas where underlying estimates in the accounts are subject to uncertainties which create a significant risk of causing a material adjustment. These assumptions are set out as follows.

In order to calculate the carrying value of the Trust's provisions there are a number of areas which require to be estimated, these are;

- The Trust will need to estimate the amount of its liability. In the case of legal claims, for example, it uses the advice of experts but the actual amount of the liability will not be known until the outcome of the litigation.

- The Trust will need to estimate the probability of a liability existing. The outcome of litigation may be uncertain but the Trust will use the advice of its experts on whether it is probable that it will be found liable.

- In the cases of pension and other benefits payable in the future, an estimate will be made of the length of time that payment will be required to be made, to estimate the present value of the estimated future payments.

## 1.2 Consolidation

### 1.2.1 NHS Charitable Fund

The NHS Foundation Trust is the corporate trustee to the James Paget University Hospitals NHS charitable fund. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

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.

Results of the consolidated group and of the Foundation Trust are reported separately in the primary statements, for all other notes to the accounts the results of the consolidated group are reported.

### 1.2.2 Other Subsidiaries

Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year.

Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

### 1.2.3 Associates

Associate entities are those over which the trust has the power to exercise a significant influence. Associate entities are recognised in the trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, e.g. share dividends are received by the trust from the associate.

Associates which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

### 1.2.4 Joint ventures

Joint ventures are arrangements in which the trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement.

Joint ventures are accounted for using the equity method.

### 1.2.5 Joint operations

Joint operations are arrangements in which the trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The trust includes within its financial statements its share of the assets, liabilities, income and expenses.

## 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 health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent 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.

Income in relation to maternity pathways is recognised based on the proportion completed during the year ended 31st March 2018.

## 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. The scheme are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

## 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;
- the cost of the item can be measured reliably; and

- assets meet the following capitalisation threshold and grouping criteria:
    - assets individually have a cost of at least £5,000; or
    - form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, 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
    - form part of the initial setting-up cost of a new building or refurbishment of a 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 valuation, using the following methods for determining fair value;

- The fair value of land and buildings is determined from reference to market based evidence by appraisal for non-specialised operational property, and on the basis of an Alternate Site Depreciated Replacement Cost of a Modern Equivalent Asset for specialised operational property where market based evidence does not exist. The valuations are carried out by professionally qualified valuers, and are performed with sufficient regularity to ensure that the carrying value does not differ significantly from fair value at the statement of financial position date. The latest land and building asset valuation undertaken was carried out by Montagu Evans LLP, and was applied on 1st March 2016. An assumptions review was conducted by Montagu Evans LLP on 1st March 2018

- Assets in the course of construction are valued at cost and are valued by professional valuers at the same time as other land and building assets after they are brought into use.
- Non-property assets are carried at depreciated historic cost as a proxy for fair value.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. 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 are not depreciated until the asset is brought into use.

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:

| | | | |
|---|---|---|---|
| Buildings | 30 to 150 years | Transport Equipment | 5 to 15 years |
| Dwellings | 30 to 60 years | Information Technology | 3 to 10 years |
| Plant and Machinery | 3 to 16 years | Furniture and Fittings | 10 to 15 years |

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

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'.

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.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
    - management are committed to a plan to sell the asset;
    - an active programme has begun to find a buyer and complete the sale;
    - the asset is being actively marketed at a reasonable price;
    - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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.

### 1.6.3 Donated and government 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.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

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.

### 1.7.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

### 1.7.3 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The estimated useful economic life of software licences is six years.

## 1.8 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is treated as described above in note 1.6.3.

## 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

## 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust’s cash management. Cash, bank and overdraft balances are recorded at current values.

## 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), which are entered into in accordance with the trust’s normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

### 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 'loans and receivables' and financial liabilities are classified as 'other financial liabilities'.

### 1.10.4 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 receivables; accrued income and 'other' receivables.

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.

### 1.10.5 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.

### 1.10.6 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 through the use of a bad debt provision. When an asset's carrying value is written-down using a bad debt provision, this is determined based upon knowledge of the operating environment and experience of past cash flows. A bad debt provision against an asset's carrying value is only written off when all reasonable efforts to recover the carrying value have been exhausted.

## 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. In a manner consistent with the Trust's accounting policy on capitalisation of non-current assets, finance leases are recognised where assets individually have a cost of at least £5,000.

The value at which both the asset and liability are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment. The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

### 1.11.2 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.

### 1.11.4 The trust as lessor

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

## 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

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 21.4, but is not recognised in the trust's accounts.

### 1.12.2 Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

## 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 organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (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 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

Income from commercial activities is subject to corporation tax under section 519A Income and Corporation Taxes Act 1988 (519A ICTA 1988), as amended by section 148 of the Finance Act 2004. However, provision of Healthcare authorised under section 43 of the National Health Service Act 2006 is not treated as commercial income. The total non-healthcare related activities carried out by the Foundation Trust during the period which are deemed to be commercial activities are not subject to corporation tax because annual taxable profits are below the de minimus limit of £50,000.

## 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.
Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

## 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 Foundation Trust has no beneficial interest in them. However, they are disclosed separately in note 24 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 the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

## 1.19 Events after the reporting period

The James Paget University Hospitals NHS Foundation has had no material events after the 31st March 2018 which require adjustment or disclosure in these financial statements.

## 2 Segmental reporting

Under the definitions of operating segments contained within International Financial Reporting Standard 8, the Trust has a single operating segment where the revenues are derived from the provision of healthcare services.

The products and services provided to external customers are identified in notes 4.1 and 4.2 below under the headings “Income from activities analysed by service type” and “Other operating income”.

All revenues from external customers are derived from within the UK, and all non-current assets are located in the UK.

## 3 Subsidiaries

The James Paget University Hospitals NHS Foundation Trust acts as the corporate Trustee of the James Paget University Hospitals Charitable Fund and in accordance with the charity’s declaration of trust, members of the Foundation Trust’s Board of Directors act as ex-officio Trustees of the Charitable Funds.

This Trustee arrangement satisfies the relevant tests of control under IAS 27 and therefore the Charitable Fund is a subsidiary of the Foundation Trust. The Foundation Trust has prepared group accounts for the year ended 31 March 2018.

The James Paget University Hospitals Charitable Fund is a registered charity located in England, and the Foundation Trust as the sole corporate Trustee has 100% of the voting rights. The Foundation Trust does not have any financial investment in the Charitable Fund.

The ability of the subsidiary to transfer funds to the Foundation Trust is significantly restricted by the charitable objects and the legal requirement for the Trustees to act independently and ensure that all funds are spent in accordance with the donors’ wishes.

## 4 Operating income

### 4.1 Income from activities analysed by service type

| | | **Year Ended 31 March 2018 £ 000** | Year Ended 31 March 2017 £ 000 |
|---|---|---|---|
| Elective income | | **28,053** | 29,314 |
| Non elective income | | **46,010** | 41,130 |
| Outpatient income | | **24,642** | 27,624 |
| A&E income | | **9,117** | 8,061 |
| Other NHS clinical income | | **62,589** | 63,749 |
| Private patient income | | **1,028** | 874 |
| Other clinical income | | **1,021** | 1,161 |
| | Note 4.2 | **172,459** | 171,913 |

| | | Year Ended 31 March 2018 £ 000 | Year Ended 31 March 2017 £ 000 |
|---|---|---|---|
| **4.2 Analysis of operating income by source** | | | |
| **Income from activities** | | | |
| NHS Foundation Trusts | | **3,718** | 3,413 |
| NHS Trusts | | **8** | 3 |
| Clinical Commissioning Groups and NHS England | | **166,684** | 166,420 |
| NHS Other | | **-** | 43 |
| Non NHS: | | | |
| Private patients | | **1,028** | 874 |
| Overseas patients | Note 4.4 | **48** | 287 |
| NHS injury scheme * | | **757** | 632 |
| Other | | **216** | 241 |
| **Total income from activities** | | **172,459** | 171,913 |
| **Other operating income** | | | |
| Research and development | | **871** | 1,017 |
| Education and training | | **6,910** | 7,171 |
| Non patient care services to other NHS bodies | | **255** | 303 |
| Sustainability and transformation fund income** | | **4,364** | 6,532 |
| Rental revenue from operating leases | Note 4.3 | **125** | 126 |
| Other income: | | | |
| Catering | | **987** | 907 |
| Accommodation | | **797** | 823 |
| Car parking | | **1,173** | 1,152 |
| Miscellaneous | | **914** | 775 |
| NHS Charitable Funds: Incoming Resources excluding investment income | | **1,345** | 1,325 |
| **Total other operating income** | | **17,741** | 20,131 |
| **Total operating income** | | **190,200** | 192,044 |

* NHS Injury Scheme income is subject to a provision for doubtful debts of 11.00% (2016/17 - 21.94%) to reflect expected rates of collection.

** Sustainability and transformation fund income of £4,364,000 has been allocated to the Trust on a non-recurrent basis during 2017/18 (2016/17 - £6,532,000) to support the financial position of the Trust, and is excluded from the financial performance assessment of the organisation.

## 4.3 Operating lease income

| | Year Ended 31 March 2018 £ 000 | Year Ended 31 March 2017 £ 000 |
|---|---|---|
| Rents recognised as income in the period | **125** | 126 |
| Contingent rents recognised as income in the period | **-** | - |
| | **125** | 126 |

Future minimum lease receipts due:

| | Year Ended 31 March 2018 | | | |
|---|---|---|---|---|
| | **Land** | **Buildings** | **Other** | **Total** |
| Within 1 year | **-** | **99** | **-** | **99** |
| Between 1 and 5 years | **-** | **216** | **-** | **216** |
| After 5 years | **-** | **154** | **-** | **154** |
| | **-** | **469** | **-** | **469** |

| | Year Ended 31 March 2017 | | | |
|---|---|---|---|---|
| | Land | Buildings | Other | Total |
| Within 1 year | **-** | 94 | **-** | 94 |
| Between 1 and 5 years | **-** | 241 | **-** | 241 |
| After 5 years | **-** | 197 | **-** | 197 |
| | - | 532 | - | 532 |

## 4.4 Overseas visitor income

| | Year Ended 31 March 2018 £ 000 | Year Ended 31 March 2017 £ 000 |
|---|---|---|
| Income recognised in this year | **48** | 287 |
| Cash payments received in-year (relating to invoices raised in current and previous years) | **37** | 29 |
| Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years) | **152** | 34 |
| Amounts written off in-year (relating to invoices raised in current and previous years) | **-** | 1 |

## 5 Operating expenses

| | | Year Ended 31 March 2018 £ 000 | Year Ended 31 March 2017 £ 000 |
|---|---|---|---|
| Services from NHS Foundation Trusts | | **376** | 135 |
| Services from NHS Trusts | | **11** | 4 |
| Purchase of healthcare from non-NHS bodies | | **531** | 61 |
| Employee expenses - executive directors | | **1,463** | 1,069 |
| Employee expenses - non-executive directors | | **120** | 140 |
| Employee expenses - staff | | **128,582** | 123,373 |
| Drug costs | | **19,996** | 19,677 |
| Supplies and services - clinical (excluding drug costs) | | **15,535** | 15,691 |
| Supplies and services - general | | **2,500** | 2,531 |
| Establishment | | **1,584** | 1,481 |
| Transport | | **90** | 104 |
| Premises | | **5,150** | 4,712 |
| Increase in provision for impairment of receivables | | **636** | 838 |
| Change in provisions discount rate | | **21** | 195 |
| Inventories write down | | **52** | 52 |
| Rentals under operating leases | | **281** | 317 |
| Depreciation on property, plant and equipment | | **4,105** | 4,325 |
| Amortisation on intangible assets | | **652** | 559 |
| Net Impairments of property, plant and equipment* | Note 10 / 13.3 | **-** | 5,100 |
| Net impairments of intangible assets | Note 12.2 | **-** | 1,490 |
| Audit fees - statutory audit** | | **61** | 61 |
| Audit fees - Charitable Fund Accounts | | **5** | 5 |
| Internal Audit and Local Counter Fraud Services | | **82** | 60 |
| Clinical negligence | | **6,818** | 6,198 |
| Legal fees | | **271** | 76 |
| Consultancy costs | | **187** | 116 |
| Training, courses and conferences | | **969** | 763 |
| Patient travel | | **53** | 56 |
| Redundancy payments | | **-** | (83) |
| Insurance | | **131** | 163 |
| Other contracted services | | **260** | 206 |
| Losses, ex gratia and special payments | | **9** | 5 |
| Other | | **5,352** | 4,841 |
| NHS Charitable funds: Other resources expended | | **307** | 272 |
| | | **196,190** | 194,593 |

* Impairments charged to operating expenses during 2016/17 are primarily as a result of a desk top interim alternate site market valuation by the Trusts external valuers Montagu Evans as at 1 March 2017.

** There is a £1,000,0000 limitation on auditor's liability.

## 6 Operating leases

### 6.1 Lease payments recognised as an expense in the period

| | Year Ended 31 March 2018 £ 000 | Year Ended 31 March 2017 £ 000 |
|---|---|---|
| Minimum lease payments | **281** | 317 |
| Contingent rents | **-** | - |
| Sublease payments | **-** | - |
| | **281** | 317 |

### 6.2 Total of future minimum lease payments due:

| | Year Ended 31 March 2018 | | | |
|---|---|---|---|---|
| | **Land £ 000** | **Buildings £ 000** | **Other £ 000** | **Total £ 000** |
| Within 1 year | **-** | **-** | **90** | **90** |
| Between 1 and 5 years | **-** | **-** | **164** | **164** |
| After 5 years | **-** | **-** | **1** | **1** |
| | **-** | **-** | **255** | **255** |

| | Year Ended 31 March 2017 | | | |
|---|---|---|---|---|
| | Land £ 000 | Buildings £ 000 | Other £ 000 | Total £ 000 |
| Within 1 year | - | - | 93 | 93 |
| Between 1 and 5 years | - | - | 81 | 81 |
| After 5 years | - | - | - | - |
| | - | - | 174 | 174 |

## 7 Employee expenses and numbers

### 7.1 Employee expenses

| | **Permanent £ 000** | **Year Ended 31 March 2018 Other £ 000** | **Total £ 000** | Year Ended 31 March 2017 £ 000 |
|---|---|---|---|---|
| Salaries and wages | **99,996** | **1,559** | **101,555** | 95,427 |
| Social security costs | **9,885** | **-** | **9,885** | 9,382 |
| Apprenticeship levy | **499** | **-** | **499** | |
| Employer contributions to NHS Pensions | **11,772** | **-** | **11,772** | 11,179 |
| Pension cost - other | **10** | **-** | **10** | 9 |
| Agency / contract staff | **-** | **6,938** | **6,938** | 9,003 |
| | **122,162** | **8,497** | **130,659** | 125,000 |
| Employee expenses recharged to other organisations | **(401)** | **-** | **(401)** | (442) |
| Employee expenses capitalised as part of assets | **(213)** | **-** | **(213)** | (115) |
| | **121,548** | **8,497** | **130,045** | 124,443 |

## 7.2 Directors' remuneration

| | Year Ended 31 March 2018 £ 000 | Year Ended 31 March 2017 £ 000 |
|---|---|---|
| Directors' remuneration | **1,183** | 1,179 |
| Employer contributions to NHS Pensions Agency | **95** | 90 |
| Benefits in kind | **7** | 4 |
| Total number of directors to whom benefits are accruing under: | | |
| Money purchase pension schemes | **1** | 2 |
| Defined benefit pension schemes | **10** | 15 |

Further details on directors' remuneration are given in the remuneration report on pages 38 to 45 of the Annual Report.

## 7.3 Average number of employees

| | Year Ended 31 March 2018 Permanent Number | Other Number | Total Number | Year Ended 31 March 2017 Number |
|---|---|---|---|---|
| Medical and dental | **124** | **173** | **297** | 291 |
| Ambulance Staff | **1** | **-** | **1** | - |
| Administration and estates | **459** | **18** | **477** | 468 |
| Healthcare assistants and other support staff | **421** | **7** | **428** | 408 |
| Nursing, midwifery and health visiting staff | **1,121** | **82** | **1,203** | 1,163 |
| Scientific, therapeutic and technical staff | **270** | **6** | **276** | 271 |
| Bank Staff | **-** | **62** | **62** | 77 |
| Agency Staff | **-** | **155** | **155** | 154 |
| | **2,396** | **503** | **2,899** | 2,832 |
| Of which number of employees engaged on capital projects | **6** | **-** | **6** | 4 |

Total nursing, midwifery and health visiting staff numbers for 2017/18, including all nursing, midwifery and health visiting bank and agency staff are 1,342 (2016/17 - 1,299). Total Medical and dental staff numbers for 2017/18, including all Medical and dental agency staff are 319 (2016/17 - 325).

## 7.4 Staff exit packages

There has been one staff exit package during the year ended 31 March 2018 with a value of £48,000 (Year ended 31 March 2017 nil, £nil).

## 7.5 Retirements due to ill-health

During the year ending 31 March 2018 there were three (2016/17 - seven) early retirements from the Trust agreed on the grounds of ill-health. The additional pension costs of these ill-health retirements (calculated on an average basis and borne by the NHS Pension Scheme) will be £157,000 (2016/17 - £361,000).

## 7.6 Retirement benefits

**Pension costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

**a) Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

**b) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. 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.

## 8 Finance income

| | Year Ended 31 March 2018 £ 000 | Year Ended 31 March 2017 £ 000 |
|---|---|---|
| Interest on cash deposits | **36** | 27 |
| NHS Charitable funds: investment income | **107** | 94 |
| | **143** | 121 |

## 9 Finance costs - interest expense

| | | |
|---|---|---|
| Finance leases | **39** | 29 |
| | **39** | 29 |

## 10 Impairment of assets recognised as operating expenses

Operating expenses include impairment costs due to:

| | | |
|---|---|---|
| Loss or damage from normal operations | **-** | 35 |
| Abandonment of assets in course of construction | **-** | 108 |
| Unforeseen obsolescence | **-** | 148 |
| Changes in market price | **-** | 4,955 |
| Other | **-** | 1,344 |
| | **-** | 6,590 |

Impairments recognised in operating expenses for the period ending 31st March 2017 were primarily due to the interim desktop revaluation of land, building and dwelling assets conducted by the Trust's externally appointed independent valuers on a modern equivalent asset alternate site basis as at 1st March 2017.

## 11 Interests in Joint Operations

The James Paget University Hospitals NHS Foundation Trust has a 22% interest in a joint operation for the provision of pathology services in Norfolk known as Eastern Pathology Alliance (EPA). The arrangement has been effective from 1st November 2013, and has not involved the establishment of a separate entity.

The Trust has recognised its interest in the joint operation using the line-by-line reporting format for proportionate consolidation. This means that included within income from activities in note 4.1 is £3,447,000 (2016/17 £3,378,000) representing a 22% share of EPA revenue, and included within operating expenses in note 5 is £6,711,000 (2016/17 £6,599,000) representing a 22% share of the operating costs of EPA.

## 12 Intangible assets

### 12.1 Intangible assets 2017/18

| | Assets Under Construction £ 000 | Software Licences £ 000 | Other £ 000 | Total £ 000 |
|---|---|---|---|---|
| Cost or valuation at 1 April 2017 | 11 | 6,099 | 30 | **6,140** |
| Additions - purchased | 368 | 21 | - | **389** |
| Additions - donated | - | 34 | - | **34** |
| Reclassifications | (206) | 206 | - | **-** |
| Disposals | - | (74) | - | **(74)** |
| **Cost or Valuation at 31 March 2018** | **173** | **6,286** | **30** | **6,489** |
| Amortisation at 1 April 2017 | - | 3,124 | 14 | **3,138** |
| Provided during the year | - | 647 | 5 | **652** |
| Disposals | - | (74) | - | **(74)** |
| **Amortisation at 31 March 2018** | **-** | **3,697** | **19** | **3,716** |
| Opening net book value at 1 April 2017 | | | | |
| Purchased | 10 | 2,621 | 16 | 2,647 |
| Finance leases | - | 324 | - | 324 |
| Donated | - | 32 | - | 32 |
| Total NBV at 1 April 2017 | 10 | 2,977 | 16 | 3,003 |
| **Closing net book value at 31 March 2018** | | | | |
| Purchased | 173 | 2,258 | 11 | **2,442** |
| Finance leases | - | 278 | - | **278** |
| Donated | - | 25 | - | **25** |
| Government granted | - | 28 | - | **28** |
| **Total NBV at 31 March 2018** | **173** | **2,589** | **11** | **2,773** |

### 12.2 Intangible assets 2016/17

| | | | | |
|---|---|---|---|---|
| Cost or valuation at 1 April 2016 | 2,102 | 4,305 | 1,367 | **7,774** |
| Additions - purchased* | 234 | 67 | - | **301** |
| Reclassifications | (2,276) | 2,276 | - | **-** |
| Impairments | (49) | (414) | (1,337) | **(1,800)** |
| Disposals | - | (135) | - | **(135)** |
| **Cost or Valuation at 31 March 2017** | **11** | **6,099** | **30** | **6,140** |
| Amortisation at 1 April 2016 | - | 2,999 | 9 | **3,008** |
| Provided during the year | - | 554 | 5 | **559** |
| Impairments | - | (310) | - | **(310)** |
| Disposals | - | (119) | - | **(119)** |
| **Amortisation at 31 March 2017** | **-** | **3,124** | **14** | **3,138** |
| Opening net book value at 1 April 2016 | | | | |
| Purchased | 2,102 | 760 | 1,358 | 4,220 |
| Finance leases | - | 371 | - | 371 |
| Donated | - | 37 | - | 37 |
| Government granted | - | 139 | - | 139 |
| Total NBV at 1 April 2016 | 2,102 | 1,307 | 1,358 | 4,767 |
| **Closing net book value at 31 March 2017** | | | | |
| Purchased | 10 | 2,621 | 16 | **2,647** |
| Finance leases | - | 324 | - | **324** |
| Donated | - | 32 | - | **32** |
| **Total NBV at 31 March 2017** | **10** | **2,977** | **16** | **3,003** |

*For consolidation purposes purchased additions includes assets funded from donations of £1,000

# Notes to the Accounts

continued

## 13 Property, plant and equipment

### 13.1 Property, plant and equipment 2017/18

| | Land | Buildings (excluding dwellings) | Dwellings | Assets under construction | Plant and Machinery | Transport Equipment | Information Technology | Furniture and Fittings | Total Trust |
|---|---|---|---|---|---|---|---|---|---|
| | £ 000 | £ 000 | £ 000 | £ 000 | £ 000 | £ 000 | £ 000 | £ 000 | £ 000 |
| **Cost or valuation at 1 April 2017** | 2,894 | 36,982 | 2,589 | 913 | 21,349 | 549 | 13,070 | 1,414 | **79,760** |
| Additions - purchased* | - | - | - | 3,625 | 304 | 123 | 146 | - | **4,198** |
| Additions - leased | - | - | - | - | 981 | - | - | - | **981** |
| Additions - donated | - | - | - | 493 | 77 | - | 6 | - | **576** |
| Reclassifications | - | 709 | - | (2,377) | 526 | - | 1,132 | 10 | **-** |
| Transfers to/from assets held for sale* | (78) | - | - | - | - | - | - | - | **(78)** |
| Disposals | - | - | - | - | (1,408) | (69) | (68) | (19) | **(1,564)** |
| **Cost or Valuation at 31 March 2018** | **2,816** | **37,691** | **2,589** | **2,654** | **21,829** | **603** | **14,286** | **1,405** | **83,873** |
| **Accumulated depreciation at 1 April 2017** | - | 136 | 7 | - | 14,695 | 415 | 9,632 | 979 | **25,864** |
| Provided during the year | - | 1,659 | 100 | - | 1,402 | 30 | 833 | 81 | **4,105** |
| Disposals | - | - | - | - | (1,356) | (69) | (68) | (10) | **(1,503)** |
| **Accumulated depreciation at 31 March 2018** | **-** | **1,795** | **107** | **-** | **14,741** | **376** | **10,397** | **1,050** | **28,466** |
| Opening net book value at 1 April 2017 | | | | | | | | | |
| Purchased | 2,894 | 34,232 | 2,582 | 914 | 4,180 | 134 | 2,347 | 264 | 47,547 |
| Finance leased | - | - | - | - | 779 | - | 1,028 | - | 1,807 |
| Government granted | - | 600 | - | - | 3 | - | 5 | 48 | 656 |
| Donated | - | 2,013 | - | - | 1,692 | - | 58 | 123 | 3,886 |
| Total NBV at 1 April 2017 | 2,894 | 36,845 | 2,582 | 914 | 6,654 | 134 | 3,438 | 435 | 53,896 |
| **Closing net book value at 31 March 2018** | | | | | | | | | |
| Purchased | 2,816 | 33,387 | 2,482 | 2,374 | 3,832 | 227 | 2,969 | 220 | **48,307** |
| Finance leased | - | - | - | - | 1,613 | - | 860 | - | **2,473** |
| Government granted | - | 559 | - | - | 2 | - | 4 | 33 | **598** |
| Donated | - | 1,950 | - | 280 | 1,641 | - | 56 | 102 | **4,029** |
| **Total NBV at 31 March 2018** | **2,816** | **35,896** | **2,482** | **2,654** | **7,088** | **227** | **3,889** | **355** | **55,407** |

* During the period ended 31 March 2018 The land was re-classified as assets held for sale:
- asset held for sale relates to the land (NBV £78,000) and Buildings (NBV £nil) of the Lowestoft Hospital site
- the Trust discontinued use of Lowestoft Hospital during 2016/17 and has been actively marketed for sale during 2017/18

# Notes to the Accounts

continued

## 13.2 Property, plant and equipment 2016/17

| | Land | Buildings (excluding dwellings) | Dwellings | Assets under construction | Plant and Machinery | Transport Equipment | Information Technology | Furniture and Fittings | Total Trust |
|---|---|---|---|---|---|---|---|---|---|
| | £ 000 | £ 000 | £ 000 | £ 000 | £ 000 | £ 000 | £ 000 | £ 000 | £ 000 |
| **Cost or valuation at 1 April 2016** | 2,858 | 41,539 | 2,505 | 3,618 | 19,874 | 515 | 11,701 | 1,386 | **83,996** |
| Additions - purchased** | - | - | - | 1,286 | 1,497 | - | 80 | - | **2,863** |
| Additions - leased | - | - | - | - | 873 | - | 367 | - | **1,240** |
| Reclassifications | - | 2,417 | - | (3,932) | 190 | 34 | 1,237 | 54 | **-** |
| Impairments | - | (6,974) | - | (59) | (64) | - | (315) | (21) | **(7,433)** |
| Other revaluations | 36 | - | 84 | - | - | - | - | - | **120** |
| Disposals | - | - | - | - | (1,021) | - | - | (5) | **(1,026)** |
| **Cost or Valuation at 31 March 2017** | **2,894** | **36,982** | **2,589** | **913** | **21,349** | **549** | **13,070** | **1,414** | **79,760** |
| **Accumulated depreciation at 1 April 2016** | - | 160 | 7 | - | 14,345 | 369 | 9,066 | 911 | **24,858** |
| Provided during the year | - | 1,936 | 93 | - | 1,318 | 46 | 850 | 82 | **4,325** |
| Impairments | - | (1,960) | - | - | (22) | - | (284) | (9) | **(2,275)** |
| Other revaluations | - | - | (93) | - | - | - | - | - | **(93)** |
| Disposals | - | - | - | - | (946) | - | - | (5) | **(951)** |
| **Accumulated depreciation at 31 March 2017** | **-** | **136** | **7** | **-** | **14,695** | **415** | **9,632** | **979** | **25,864** |
| Opening net book value at 1 April 2016 | | | | | | | | | |
| Purchased | 2,858 | 38,255 | 2,498 | 3,614 | 4,020 | 146 | 1,762 | 253 | 53,406 |
| Finance leased | - | - | - | - | - | - | 756 | - | 756 |
| Government granted | - | 729 | - | - | 5 | - | 66 | 77 | 877 |
| Donated | - | 2,394 | - | 4 | 1,504 | - | 51 | 146 | 4,099 |
| Total NBV at 1 April 2016 | 2,858 | 41,378 | 2,498 | 3,618 | 5,529 | 146 | 2,635 | 476 | 59,138 |
| **Closing net book value at 31 March 2017** | | | | | | | | | |
| Purchased | 2,894 | 34,232 | 2,582 | 914 | 4,180 | 134 | 2,347 | 264 | **47,547** |
| Finance leased | - | - | - | - | 779 | - | 1,028 | - | **1,807** |
| Government granted | - | 600 | - | - | 3 | - | 5 | 48 | **656** |
| Donated | - | 2,013 | - | - | 1,692 | - | 58 | 123 | **3,886** |
| **Total NBV at 31 March 2017** | **2,894** | **36,845** | **2,582** | **914** | **6,654** | **134** | **3,438** | **435** | **53,896** |

**For consolidation purposes purchased additions includes assets funded from donations of £516,000

## 13.3 Analysis of property, plant and equipment

Land, building and dwelling assets were last subject to a desk based interim valuation carried out by the Trust's externally appointed independent valuers on an alternate site basis as at 1st March 2017.

There were no net impairments during 2017/18 (2016/17 - £6,649,000), £nil (2016/17 - £6,590,000) has been recognised in operating expenses, and £nil (2016/17 - £59,000) has been recognised directly in equity during the period.

## 13.4 Analysis of revalued property, plant and equipment

| | Land | Buildings (excluding dwellings) | Dwellings | Total |
|---|---|---|---|---|
| | £ 000 | £ 000 | £ 000 | £ 000 |
| **Net book value of PPE in the revaluation reserve** | | | | |
| As at 1 April 2017 | **1,179** | **595** | **1,069** | **2,843** |
| Movement in year | **-** | **-** | **-** | **-** |
| **As at 31 March 2018** | **1,179** | **595** | **1,069** | **2,843** |
| As at 1 April 2016 | 1,143 | 654 | 892 | 2,689 |
| Movement in year | 36 | (59) | 177 | 154 |
| **As at 31 March 2017** | 1,179 | 595 | 1,069 | 2,843 |

## 13.5 Investments

| | Year Ended 31 March 2018 | Year Ended 31 March 2017 |
|---|---|---|
| | £ 000 | £ 000 |
| **NHS Charitable funds: Other investments** | | |
| Carrying value at 1 April | **3,151** | 2,715 |
| Acquisitions in year - other | **529** | 223 |
| Movement in fair value of Available-for-sale financial assets recognised in Other Comprehensive Income | **(36)** | 363 |
| Disposals | **(444)** | (150) |
| Carrying value at 31 March | **3,200** | 3,151 |

# 14 Inventories

## 14.1 Inventories recognised in current assets

| | Total as at 31 March 2018 £ 000 | Total as at 31 March 2017 £ 000 |
|---|---|---|
| Drugs | **1,140** | 1,080 |
| Consumables | **1,652** | 1,530 |
| Energy | **22** | 22 |
| | **2,814** | 2,632 |

## 14.2 Inventory Movements

| | | |
|---|---|---|
| Carrying Value at 1 April | **2,632** | 2,771 |
| Additions | **30,337** | 29,135 |
| Inventories recognised in expenses | **(29,222)** | (29,222) |
| Write down of inventories recognised as an expense | **(52)** | (52) |
| | **3,695** | 2,632 |

At 31st March 2018 the Charitable Funds held inventories of £nil (31st March 2017 £nil)

| | Total as at 31 March 2018 £ 000 | Total as at 31 March 2017 £ 000 |
|---|---|---|
| **15 Trade and other receivables** | | |
| **15.1 Current trade and other receivables** | | |
| NHS receivables - revenue | **2,578** | 3,126 |
| Other receivables with related parties - revenue | **11** | 64 |
| Provision for impaired receivables | **(1,316)** | (983) |
| Prepayments | **848** | 707 |
| Accrued income | **5,546** | 7,697 |
| Operating lease receivables | **11** | 13 |
| PDC dividend receivable | **8** | 98 |
| VAT receivable | **225** | 257 |
| Other receivables - revenue | **1,941** | 1,830 |
| NHS Charitable funds: Trade and other receivables | **35** | 40 |
| | **9,887** | 12,849 |
| **15.2 Non-current trade and other receivables** | | |
| Provision for impaired receivables | **(467)** | (322) |
| Prepayments | **44** | 50 |
| Other receivables | **628** | 492 |
| | **205** | 220 |
| **15.3 Provision for impairment of receivables** | | |
| Provision at 1 April | **1,305** | 717 |
| New provisions arising | **1,085** | 855 |
| Amounts utilised | **(158)** | (250) |
| Unused amounts reversed | **(449)** | (17) |
| **Provision at 31 March** | **1,783** | 1,305 |
| **15.4 Analysis of financial assets past due or impaired** | | |
| **Analysis of impaired financial assets** | | |
| 0 - 30 days | **71** | 58 |
| 30 - 60 days | **67** | 88 |
| 60 - 90 days | **36** | 67 |
| 90 - 180 days | **113** | 127 |
| Over 180 days | **1,496** | 965 |
| **Total at 31 March** | **1,783** | 1,305 |
| **Ageing of non-impaired financial assets past their due date** | | |
| 0 - 30 days | **4,765** | 8,685 |
| 30 - 60 days | **1,028** | 1,001 |
| 60 - 90 days | **175** | 246 |
| 90 - 180 days | **550** | 862 |
| Over 180 days | **1,051** | 1,224 |
| **Total at 31 March** | **7,569** | 12,018 |

## 16 Cash and cash equivalents

| | Trust Total 2018 £ 000 | Charitable Funds Total 2018 £ 000 | Trust Total 2017 £ 000 | Charitable Funds Total 2017 £ 000 |
|---|---|---|---|---|
| **At 1 April** | **11,617** | **1,101** | 10,874 | 1,444 |
| Net change in year | **(2,034)** | **(211)** | 743 | (343) |
| **At 31 March** | **9,583** | **890** | 11,617 | 1,101 |
| **Broken down into:** | | | | |
| Cash at commercial banks and in hand | **80** | **890** | 182 | 1,101 |
| Cash with the Government Banking Service | **9,503** | **-** | 11,435 | - |
| **Cash and cash equivalents as in SoFP** | **9,583** | **890** | 11,617 | 1,101 |
| Bank overdraft | **-** | **-** | - | - |
| **At 31 March** | **9,583** | **890** | 11,617 | 1,101 |

Total cash and cash equivalents for the group as at 31 March 2018 are £10,473,000 (31 March 2017 - £12,718,000).

## 17 Trade and other payables

### 17.1 Current trade and other payables

| | Total as at 31 March 2018 £ 000 | Total as at 31 March 2017 £ 000 |
|---|---|---|
| NHS payables - revenue | **587** | 644 |
| Amounts due to other related parties - revenue | **1,762** | 1,566 |
| Trade payables - capital | **256** | 333 |
| Other trade payables | **2,874** | 2,776 |
| Social security costs payable | **1,404** | 1,347 |
| Other taxes payable | **1,198** | 1,087 |
| Other payables | **2,754** | 2,746 |
| Accruals | **5,628** | 4,413 |
| NHS Charitable funds | **102** | 288 |
| | **16,565** | 15,200 |

### 17.2 Non-current trade and other payables

| | | |
|---|---|---|
| Amounts due to other related parties - revenue | **-** | - |
| Other payables | **27** | 6 |
| | **27** | 6 |

Amounts due to other related parties include:

## 18 Other liabilities

### 18.1 Other liabilities - current

| | Total as at 31 March 2018 £ 000 | Total as at 31 March 2017 £ 000 |
|---|---|---|
| Deferred income | **1,496** | 772 |
| | **1,496** | 772 |

## 19 Borrowings

### 19.1 Current borrowings

| | | Total as at 31 March 2018 £ 000 | Total as at 31 March 2017 £ 000 |
|---|---|---|---|
| Other loans | | **-** | - |
| Obligations under finance leases | Note 20 | **459** | 322 |
| | | **459** | 322 |

### 19.2 Non-current borrowings

| | | Total as at 31 March 2018 £ 000 | Total as at 31 March 2017 £ 000 |
|---|---|---|---|
| Other loans | | **-** | - |
| Obligations under finance leases | Note 20 | **2,431** | 1,925 |
| | | **2,431** | 1,925 |

## 20 Finance lease obligations

| | Total as at 31 March 2018 £ 000 | Total as at 31 March 2017 £ 000 |
|---|---|---|
| **Minimum finance lease payments due:** | | |
| no later than one year | **534** | 371 |
| later than one year and no later than five years | **2,498** | 1,778 |
| later than five years | **153** | 294 |
| **Gross finance lease liabilities** | **3,185** | 2,443 |
| Finance charges allocated to future periods | **(295)** | (196) |
| **Net finance lease liabilities** | **2,890** | 2,247 |
| **Net finance lease liabilities are due:** | | |
| no later than one year | **459** | 322 |
| later than one year and no later than five years | **2,283** | 1,639 |
| later than five years | **148** | 286 |
| | **2,890** | 2,247 |

## 21 Provisions

### 21.1 Provision for liabilities and charges

| | Pensions - Other staff | Other Legal Claims | Other | Total as at 31 March 2018 | Total as at 31 March 2017 |
|---|---|---|---|---|---|
| | £ 000 | £ 000 | £ 000 | £ 000 | £ 000 |
| At 1 April | 795 | 57 | 2,170 | **3,022** | 4,796 |
| Change in the discount rate | 7 | - | 14 | **21** | 195 |
| Arising during the year | 28 | 32 | 800 | **860** | 1,410 |
| Utilised during the year | (60) | (5) | (485) | **(550)** | (305) |
| Reversed unused | (47) | (25) | (1,004) | **(1,076)** | (3,101) |
| Unwinding of discount | 2 | - | 2 | **4** | 27 |
| **At 31 March** | **725** | **59** | **1,497** | **2,281** | 3,022 |
| Expected timing of cash flows | | | | | |
| Within 1 year | 59 | 59 | 821 | **939** | 1,414 |
| Between 1 and 5 years | 233 | - | 155 | **388** | 447 |
| After 5 years | 433 | 0 | 521 | **954** | 1,161 |
| **Total** | **725** | **59** | **1,497** | **2,281** | 3,022 |

### 21.2 Current provisions

| | Total as at 31 March 2018 | Total as at 31 March 2017 |
|---|---|---|
| | £ 000 | £ 000 |
| Pensions - other staff | **59** | 62 |
| Other legal claims | **59** | 57 |
| Other | **821** | 1,295 |
| **At 31 March** | **939** | 1,414 |

### 21.3 Non-current provisions

| | | |
|---|---|---|
| Pensions - other staff | **666** | 733 |
| Other | **676** | 875 |
| **At 31 March** | **1,342** | 1,608 |

### 21.4 Clinical negligence liabilities

£74,070,000 is included in the provisions of the NHS Litigation Authority at 31 March 2018 (31 March 2017 - £68,150,000) in respect of clinical negligence liabilities of the Foundation Trust.

### 21.5 Contingent liabilities

The Trust has £49,000 of contingent liabilities at 31 March 2018 (31 March 2017 - £45,000) in respect of potential excess payments for NHS Litigation Authority claims for Public and Employer Liability claims outstanding where timing is expected to be within the next 12 months.

## 22 Revaluation reserve

| | Property, plant and equipment 2018 | Total 2018 | Property, plant and equipment 2017 | Total 2017 |
|---|---|---|---|---|
| | £ 000 | £ 000 | £ 000 | £ 000 |
| **At 1 April** | **2,843** | **2,843** | 2,689 | 2,689 |
| Impairments | **-** | **-** | 213 | 213 |
| Revaluations | **-** | **-** | (59) | (59) |
| **At 31 March** | **2,843** | **2,843** | 2,843 | 2,843 |

## 23 Financial instruments

### 23.1 Analysis of financial assets and liabilities by category

**Assets as per Statement of Financial Position**

| | Loans and receivables £ 000 | Total £ 000 |
|---|---|---|
| **Financial assets as at 31 March 2018** | | |
| NHS trade and other receivables excluding non financial assets | **2,578** | **2,578** |
| Non-NHS trade and other receivables excluding non financial assets | **7,855** | **7,855** |
| Cash and cash equivalents | **9,583** | **9,583** |
| NHS Charitable funds: financial assets | **4,119** | **4,119** |
| **Total financial assets as at 31 March 2018** | **24,135** | **24,135** |
| **Financial assets as at 31 March 2017** | | |
| NHS trade and other receivables excluding non financial assets | 3,126 | 3,126 |
| Non-NHS trade and other receivables excluding non financial assets | 10,382 | 10,382 |
| Cash and cash equivalents | 11,617 | 11,617 |
| NHS Charitable funds: financial assets | 4,282 | 4,282 |
| **Total financial assets as at 31 March 2017** | 29,406 | 29,406 |

£636,000 of impairment losses on loans and receivables (31 March 2017 - £838,000 loss) has been recognised within operating expenses during the year under the heading 'bad debts' within note 5.

| | Other financial liabilities £ 000 | Total £ 000 |
|---|---|---|
| **Liabilities as per Statement of Financial Position** | | |
| **Financial liabilities as at 31 March 2018** | | |
| Obligations under finance leases | **2,890** | **2,890** |
| NHS trade and other payables excluding non financial liabilities | **587** | **587** |
| Non-NHS trade and other payables excluding non financial liabilities | **13,302** | **13,302** |
| NHS Charitable funds | **100** | **100** |
| **Total financial liabilities as at 31 March 2018** | **16,879** | **16,879** |
| **Financial liabilities as at 31 March 2017** | | |
| Obligations under finance leases | 2,247 | 2,247 |
| NHS trade and other payables excluding non financial assets | 644 | 644 |
| Non-NHS trade and other payables excluding non financial assets | 11,841 | 11,841 |
| NHS Charitable funds | 264 | 264 |
| **Total financial liabilities as at 31 March 2017** | 14,996 | 14,996 |

### 23.2 Maturity of financial liabilities

| | As at 31 March 2018 £ 000 | As at 31 March 2017 £ 000 |
|---|---|---|
| **Financial liabilities maturing in** | | |
| one year or less | **14,419** | 13,064 |
| more than one year but not more than two years | **486** | 328 |
| more than two years but not more than five years | **1,825** | 1,318 |
| more than five years | **148** | 286 |
| | **16,878** | 14,996 |

## 23.3 Fair value of financial assets and liabilities

| | Book value as at 31 March 2018 £ 000 | Fair value as at 31 March 2018 £ 000 |
|---|---|---|
| **Financial assets** | | |
| NHS Charitable funds | **2,646** | **2,646** |
| **Total** | **2,646** | **2,646** |
| **Financial liabilities** | | |
| Non-current trade and other payables excluding non financial liabilities | **27** | **27** |
| Other | **2,431** | **2,431** |
| **Total** | **2,458** | **2,458** |

The fair value of financial assets and liabilities for the James Paget University Hospitals NHS Foundation Trust is not significantly different from the book value. The assets of the NHS Charity are held in listed securities and as such the market value can fluctuate causing variances between the book value and the fair value. The carrying values of other short-term receivables and payables are a reasonable approximation of the fair value.

The Trust has limited exposure to interest rate risk, currency risk, credit risk, liquidity risk, and other specific price risks, and therefore does not actively seek to manage risk in these areas.

# 24 Third party assets

The Foundation Trust held £4,000 cash at bank and in hand at 31 March 2017 (31 March 2017 - £1,000) which relates to monies held on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts. Gross inflows and outflows during the reporting period are £3,000 and £nil respectively (2016/17 - £nil and £2,000).

# 25 Financial commitments

## 25.1 Capital commitments

The Foundation Trust has £2,302,000 of contractual capital commitments as at 31 March 2018 mainly related to building schemes in progress (31 March 2017 - £102,000 mainly window replacements).

## 25.2 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements) during 2017/18 as follows, analysed by the period during which the commitment expires:

| | 2018 £ 000 |
|---|---|
| Expiry in less than one year | **2,203** |
| Expiry in more than one year but less than five years | **2,000** |
| Expiry in more than five years | **52** |
| **Total** | **4,255** |

# 26 Related party transactions

## 26.1 Key management personnel compensation

| | Year Ended 31st March 2018 £ 000 | Year Ended 31st March 2017 £ 000 |
|---|---|---|
| Salaries and other short term benefits | **1,339** | 1,330 |
| Post employment benefits | **95** | 90 |
| **Total** | **1,434** | 1,420 |

Key management personnel has been interpreted as all the executive, non-executive and non-voting directors of the Trust.

## 26.2 Related party payments, receipts and balances

During the year none of the Board members or members of the key management staff, or parties related to them, have undertaken any material transactions (other than employment benefits) with the James Paget University Hospitals NHS Foundation Trust.

All bodies within the scope of the Whole Government Accounts (WGA), including the James Paget University Hospitals NHS Foundation Trust are considered to be under the common control of the UK government, and are therefore considered to be related parties. Within the group structure of WGA, the immediate parent of the Trust is the Department of Health. The James Paget University Hospitals NHS Foundation Trust also acts as the corporate Trustee of the James Paget University Hospitals Charitable Fund and in accordance with the charity's declaration of trust, members of the Foundation Trust's Board of Directors act as ex-officio Trustees of the Charitable Funds. In accordance with note 1.2 the Charitable Fund has been consolidated into these group accounts and is therefore no longer reported as a related party. The values of transactions with these entities are detailed below:

| | **Payments 31st March 2018 £ 000** | Payments 31st March 2017 £ 000 | **Receipts 31st March 2018 £ 000** | Receipts 31st March 2017 £ 000 |
|---|---|---|---|---|
| Value of transactions with other related parties | | | | |
| Non-consolidated subsidiaries and associates / joint ventures | **23,606** | 21,977 | **279** | 216 |

| | **Amounts payable 31st March 2018 £ 000** | Amounts payable 31st March 2017 £ 000 | **Amounts receivable 31st March 2018 £ 000** | Amounts receivable 31st March 2017 £ 000 |
|---|---|---|---|---|
| Value of balances with other related parties | | | | |
| Non-consolidated subsidiaries and associates / joint ventures | **4,236** | 4,105 | **251** | 271 |
| Value of balances with related parties in relation to doubtful debts | - | - | **10** | 5 |

Paragraph 25 of IAS 24 allows entities which are related parties because they are under the same government control to reduce the volume of the detailed disclosures. The GAM interprets this such that DHSC group bodies must disclose the Department of Health and Social Care as the parent department and provide a note of the main entities within the public sector with which the body has had dealings, but that no information needs to be given about these transactions.
In line with this, these related parties notes only collect details of transactions and balances with bodies or persons outside of the whole of government accounts boundary.

## 27 Losses and special payments

| | **31 March 2018 Total no of cases Number** | **31 March 2018 Total value of cases £000's** | 31 March 2017 Total no of cases Number | 31 March 2017 Total value of cases £000's |
|---|---|---|---|---|
| **Losses:** | | | | |
| Losses of cash | **1** | **-** | - | - |
| Bad debts and claims abandoned | **12** | **-** | 51 | 3 |
| Damage to buildings, property etc. (including stores losses). | **1** | **5** | 1 | 20 |
| **Total Losses** | **14** | **5** | 52 | 23 |
| **Special Payments:** | | | | |
| Extra contractual to contractors | **1** | **3** | 1 | 6 |
| Ex gratia payments | **17** | **13** | 22 | 47 |
| Special Severance payments | **1** | **48** | - | - |
| **Total Special Payments** | **19** | **64** | 23 | 53 |
| **Total losses and special payments** | **33** | **69** | 75 | 76 |

## 28 Charitable Funds summary statements 2017/18

### 28.1 Summary Statement of Financial Activities

| | IFRS Year Ended 31 March 2018 £ 000 | Charity Consolidation Eliminations* | Year Ended 31 March 2018 £ 000 |
|---|---|---|---|
| Incoming Resources: excluding investment income | **1,345** | - | **1,345** |
| **Total operating income** | **1,345** | - | **1,345** |
| Employee benefits: | | | |
| - expended with the Foundation Trust | **(119)** | 119 | **-** |
| Other resources expended | | | |
| - with the Foundation Trust | **(1,194)** | 729 | **(465)** |
| - with bodies outside the NHS | **(307)** | - | **(307)** |
| - audit fee (payable to the external auditor) | **(5)** | - | **(5)** |
| **Total operating expenditure** | **(1,625)** | 848 | **(777)** |
| Incoming Resources: investment income | **107** | - | **107** |
| **Net (outgoing) / incoming resources before other recognised gains and losses** | **(173)** | 848 | **675** |
| Fair value gains / (losses) on investment assets | **(36)** | - | **(36)** |
| **Net Movement in funds** | **(209)** | 848 | **639** |

### 28.2 Summary Balance Sheet

| | | | |
|---|---|---|---|
| **Non-current assets** | | | |
| Other Investments | **3,200** | - | **3,200** |
| **Total non-current assets** | **3,200** | - | **3,200** |
| **Current assets** | | | |
| Trade and other receivables | **35** | - | **35** |
| Cash and cash equivalents | **890** | - | **890** |
| **Total current assets** | **925** | - | **925** |
| **Current liabilities** | | | |
| Trade and other payables | **(424)** | 322 | **(102)** |
| **Total current liabilities** | **(424)** | 322 | **(102)** |
| **Net assets** | **3,701** | 322 | **4,023** |
| **Funds of the charity** | | | |
| **Restricted funds:** | **183** | - | **183** |
| **Unrestricted funds:** | | | |
| Unrestricted income funds | **2,964** | - | **2,964** |
| Revaluation reserve | **554** | - | **554** |
| **Total Charitable Funds** | **3,701** | - | **3,701** |

Charitable Funds are presented under UK GAAP and are consistent with SORP 2015. In restating the charity accounts to be consistent with the IFRS based accounting policies of the Foundation Trust, the commitments accrual of £776,000 (2016/17 £672,000) reported under UK GAAP has been removed. The separate accounts of the Charity can be found on the Charity Commission website.

* Consolidation eliminations illustrate the impact on the balances of the group accounts, and do not impact on the underlying performance of the Charitable Fund which retains a movement in funds of (£330,000), and net assets of £2,926,000.

## 29 Charitable Funds summary statements 2016/17

### 29.1 Summary Statement of Financial Activities

| | IFRS Year Ended 31 March 2017 £ 000 | Charity Consolidation Eliminations* | Year Ended 31 March 2017 £ 000 |
|---|---|---|---|
| Incoming Resources: excluding investment income | **1,325** | - | **1,325** |
| **Total operating income** | **1,325** | - | **1,325** |
| Employee benefits: | | | |
| - expended with the Foundation Trust | **(119)** | 119 | **-** |
| Other resources expended | | | |
| - with the Foundation Trust | **(1,079)** | 1,079 | **-** |
| - with bodies outside the NHS | **(272)** | - | **(272)** |
| - audit fee (payable to the external auditor) | **(5)** | - | **(5)** |
| **Total operating expenditure** | **(1,475)** | 1,198 | **(277)** |
| Incoming Resources: investment income | **94** | - | **94** |
| **Net (outgoing) / incoming resources before other recognised gains and losses** | **(56)** | 1,198 | **1,142** |
| Fair value gains / (losses) on investment assets | **363** | - | **363** |
| **Net Movement in funds** | **307** | 1,198 | **1,505** |

### 29.2 Summary Balance Sheet

| | | | |
|---|---|---|---|
| **Non-current assets** | | | |
| Other Investments | **3,151** | - | **3,151** |
| **Total non-current assets** | **3,151** | - | **3,151** |
| **Current assets** | | | |
| Trade and other receivables | **40** | - | **40** |
| Cash and cash equivalents | **1,101** | - | **1,101** |
| **Total current assets** | **1,141** | - | **1,141** |
| **Current liabilities** | | | |
| Trade and other payables | **(382)** | 94 | **(288)** |
| **Total current liabilities** | **(382)** | 94 | **(288)** |
| **Net assets** | **3,910** | 94 | **4,004** |
| **Funds of the charity** | | | |
| **Restricted funds:** | **244** | - | **244** |
| **Unrestricted funds:** | | | |
| Unrestricted income funds | **2,925** | - | **2,925** |
| Revaluation reserve | **741** | - | **741** |
| **Total Charitable Funds** | **3,910** | - | **3,910** |

Charitable Funds are presented under UK GAAP and are consistent with SORP 2015. In restating the charity accounts to be consistent with the IFRS based accounting policies of the Foundation Trust, the commitments accrual of £672,000 (2015/16 £729,000) reported under UK GAAP has been removed. The separate accounts of the Charity can be found on the Charity Commission website.

* Consolidation eliminations illustrate the impact on the balances of the group accounts, and do not impact on the underlying performance of the Charitable Fund which retains a movement in funds of (£364,000), and net assets of £3,255,000.